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"No Health in High Politics: The Failure to Sustain Primary Health Care in India and Nigeria"

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Contents

Abstract

Health matters rarely reach prominence in high politics (pertaining to matters that are considered to influence the existence of the state) - and when they do, they are overwhelmingly global health emergencies. This has clearly had a trackable impact on domestic primary health policy in the developing world over time - but where does this sidelining of everyday health at nearly all levels of analysis come from? This thesis sorts and analyzes the factors that underpin the failure of primary health care (PHC) in the context of otherwise rapidly developing Lower Middle Income Countries to answer this question. Despite a global promise to support health in the 1946 WHO Constitution and an early interest in sustaining efficacious PHC in the developing world with the Alma-Ata Declaration of 1978, global health policy has lacked the imperative to actualize change on the national level. To illustrate this, a big-picture analysis will distinguish between high and low politics regarding health using examples, shedding light on the potential external or supranational reasons for the continued sidelining of PHC development. Subsequently, case studies of India and Nigeria will clarify how these external inputs, or "upstream contexts" play out (and are indeed mirrored) on the domestic level. Through this analysis, this thesis draws One main conclusion for both levels of analysis. First, the supranational "distraction" from PHC has been ongoing - where Cold War security concerns marked the beginning of this narrative, neoliberal market orientation more recently maintained dominance in developmental discourse - the influence of which is still felt today. The second conclusion relates to the case studies: in both cases, imposed or adopted security-oriented (and then) neoliberal development norms prolonged the underdeveloped nature of very vertical national health policy. Only recently have initiatives been established in India (and to a lesser extent in Nigeria) which seek to (1) reverse some imbalances generated in the era of neoliberal intensification and (2) draw PHC into the realm of high politics through horizontality rather than verticality. That is: the acknowledgement that health matters and financial and/or security matters must be handled evenly, as they are interconnected.

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Gesundheitsthemen geraten selten in den Vordergrund der „hohen Politik" (also Themen, von denen angenommen wird, dass sie Einfluss auf die Existenz eines Staates haben) – und wenn doch, dann handelt es sich überwiegend um globale Gesundheitsnotfälle statt Alltagsgesundheit. Trotz eines globalen Versprechens zur Förderung der Gesundheit in der WHO-Verfassung von 1946 und eines frühen Interesses an der Aufrechterhaltung einer wirksamen primären Gesundheitsversorgung in Entwicklungsländern durch der Alma-Ata-Erklärung von 1978 scheint die wahrgenommene Bedeutung von PHC auf internationaler und nationaler Ebene im Vergleich zu Aspekten wie Sicherheit und Wirtschaft immer noch gering zu sein. Dieses Fehlen der primären Gesundheitsversorgung (engl. PHC) in der hohen Politik hat sich im Laufe der Zeit eindeutig auf die nationale PHC in den Entwicklungsländern ausgewirkt - aber woher kommt diese Ausgrenzung der Alltagsgesundheit in nationalem sowie internationalem Diskurs? Diese These verschafft Einblick in diese Frage durch eine sorgfältige Analyse und Einordnung der Faktoren, die dem Scheitern der PHC im Kontext der sich ansonsten schnell entwickelnden Länder mit niedrigem mittlerem Einkommen (engl. LMICs) zugrunde liegen. Um dies zu veranschaulichen, wird eine umfassende Analyse anhand von

Beispielen zwischen „hoher“ und „niedriger“ Politik unterscheiden und mögliche externe oder supranationale Gründe für die anhaltende Verdrängung der PHC-Entwicklung beleuchten. Anschließend werden Fallstudien aus Indien und Nigeria klären, wie sich diese externen Inputs oder „Upstream-Kontexte“ (*Upstream Contexts*) auf der inländischen Ebene auswirken und tatsächlich widergespiegelt werden. Durch diese Analyse zieht diese These eine Hauptschlussfolgerung für beide Analyseebenen. Erstens bleibt die supranationale „Ablenkung“ von PHC bestehen: Während Sicherheitsbedenken des Kalten Krieges den Anfang dieses Narrativs bildeten, dominiert bis vor kurzem Zeit die neoliberale Marktorientierung im Entwicklungsdiskurs – deren Einfluss bis heute spürbar ist. Die zweite Schlussfolgerung bezieht sich auf die Fallstudien: In beiden Fällen verlängerten auferlegte oder freiwillig übernommene sicherheitsorientierte (und dann) neoliberale Entwicklungsnormen den unterentwickelten Charakter einer sehr vertikalen nationalen Gesundheitspolitik. Erst kürzlich wurden in Indien (und in geringerem Maße auch in Nigeria) Initiativen gegründet, die darauf abzielen, (1) einige im Zeitalter der neoliberalen Intensivierung entstandene Ungleichgewichte umzukehren und (2) PHC durch Horizontalität statt Vertikalität (d.h. die Anerkennung, dass Gesundheitsfragen und Finanz- und/oder Sicherheitsfragen gleichberechtigt behandelt werden müssen, da sie miteinander verbunden sind) in den Bereich der hohen Politik und deswegen ins Bewusstsein zu bringen.

Keywords: global health policy, primary health care (PHC), India, Nigeria, high politics, neoliberalism, horizontality

On my honour as a student of the Diplomatische Akademie Wien, I submit this work in good faith and pledge that I have neither given nor received unauthorized assistance on it.

Acronyms and Abbreviations			
NTD	Neglected Tropical Disease	**NHMIS**	National Health Management Information System
OPP	Out of Pocket Payment	**WDC**	Ward Development Committee
CDP	Community Development Programme	**LMIC**	Low- or Middle-Income Country
NRHM	National Rural Health Mission	**LIC**	Low Income country
CHC	Community Health Centre	**HIC**	High Income Country
NH	Narayana Hrudalaya	**FCTC**	Framework Convention on Tobacco Control (WHO)
ABP	Ayushman Bharat Program	**PEPFAR**	President's Emergency Plan For AIDS Relief
HWC	Health and Wellness Centre	**IHR**	International Health Regulations
AB-HWC	Ayushman Bharat Health and Wellness Centre	**SAP**	Structural Adjustment Plan
BHSS	Basic Health Services Scheme	**DAH**	Development Assistance for Health
LGA	Local Government Area	**ODA**	Official Development Assistance (OECD)
NPHCDA	National Primary Healthcare Development Agency	**IFC**	International Finance Corporation
WHS	Ward Health System	**TRIPS**	Agreement on Trade-Related Aspects of Intellectual Property Rights
WMHCP	Ward Minimum Health Care Package	**IP**	Intellectual Property

Figure I[1]

[1] Figure I: These acronyms and abbreviations related to health matters and country classifications will appear in the thesis. They will also be defined in-text.

Introduction

Background and Research Question

From the 6th to the 12th of September of 1978, world leaders gathered in Alma-Ata, now known as Almaty, the capitol of the Kazakh Soviet Socialist Republic (now Kazakhstan), to discuss and establish general agreements on an issue vital to the continued development and prosperity of mankind. For these fleeting 6 days, deep in the heart of a developing country resting on the margins of international concern, leaders attending this conference were able to temporarily block out the ever-present hum of the Cold War, a decades-long source of tension that had established itself at the top of all prominent international agendas. War was far from the minds of the representatives in Alma-Ata that week. A deeper human concern faced them, yet, due to its lack of immediacy and the long-established norms of national sovereignty and responsibility on the subject, it remained obscured on the global stage. This, the long-term, deep-seated problem to be addressed in Alma-Ata, was rooted in the perception that, without this *one* thing, this *one* element of humanity, development on all levels would cease to occur. This problem was accessible healthcare – or more accurately, the lack thereof on a global scale.

The consensus which emerged from this conference, the Alma-Ata Declaration, established agreement among signatories that good health was a human right, and that health did not simply mean "the absence of disease or infirmity."[2] They also agreed that enabling certain types of healthcare would enhance all states' abilities to protect this human right. The WHO had officially codified such sentiment in its constitution of 1946, but those present at Alma-Ata understood that this initial vision, along with notions of health as a concept worthy of high politics had been replaced by securitized discourse following building Cold War tensions.[3] In the Alma-Ata Declaration, one type of healthcare of central importance was primary healthcare (PHC). Under section VI of the declaration, PHC is defined as "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of selfreliance and self-determination."[4] The declaration was intended to enhance and uphold efforts not dissimilar to the contemporary Sustainable Development Goal (SDG) #3 – to provide access to safe food and water, sanitation,

[2] World Health Organization, "Declaration of Alma-Ata." p.1
[3] World Health Organization, "Constitution of the World Health Organization," preamble, Article 2: *Functions*.
[4] World Health Organization, "Declaration of Alma-Ata." p.2

education on health, to prevent local diseases, enable widespread immunization and reduce maternal and child mortality.[5] Underpinning these valiant aims would (ideally) be strong political support from national governments related to public prioritization, funding, and policymaking.[6] These ideals would, according to the declaration, be implemented and finetuned until the year 2000, by which time it was envisioned that a most everyday health concerns plaguing the world at the end of the 1970s, far from remaining active problems, would have become mere lessons from the past.

While there has been a revival in concerns related to health in international relations during the height of Covid-19, matters related to global standards of health – especially *non-emergency,* or everyday health – have continued to go unprioritized in mainstream and indeed *upstream* international relations discourse. This is significant not only for developed countries with institutionalized private healthcare and growing societal inequalities, but also overwhelmingly for developing countries, which bear a significant degree of the world's burden of (preventable) disease *on top* of contending with similar societal inequalities. The overarching goal of the Alma-Ata Conference (hereafter simply Alma-Ata) was to enhance the prospects of development through health, yet many signatories to the convention remain lower-income countries (LICs) and struggle to publicly support health in their states, provinces, towns, and villages. Thus, this thesis will set out not only to investigate why the PHC goals outlined in sections V, VIII (3), (7) and VIII of the Declaration of Alma-Ata have gone largely unfulfilled from a global perspective – but also, more specifically, why domestic PHC policy has failed in rapidly growing and developing countries like India and Nigeria. Even though overarching reasons for PHC failure differ from country to country, the findings of this thesis will indicate some commonalities which may be more frequently observed in the context of the context of lower middle income countries (LMICs), should further research be conducted in this area.

Outline

This thesis is divided into to six chapters which could include subchapters. The introductory chapter will include subchapters for relevant background information, literature review, and methodology. In these subchapters, a research question will be set, the problems with PHC coverage defined, and the core resources described. There will also be an indication

[5] World Health Organization, "Declaration of Alma-Ata." p.2
[6] Ibid.

of the shortfalls of existing research, as well as a description of the research method. The following chapter, titled "Theory – "Upstream Contexts" will provide an overview of existing public health theories and their potential connections to two prominent constructive elements of international relations – power, development, and economics. This will be followed by the third chapter, on hypotheses, which are believed to be applicable to *any* LMIC with similar characteristics as the chosen case study countries. These characteristics will also be described. Both case studies will have their own chapter. India will be the first case study presented, as its PHC situation (as it relates to development, for example) has been more extensively studied than that of Nigeria. Each case study chapter will include the relevant historical background necessary to understand the development and failure of PHC in each context. This will precede a description of the historical, post-colonial PHC system. This subchapter will be followed in each case by a description of the contemporary PHC system, followed by a final subchapter on potential solutions – and in the case of India, existing examples of success. Analysis will occur throughout each chapter and will be expanded upon for the final thesis. The concluding chapter will again connect the findings from the case studies to the hypotheses and offer suggestions as to future research.

Theory – "Upstream Contexts"

Literature Review

Resources for this thesis include medical journals, UN documents, surveys, statistical studies and academic articles with a political focus. Chapters from *The Oxford Handbook of Global Health Politics* will provide insights on the bridges that could exist between typical international relations theories and health policy discourse. A varied collection such as this ensures that certain gaps in existing scholarship can be filled, and hypotheses can be sorted, and their likelihood gauged. An element inherent to the concepts outlined in this thesis is time. Thus, articles and very recent resources (2022) to quite dated (1982 and prior) will contribute to the conclusions drawn in this thesis.[7] This research format will enable a clearer timeline in each case study to emerge. General periods or stages can be established by tracing the start and end of various time-bound development plans which occurred both in India and Nigeria. No piece of literature found has provided a timeline specific to the development of PHC as it relates

[7] Deodhar, "Primary Health Care in India." and Lahariya, "Health & Wellness Centers to Strengthen Primary Health Care in India: Concept, Progress and Ways Forward."

to political changes or economic development – most often, the contents of two or more articles must be combined to yield a full picture from multiple angles.[8] Additionally, in the Indian case, no article (as yet) has covered the complete time period in which PHC emerged as a solution and was developed into its present state (from 1946 onwards), though some articles have provided an abridged account of the early development of the PHC movement on the global level.[9] Generally, the contents of three or four articles can be combined in each case study to sketch out a complete timeline.

In short, existing literature offers plenty of scattered hypotheses, but very few combine all elements (the political, the epidemiological and the societal) which are considered prominent in this thesis. Country-specific literature offers hints, but no concrete method with which to sort its hypotheses by impact or by cause or effect. In the case of resources which analyze health on the global level, concrete ties to economic and political theory *have* been made.[10] Yet many of these provide only general overviews of the ways *regions* might interact with global health policy, rather than a deep insight into a specific country's involvement in global health. Additionally, in articles *not* intending to explain overarching failure of PHC, but instead focusing on narrower local or even national elements, certain assumptions are made about the cause of PHC failure without always providing analysis explaining why this is the case.[11] The implied conclusions of these kinds of articles can be called "symptom hypotheses." These assume that PHC failure can be implicitly blamed on factors that, after closer inspection, do not appear to be root causes. These 'symptom' factors appear to worsen the PHC outlook significantly enough in the short-term to be mistaken as root causes – a conclusion this thesis will attempt to challenge.

While all literature agrees that PHC initiatives in both case study countries have fallen short of the ideal, and some papers overlap in their answers, a macro-analysis which could tie all reasonable arguments together seems to be missing. After extensive statistical reporting or qualitative analysis, authors appear content to assert that all problems mentioned are of equal

[8] Nundy, "Primary Health Care in India: Review of Policy, Plan and Committee Reports" and Lahariya, "Health & Wellness Centers to Strengthen Primary Health Care in India." and Deodhar, "Primary Health Care in India."

[9] Benatar, Sanders and Gill, "The Global politics of Healthcare Reform" p.449-453

[10] Huang, "Emerging Powers and Global Health Governance: The Case of BRICS" and Harmer, and Kennedy, "Global health and International Development"

[11] Aregbeshola, and Khan. "Primary Health Care in Nigeria: 24 Years after Olikoye Ransome-Kuti's Leadership." and Pandve and Pandve. "Primary Healthcare System in India: Evolution and Challenges."

strength – or more confusingly in limited cases, that one problem alone is responsible.[12] This thesis will not generate completely new causes for failure but will instead organize existing theories not only by their strength (or verity), but by their position in the chain of cause and effect. Every anchoring aspect of this thesis – Alma-Ata, PHC, global health policy, the developing context – has been written about before, but these aspects have seldom been combined to reflect how failures on the national level are indicative of greater structures in global health prioritization and policymaking.

Health as a concept struggles to find and maintain a place in international relations discourse. In questioning why this has been the case, scholars have pointed out that any international talking point will find itself in one or two broad categories: 'low' or 'high' politics.[13] Whereas security and economic concerns make up a majority of "high politics," cultural and health affairs are relegated to 'low politics" – a category whose title even suggests a lack of urgency or consequence. This has resulted in a scholarly gap in literature on either the nexus of health and high politics, or health *in* high politics, but has also influenced the existing body of literature on health policy; overwhelmingly, analyses of global health politics are framed in terms of power or economics.

This is telling – health may not stand on its own as a category in international discourse – yet, given its securitization or its commodification, there is strength enough to the argument that health is capable of being a concern of high politics. The problem, however, is that emergency, rather than everyday health concerns fit much more cleanly into the securitized discourse of mainstream international relations, which normalizes the focus on solving immediate, short-term health problems rather than considering systemic changes to solve long-term health policy problems. Ultimately, "scholarship in [the area of health inequalities] has struggled to systematically study the upstream and social, political, and economic contexts within which health inequalities are produced and perpetuated," a failure which this thesis will attempt to address.[14] These "upstream contexts" – often deeply linked to notions of "high

[12] Aigbiremolen, Alenoghena, Eboreime et.al., "Primary Health Care in Nigeria: From Conceptualization to Implementation" deems the biggest problem in Nigeria to be low political engagement, yet also seems to hint at other causes (like bottom-up engagement and horizontality) while electing to leave them unexplored.

[13] Kornprobst and Strobl. "Global health: an order struggling to keep up with globalization." p.28

[14] Shawar and Ruger, "The Politics of Global Health Inequalities: Approaches to Studying the Role of Power" p.61 and Benatar, Sanders and Gill, "The Global politics of Healthcare Reform" p.459:
Health policy discourse does not often rest long upon what Benatar et.al. call "upstream causal forces" of malfunctioning health systems, since immediate health concerns and causes of poor health can (perhaps) be easily and publicly solved with panache. Shawar and Ruger argue that the "largely ignored causes of poor health and disease are ultimately rooted in social determinants (political and economic forces) that differentially impact people's lives locally and globally. . . . Upstream causal

politics," include IR theories on power and security and neoliberal economic theory and the ideas behind development and have been used as the foundations from which hypotheses in this thesis will be developed.

Power and the Securitization of Health

A typical marker of IR theories is the discussion of power. Power is often considered the result of financial or material prosperity, and something that, if obtained, negatively impacts the financial or material prosperity of others. Working from this basic (and even contested) definition, health and its policy can be influenced by power, which can come from the international system, the state, or even the "mandate, charisma, moral authority or technical expertise" of individuals.[15] In more concrete terms, an example of power in health policy could be that health ministers who represent states at the international level rarely have a significant enough degree of domestic political power to sway officials also tasked with maintaining national security or infrastructure in the direction of improving national health policy.[16] Such a pattern could partially account for the widespread failure to implement all agreed-upon points of the Alma-Ata Declaration.

Power has also been categorized to better explain its impact on health matters. For example, one article explains the difference between compulsory and institutional power. In the former, "the direct control of one actor over the conditions of existence and/or the actions of another," which brings to mind instances of a high income country (HIC) gaining power over an LMIC bilaterally through development aid.[17] The latter "concerns an 'actors' indirect control over the conditions of action of a socially distant 'other,'" like policies of structural adjustment handed down to LMICs from the World Bank or the International Monetary Fund.[18] Both of these definitions of power play out on the global level, and are not necessarily limited to issues of global health crises or panics, revealing their relevance to PHC.

In a globalized world, a health threat *somewhere* becomes a health threat *everywhere* almost overnight if no security measures are taken.[19] The "medicalisation of security"

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forces include the structure of the global political economy; corruption; . . . demographic changes resulting from wars, refugees, and ageing populations."

[15] Shawar and Ruger, "The Politics of Global Health Inequalities" p.73: This form of power is only analyzed to a limited extent in mainstream IR theories on power.

[16] Schrecker, "The State and Global Health" p.280

[17] Shawar and Ruger, "The Politics of Global Health Inequalities" p.74: though compulsory power can also be seen in aid sent from one LMIC to another, as could be the case in India, given the country's engagement with bilateral international health funding (see page X)

[18] Ibid. p,74

[19] Rushton, "Security and Health," p.125

references a mindset shift HICs which places health risks – especially those posed by emerging infectious diseases like neglected tropical diseases (NTDs), HIV/AIDS, bioterrorism and antimicrobial resistant strains – at the center of policy decision-making.[20] It must be said that in those situations where a health concern poses a legitimate threat to a significant global (or even domestic) population, the securitization of health is an advantage if managed correctly. It has allowed states to draw up preparation plans and enact practice-runs of disaster preparedness programs "in normal times."[21] The focus on health emergencies has also shown states the importance of developing, and in some cases stockpiling, valuable resources to combat an acute health event, should it occur.

At the root of such action is the elevation of health matters from the realm of low politics to high politics, which seems like an objectively good thing. Yet opportunity costs must be considered. In the case of some states, developing sufficient stockpiles of medications, PPE, vaccines, and other health materials could lessen the effectiveness of the everyday health system. The allocation of financial support to efforts aimed at preventing the next big outbreak of *something* could strip funding from "other health areas where urgent needs exist," in LMICs, like the perpetual battle against infant and maternal mortality, or the pursuit of comprehensive childhood vaccination.[22] Perhaps these other urgent areas, if left unaddressed, could be the *cause* of the next outbreak event. Thus, a balance must be met in the securitization of health, and it must not reach the point where everyday health matters are ignored in the interest of staving off a *potential* – that is, uncertain – future threat.

When the securitization of health met (both compulsory and institutional) power, a new global health paradigm emerged. The US pioneered *global* efforts to "defeat" HIV/AIDS near the turn of the century, and the initial aim, given that AIDS was already present and prevalent in the US, was to stabilize the political situation in other countries – namely, LMICs and what global health crisis scholar Simon Rushton calls "next wave states" like India and China, which were considered to be pioneers in industry as well as cornerstones of regional security, and could have plenty to offer the US economy if allowed to flourish.[23] The problem with such efforts was tunnel vision: the cacophonous urgency in discourse on health crises like HIV/AIDS, but also Malaria and even SARS, would drown out the calls from LMICs for help with their PHC systems.

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[20] Rushton, "Security and Health," p.126 quoted from Elbe, Stefan, *Security and Global Health* 2010, and Aginam, Obijiofor, "The Global Politics of Neglected Tropical Diseases" pp. 574 – 577

[21] Rushton, "Security and Health," p.132

[22] Ibid. p.137

[23] Ibid. p.129

The PHC movement that erupted in the 1970s was most ardently supported by those in the nonaligned movement (given the Cold War context) but also among left-leaning or socialist-friendly states, which arguably meant that PHC, from the outset, stood on shaky ground among Western powers, despite overwhelming initial support of it as a concept by the WHO.[24] In the West, "business power" and the influence of the business sector on politics and public policy decisions was on the rise, and would ultimately result in a significant shift in the global economic outlook of the next decades.[25] For power and securitization to change the direction of global health discourse – and therefore of health policies applied to *and by* LMICs, another ingredient was needed: economic change.

The Rise of Neoliberalism and the Sidelining of Primary Health

Alma-Ata 1978 was considered "radical" as it occurred after many former colonies had freshly joined the UN system and argued that primary healthcare, rather than *only* economic restructuring, a primary focus of the "developed world" at the time, was integral to the rise of the "developing world."[26] While true that the WHO and its members were generally enthusiastic about Alma-Ata, the US was decidedly cool toward the PHC movement – most probably due to the involvement of many countries that *could have* represented a rise in the global influence of socialist policies in the Cold War period (including many LMICs). The US, along with its World Health Assembly allies, pulled its funding from the WHO in the aftermath of the Alma-Ata Declaration. The loss of the US (and US institutions) as a primary funder allowed remaining funders to have more influence on the WHO. At the same time, the IMF and the World Bank, two US-based international organizations, were growing in influence – and since voting privileges in these institutions depended on the value of contributions, the US was able to somewhat circumvent the WHO with its own Structural Adjustment Plan (SAP) development initiatives – few of which were health-focused.[27]

The term "development" in international relations suggests growth for the better, but one must ask – to whose benefit? Global health policy scholars Andrew Harmer and Jonathan Kennedy posit that there are two overarching types of development: immanent or unintentional, and planned or intentional.[28] It is this second category which has had the more decisive impact

[24] Benatar, Sanders and Gill, "The Global politics of Healthcare Reform" p.449
[25] Shawar and Ruger, "The Politics of Global Health Inequalities" p.65 quoted from Chernomas, Robert and Ian Hudson, *Social Murder: And Other Shortcomings of Conservative Economics"* 2007
[26] Harmer, and Kennedy, "Global health and International Development" p.225
[27] Ibid.
[28] Harmer, and Kennedy, "Global health and International Development" p.217

on national and global health – arguably since the industrial revolution. Presently, planned development has taken the form of the Sustainable Development Goals. But in the early 1980s, Western influences, spearheaded by the US and emboldened by a Cold War "victory," devised a new plan by which economic trajectories everywhere could be changed and streamlined – all in the interest of promoting Western-style development.[29] Pro-market ideologies took hold in the "developed world" in the beginning of the 20th century and were spearheaded in the US and UK – both highly influential countries in India and Nigeria – at around the same time, suggesting that these HIC-endorsed economic policy structures would come to play a greater role in international relations.

The Washington Consensus, a series of 10 economic policy steps that closely mirrored the configuration of the US-based IMF and the World Bank, served as a vehicle by which neoliberal ideas could be exported to countries that sought their own economic prosperity and even economic independence from their immediate neighbors. The idea was as follows: given the implementation of neoliberalism through the 10 Washington Consensus points, these countries could grow and produce as the US did. In this era of trickle-down economics, the misguided idea of trickle-down health would emerge.[30]

Along with the normalization of neoliberalism came the normalization of *privatized healthcare* and the idea of "user fees" – these being more commonly known as out-of-pocket payments (OPPs). Now it is known that OPPs have *lessened* access to healthcare – but at a time in which ideas of full market freedoms and meritocracy were supported by individuals and governments alike, the widespread narrative indicated that something of a higher cost – even healthcare –must be of higher quality.[31] Privatization efforts and the imposition of ever-higher private fees did not merely spring from individual countries' internal policies. Along with displaying clear indications of neoliberal ideological underpinnings, donor countries *as well as donor NGOs* were very quick to support these changes in health systems in tandem with other development and adjustment plans in the business sector. One scholar even calls this overwhelming shift toward top-down supported privatization "programmatic neoliberal blindness."[32]

Structural Adjustment Programs devised through the IMF and World Bank and heavily backed by the US included the Development Assistance for Health (DAH). The DAH has since

[29] Harmer, and Kennedy, "Global health and International Development" p.217
[30] Ibid. p.220
[31] Ibid. p.222
[32] Harmer, and Kennedy, "Global health and International Development" p.222, quoted from Keshavjee, Salmaan, *Blind Spot: How Neoliberalism Infiltrated Global Health,* 2014 p.15

receded from prominence in international health financing, eventually overshadowed by the normalization of significant development funding coming from wealthy families and even individuals, as showcased by the Bill and Melinda Gates Foundation (and the contributions made by Warren Buffet). But in the 1990s, DAH served as a signal of sorts by which other HICs could determine the direction and volume of their own health aid based upon what was considered most urgent or most politically influential – usually health crises.[33]

In the 25 years since the conception of the Washington Consensus and the prominence of funding and aid from the IMF and World Bank, the development in LMICs had in fact *slowed* – especially in key areas related to health like infant and child mortality.[34] The Enough time has passed that important studies were able to be conducted on the effect of SAPs and development programs that aligned with neoliberal norms. In several African countries, the life expectancy sank by between 5 and more than 10 years from 1980 to the early 2000s. It was also discovered that healthcare expenditure in these areas *dropped* as much as 20%.[35] In 2010, it was found that "for every US$1 of DAH given to a government, government health expenditures from domestic resources fell by between $0.43 and $1.14."[36] The hypothesis which followed suggested that the receiving governments tended to reallocate their donated funds to other areas – though this is hardly the root of the problem, say Harmer and Kennedy. Instead, the underspending in health being vastly overshadowed by the (up to) US$2.6 trillion *escaping* LMICs in development and health aid is the far greater issue.[37] A 2017 study of 2012-2016 data concluded that, while development aid assistance for health appeared significant at $128 billion, it only covered 29% of aid given to LMICs – and only a *microscopic* 0.02% of that 29% went towards general health.[38] More startlingly, the same study concluded that as much as $5 trillion *left* LMICs in 2012 with a significant chunk of this outflow falling into the category of interest on debt repayment and payments to foreign patent holders. Harmer and Kennedy comment on this imbalance capital flow: "with one hand, wealthy donors give a tiny amount of money to help poor countries improve the health of their populations; with the other, the very same donors take an almost incomprehensibly large amount of money out of those

[33] Harmer, and Kennedy, "Global health and International Development" p.225
[34] Ibid. p.221
[35] Ibid., quoted from Stein in Rowden, Rick. *The Deadly Ideas of Neoliberalism,* 2009 pp.154, 155
[36] Ibid. p.226
[37] LMICs have started to participate in the development aid funding and donation structure *as donors* while still experiencing widespread ineffectiveness in their domestic health systems.
[38] Harmer, and Kennedy, "Global health and International Development" p.225 featuring data from Hickel, Jason, *The Divide: A Brief Guide to Global Inequality and its Solutions,* 2017

poor countries' economies" leaving them even less able to resolve their domestic PHC concerns.[39]

A Closer Look at Debt Trap Diplomacy as a Hinderance to PHC

During industrialization in the mid-19th century, the massive inequalities that stemmed from societies recast along lines of an owning minority and a working majority also translated to health prospects. Low wages and crowded and unsanitary living conditions drove *down* life expectancies in industrial forerunners like the United Kingdom, setting the precedent that industrial development necessitated some degree of abandonment of everyday health.[40] These industrial norms would then be implanted into the colonies. The "reversal of fortune" of the colonial era also saw the decline in previously advanced societies in East and South Asia, Africa, the Middle East, and Latin America. This economic theory pioneered by economist Daron Acemoğlu, indicates that industrializing nations initially chose colonies based on their existing levels of natural resources, geography, or labor power – and that these nations, previously rather prosperous in the pre-industrial world, have become today's LMICs.[41]

In 1970s, economic crises swept the globe, and LMICs often had very little in the way of financial stability, necessitating them to take out loans provided by HICs. These loans were, as their very name suggests, not donations: in exchange for providing financial support to a high-risk borrower like an LMIC, that LMIC would have to promise (and implement) any chosen financial or 'structural adjustment reforms' - more often than not, these reforms were intended to be copy-pasted versions of plans which had made HICs prosperous *in a world where no state had previously become prosperous through these methods*.[42] Even in 2005, advisors to the UN were already aware that investments in and donations to LMICs regarding health were a double-edged sword:

> "[D]ozens of heavily indebted poor and middle-income countries are forced by creditor governments to spend large parts of their limited tax receipts on debt service, undermining their ability to finance investments in human capital and infrastructure. In a pointless and debilitating churning of resources, the creditors

[39] Harmer, and Kennedy, "Global health and International Development" p. 225
[40] Ibid. p.219
[41] Acemoglu, Johnson, and Robinson, "Reversal of Fortune: Geography and Institutions in the Making of the Modern World Income Distribution," p. 2, 4, 14-20
[42] Benatar, Sanders and Gill, "The Global politics of Healthcare Reform" p.448

> provide development assistance with one hand and then withdraw it in debt servicing with the other."[43]

Today, donors to LMICs may have close relationships with heads of state or governments, perhaps due to technocratic expertise and finance. This not only leads to a situation in which domestic elites are the sole handlers of funding, but also that this funding is likely *never* to "trickle down" as such donor programs initially intended, to the most in-need population and allows "political executives [to] circumvent many routes of domestic political accountability."[44]

It is widely known that LMICs carry an outsized degree of the world's disease burden, a chicken-and-egg problem which sees inadequate social and political institutions and high rates of transmissible infectious diseases both seemingly worsening the situation of the other. In the early years of the global neoliberal shift, funding in LMICs took the form of "World Bank . . . loans and credits and . . . earmarked support . . . from bilateral donors for vertical projects or programmes," like the US' PEPFAR initiative against HIV/AIDS.[45] This preoccupation with health crises – notably outbreaks of Ebola, HIV/AIDS and Malaria – has led the domestic health systems in LMICs to be overwhelmingly "vertical" in nature – that is, "disease-focused and defined" rather than primarily devoted to everyday care, like pediatric check-ups, eye exams, or even the identification and management of chronic pain.

"Healthcare services as a public good" is an idea which seems to oppose "market civilization" ideals espoused by neoliberalism.[46] Therefore it should not be surprising that the PHC movement in the late 1970s failed to gain traction in a widespread and meaningful way – especially among LMICs, who were, at the time, searching for competitive models of development. Whereas in some societies (notably in India before colonial era) health was considered a social good, the pure market system assumes that services and commodities exist in the market but are only available to those that have the means to pay for them. Thus, the market, according to public health scholars Solomon Benatar, David Sanders and Stephen Gill, becomes the determinant of individuals' propensity to access health services.[47] Hallmarks of

[43] Schrecker, "The State and Global Health" p.288, quoted from the UN Millennium Project, *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals"* 2005, p. 35
[44] Schrecker, "The State and Global Health" p.290
[45] Benatar, Sanders and Gill, "The Global politics of Healthcare Reform" p.452
[46] Ibid. p.446
[47] Ibid.

a health sector in a neoliberal context are: shrunken state sector involvement, a reduction of medical professionals and an increase in management personnel, the increased assignment of public tasks and services to private entities, a significant increase in patient engagement with the insurance industry *and* increased prevalence of OPPs, and a new and distinctly capitalist sense of competition between service providers – which were decentralized and transformed into conglomerates. The primary overarching goal behind cure- rather than care-centered medical practices was "cost containment."[48] Now the circle can be completed: power and securitization, enabled by global economic norms, have shaped global public health policy in the last 40 years.

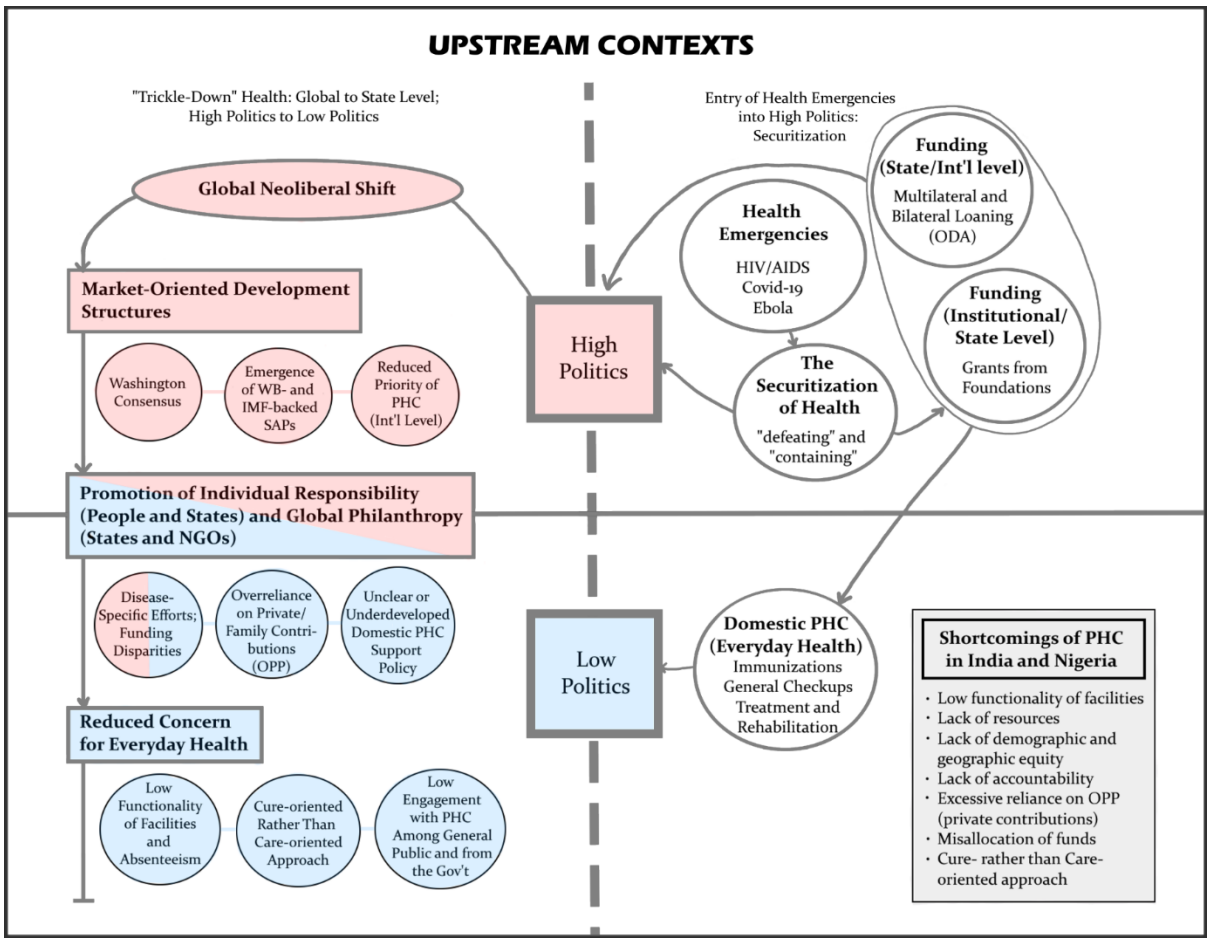

Figure II[49]

[48] Benatar, Sanders and Gill, "The Global politics of Healthcare Reform" p. 451

[49] Figure II: This diagram illustrates two distinct factors as upstream contexts: on the left, the Global neoliberal shift and the idea of "trickle-down" health, and on the right, the entry of health emergencies into High Politics through securitization. The divide between high and low politics is applicable to both sides of the diagram. Most generally, the left side of the diagram is intended to show that most of the shortcomings of both case studies' PHC systems occur on the Low Politics level but originate on the High Politics level. Note that the series of three bubbles under each subcategory occur simultaneously

Weighing Hypotheses

Given these existing theories on "upstream" factors like colonial and state power, development and neoliberalism, some potential hypotheses as to the failure of Alma-Ata (but more significantly, PHC) in the developing world begin to emerge. These consider the listed upstream factors, but also internal conditions that will be described in the case study chapters. In the research process, a total of 4 hypotheses were created – three of which seemed to hold plausible explanatory weight until more details were revealed.

These 4 hypotheses can be sorted by their proximity to the health sector: either dealing with circumstances outside the health sector or circumstances within the health sector. In the former category, two arguments stand out. First, there is the question of insufficient political engagement with health, which has plagued the post-Alma-Ata world. The general rise in nationalist or at the very least, autarkic sentiment worldwide has reduced states' inclinations to act out of global solidarity – especially since the Alma-Ata and Astana conventions are agreements, rather than legally binding treaties with frameworks to monitor and attempt to control policy rollout. There are other legally agreed-upon conventions like the International Health Regulation (IHR), but these deal overwhelmingly with cases of health *emergencies*, while questions of public health care have been largely left to national governments and domestic groups to handle – governments whose motivation and prioritization regarding "standard" health measures is low.[50] This will be referred to as the insufficient political/legal engagement hypothesis. Stemming from this hypothesis is the fact that there is overwhelmingly low use of PHC systems within countries that experience insufficient political engagement. This is often presumed to be a cause itself – a cause that would fit into the category which addresses factors *within* the healthcare sector. Yet this thesis maintains that low use of PHC facilities is rather a symptom of factors at play *outside* of the health sector.

Another argument which falls under the non-health sector umbrella is called the economic and/or political instability hypothesis, which could be further tarnished by International ideological tensions and differences. On the world stage, all states have some inherent interest to maintain and improve the health of their citizens. But this widely shared

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but reinforce each other. The right side of the diagram shows that PHC has not experienced the securitization (and therefore, not the consideration in High Politics) that health emergencies have. A grey box is given to remind viewers of the most prevalent shortcomings of each country's PHC system. These factors will be described in greater detail in the case study chapters.

[50] Kavanagh, Matthew M., Renu Singh, and Mara Pillinger. "PLAYING POLITICS: The World Health Organization's Response to COVID-19." p. 44

interest is often overshadowed by ideological or political tensions in the non-health sector, like trade disputes and even wars. Additionally, the Covid-19 pandemic proved that even medical emergency issues could generate tensions between states. These matters hinder the process of creating a "comprehensive and equitable" global PHC environment.[51] The conclusion that both hypotheses boil down to is rather bleak, but unsurprising: solidarity in strengthening non-emergency health is often relegated to the realm of political afterthought while leaders and power groups choose to handle non-health (or emergency health) matters deemed more pressing or more immediately catastrophic – thus an emergence of the high- vs. low politics argument.

In the latter category (circumstances within the health sector), two additional broad hypotheses emerge. The first could even overlap with the previously discussed hypothesis: the idea that emergency health problems trump long-term health problems even within the healthcare sector. The frames used to bring health struggles to the fore in international discourse have been conducive to short-term solutions or disease-specific solutions – specifically, framing health as a security issue inherently implies that a problem exists that needs to (and *can*) be dealt with in a *short* timeframe. This sort of posturing can work very well for regional communicable disease outbreaks or global pandemics, but it is ineffective for issues related to improving health infrastructure and access in the *long-term*. Framing health as an issue of security "is fundamentally utilitarian and leads to a triage of short-term 'high politics' policy choices based on national (and even electoral) self-interests rather than global health need."[52] Yet this choice to focus on health emergencies also involves decisions from donor countries. Lender countries have increasingly set the tone of international public health policy discourse in the neoliberal era – money talks, which leads to the final hypothesis, which seems to be applicable both inside and outside the healthcare sector.

This is the argument related to development aid, which points to funding and financing blunders as the cause for failure of Alma-Ata. According to one report, "the securitization of certain diseases, notably HIV and pandemic influenza, both recognized as security threats by the United Nations, has led to collective health financing vastly disproportionate to their actual burdens or potential risk."[53] In other words, (too much) money flows to emergencies, leaving

[51] Park, Sophie and Ruth Abrams, "Alma-Ata 40th birthday celebrations and the Astana Declaration on Primary Health Care 2018" p.221
[52] Labonté, Ronald. "Health in All (Foreign) Policy: Challenges in Achieving Coherence." p. i51
[53] Labonté, "Health in All (Foreign) Policy" p. i51

little for general, everyday health concerns. This theory also has implications for developing countries. Since the Covid-19 pandemic, higher income countries have distanced themselves more from the World Health Organization (WHO) due to its focus on low- and middle-income countries (LMICs) because "high-income countries tend to worry less if WHO's recommendations are geared toward establishing a globally applicable baseline, because they can supplement those recommendations with guidance from other sources" like domestic health agencies and private donors.[54] On the domestic level in the developing world, this funding faces its own hurdles: it may be reallocated to other developmental areas related to high politics: security or industry/the economy. The funding may fall victim to rent seeking, or it may well be allocated to a facility, state, region or even cause, but without sufficient political backing to ensure its optimal use. Consequently, individuals suffer from a lack of consistent coverage – especially in rural or underserved areas – and the lack of focus on PHC from a political and educational standpoint may mean that, aside from the lack of funds, a lack of knowledge on basic hygiene and the origins of common diseases persists. This hypothesis therefore may appear to only stem from an economic perspective, but it also implies a degree of state power and agency in deciding PHC outcomes, as well as the "neoliberal effect" that international donations and funding has had on the development of PHC in the developing context.

Several sources have suggested that the rise in private healthcare which requires significant out-of-pocket (OPP) payments is a cause for the failure of Alma-Ata's accessible PHC goals. This thesis instead takes the position that such a development in many countries is a symptom, rather than a cause, of failure. Yet it is a symptom which effectively *worsens* the prospect of ever achieving the Alma-Ata goals, due to its propensity to coincide with a curative, rather than care-based approach, and due to its "promot[ion of] individualisation rather than collective responsibility for health."[55] Privatized healthcare is definitely an important part of the story of PHC's downfall in the developing world, but it is by no means the root. Rather, the failure of Alma-Ata in the developing context explored by this thesis appears to stem from a combination of bottom-up domestic struggles related to political instability after independence coupled with the advent of neoliberal power, top-down influence, and funding patterns.

[54] Kavanagh, Singh, and Pillinger. "PLAYING POLITICS" pp. 43, 35
[55] Park and Abrams, "Alma-Ata 40th birthday celebrations" p.220

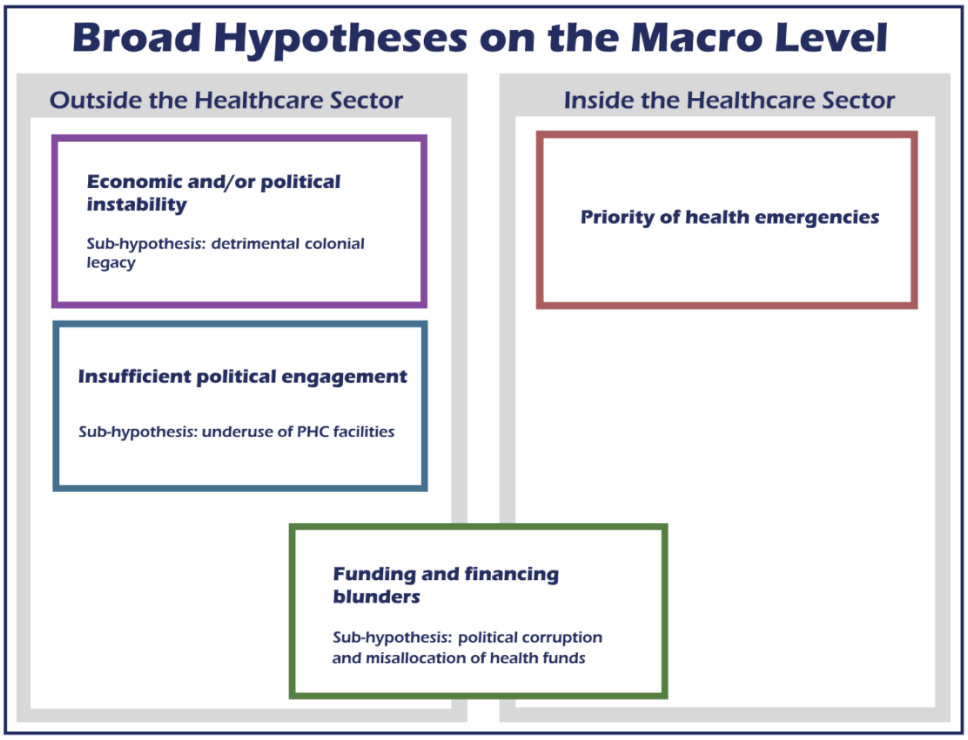

Figure III[56]

Methodology

Qualitative analysis will be the method of research relied upon to write this thesis. Scholarly literature will be analyzed to paint a comprehensive picture of health in each case study country, as well as the state of PHC, especially in terms of public discourse, in the world. Some qualitative analysis of other scholars' statistical or quantitative findings will be included, as it would be difficult to get a grasp of the effectiveness of a national health system without knowing (for example) the ratio of medical professionals to potential patients over time, or the comparison between vaccine availability and maternal death rates. Selected data will be included in a compiled table in the chapter marked "figures." No new quantitative analysis will contribute to the construction of this thesis. While the importance of an analysis of data cannot be understated, an additional element of great importance is the highly subjective capacity of human perception. If a PHC system is perceived by the people at large to be ineffective, one

[56] Figure III: This diagram outlines the hypotheses which are applicable to India and Nigeria, but also *could* reasonably fit the situation of other LMICs and developing economies. Sub-hypotheses are ideas that were repeatedly mentioned as causal factors in other articles but are deemed by this thesis to carry less causal weight than indicated in other resources (see Pages 16-19 for reasoning).

must understand community priorities and cultures to know where medical science and policymaking is falling short, even if these ostensibly adhere to overarching national standards.

Since this thesis covers problems related to health and will eventually delve into the specifics of both Indian and Nigerian politics, a table of acronyms has been provided at the beginning of the thesis, and two tables of statistical health information will be provided at the end of this chapter to provide context. For the sake of coherence, each case study will be presented separately, from opening to analysis. Case study countries India and Nigeria were chosen for their large, heterogeneous population, their pivotal and influential role in their respective regions, their similar economic developmental classification by the World Bank (as lower-middle-income countries) and because they supported early initiatives to implement PHC (as well as Alma-Ata).[57]

The previous chapters have served as the initial analytical component to this thesis, without which any analyses of the case studies would lack significant depth and context. The Theory – "Upstream Contexts" chapter has offered frames with which PHC has been viewed on the global level in existing scholarship. Through the lenses of analysis established in this chapter, each case study will describe if and to what extent these frames can be applied to a specific national context. Resulting from this chapter, enumerated potential weaknesses to PHC on an global scale can be evaluated and their causal weight gauged in the domestic context in the subsequent chapters. To offer a hint: no variable that appears in this thesis exists in a vacuum. No single, isolatable problem has undermined the achievement of PHC singlehandedly – either nationally or globally – in the last four decades. It will be this interconnected web of potential causes (refer to figure II) which will be compared, weighed, and then applied to each of the two cases. Thus, the goal of this thesis will not be to isolate a single cause. Rather, it will be to order the causes found, from most to least influential, to better understand where problems arise and when they could be corrected. Put simply, health policy will be analyzed on a macro- and then meso- level (that is, globally and then nationally) to illustrate how global patterns in health policy, established over the last half century, are playing out in key LMICs that many in 1978 predicted would be health pioneers in the developing world well before 2000.

[57] World Bank, "World Bank Country and Lending Groups"

Population Data (2022)		
	India	Nigeria
Total Population	1,422,026,527	221,153,992
Youth population (0-15 years)	357,161,739 (**25.12%**)	94,899,784 (**42.91%**)
Working age population (15 to 64)	966,033,167 (**67.93%**)	119,664,698 (**54.11%**)
Elderly population (65 and older)	98,831,621 (**6.95 %**)	6,589,510 (**2.98%**)

Figure IV[58]

Health Data on India and Nigeria from World Health Statistics 2022 (WHO)								
	Life Expectancy at Birth	Maternal mortality rate (per 100,000 live births)	Under five mortality rate (per 1,000 live births)	Prevalence in anemia in girls and women aged 15-49 (%)	Number of medical doctors per 10,000 people	Domestic government health spending as a percentage of general government spending	Population who spend more than 10% total household income on health (%)	Population who spend more than 25% total household income on health (%)
India	70.8	145	33	53	7.4	3.4	17.3	6.5
Nigeria	62.2	917	114	55.1	3.8	3.8	15.8	4.1

Figure V[59]

[58] Figure IV: *Selected* population Data (2022) from United Nations, "World Population Prospects 2022" population pyramids. These figures have been chosen to illustrate the similarities in population structure, from which a number of health-related conclusions will be drawn. Unbolded numbers represent the number of people, bolded numbers represent the percentage of the total population this number of people represents. Age categories are consistent with current UN classifications.

[59] Figure V: Comparative benchmark health data on India and Nigeria taken from the World Health Statistics report by the WHO. Data is from 2019-2020. These selected data indicate key shortfalls of each country's PHC system respectively and also represent key similarities in each country. Category names delineate which unit of measure is applicable to the given numbers.

Case 1: India

India will serve as the first case study due to its history of involvement in global health policy but also due to its rapidly growing nature. With a post-independence industrial push, a sizeable economy, and a population to rival China's, India is a LMIC which arguably *should* have actualized strong domestic health infrastructure. Yet, the favored health hypothesis among policymakers in the 1990s – that, "as countries become wealthier, they become healthier," has since been proven false in the Indian context.[60] While there may be some correlation between wealth and health, the link is decidedly *not* a causal one. The trajectory of Indian PHC, especially after 1980, casts doubt on this hypothesis.

India is also a textbook example of the "reversal of fortune" theory. The region produced 23% of the global economic output in 1600, would only be responsible for 3% by 1947 when it achieved independence. Imperialism transformed India – in measurable economic terms – for the worse: by 1947, India was considered "one of the poorest, most backward, illiterate and diseased societies."[61] While difficult to obtain hard data on Indian health pre-independence, a reversal of fortune was clearly not limited to the economic outlook of the country. A drop in global economic output of the scale experienced by India may only be one small numerical example, but it is indicative of a larger pattern which can still be seen today: as output falls, income is likely to fall – and as income falls, individuals are less likely to be able to meet their health needs, whether this comes from a lack of ability to pay, or a lack of social standing and visibility. This begs the question, where did India "begin" in terms of PHC?

What is – or *Was* – Health in India? A Brief Historical Overview

According to Indian scholar N. S. Deodhar, India's legacy of human-centered health dates back to 3000 BCE., where "*Arogya* or health was given high priority in daily life, and rules set and advocated for attaining *Arogya* indicate that the concept of health was not limited to the state of absence of disease, but included physical, mental, social, and spiritual well-being."[62] It was not until the influence of the British that health was redefined across India to be something which was primarily intended to benefit the colonizer rather than the colonized, and more comprehensively served the needs of the armed forces and of the wealthy.[63] Western medicine was largely kept distant from the majority of the native population. Health

[60] Harmer, and Kennedy, "Global health and International Development" p.218
[61] Ibid. p.220
[62] Deodhar, "Primary Health Care in India." p.76
[63] Ibid. p.77

departments were established by the provinces as early as 1919, but neither healthcare nor education was based on the needs or the norms of the majority.[64] The legacy of the colonial era was that "high technology was accepted without cost-effectiveness analysis relevance to health needs. The resultant lopsided development of the health services significantly slowed the pace of providing essential health care to the rural population and the urban poor."[65] The reversal of fortune effect clearly also impacted health, given Deodhar's description of precolonial *Arogya* and its elimination from the understanding of health among the powerful. That which emerged in its place in the imperial context was a "model of medical services [that] resulted in emphasis on "cure" rather than "care.""[66]

In an ideal(istic) scenario, a newly independent India would have immediately shed the imperial definitions of health that had been imposed on it and established a space in which health would be discussed and treated as a matter of care for the majority, rather than cure for the elite minority. Yet, the uncomfortable reality of new independence is that old systems – whether economic, political, or health-related – are hard to shake. Operational issues made a shift to modern *Arogya* difficult to achieve: a "malady [of] distribution of facilities" has plagued even the most well-intentioned development plans in India's independent past, leading to realities in which, for example, despite a tenfold increase in medical doctors, most (around 80%) were only willing to practice in urban areas by the early 1980s.[67] On paper, increases in technically-trained staff and health facilities look like significant improvements, until one takes a closer look at their placement, and realizes the vast majority of both are concentrated in Urban areas, even to this day, where they are least urgently needed. Such struggles even 3 decades *after* independence indicate that an examination of Indian development plans since independence might hold a further answer as to India's failure to implement comprehensive PHC.

A Timeline of Domestic Structural Development Plans 1947-1983

PHC has been a policy concern in India since independence. For all the faults that would emerge thereafter, it must be said that India's swift initial attempts to nationalize and strengthen healthcare was promising, as such a change was to occur in lockstep with "high politics" improvements like economic reorganization and political stabilization. The Bhore Committee – a group tasked with making domestic healthcare recommendations – was established *pre-*

[64] Deodhar, "Primary Health Care in India." p.77
[65] Ibid. pp.77, 78
[66] Ibid. p.87
[67] Ibid.

independence in 1943, and their first report published in 1946. The basic premise of the report was that "inability to pay should not prevent people from accessing health services."[68] Along with this came four additional objectives: to establish networks of PHC facilities in order to improve rural healthcare infrastructure, to ensure full participation of the people in developing health services, to bring about a new focus on education with health at the center of the curriculum, and to focus on training the necessary medical professionals to achieve these ends.[69] The Bhore committee's goals were "accepted and provided in the Constitution of India that the health of the people is the responsibility of the state."[70] After independence, Indian reform would take place in a series of 5-year plans. The first 5-year plan from 1951-1955 launched the 1952 Community Development Programme (CDP) which sought to greatly improve healthcare and sanitation by establishing PHC facilities and subcenters.[71] The 1952 CDP was well-intentioned but lacked resources and reflected the reality that it (and the Bhore committee ideals before it) were almost too idealistic in terms of immediate growth and development and could not be achieved in the short time window of a 5-year plan.

In the second 5-year plan from 1956-1961 a new committee, the Health Survey Planning Committee (or, the Mudaliar Committee) was appointed by the Indian Government to take stock of the improvements made since the Bhore report. The findings led to the recasting of health goals: here it was recommended that PHC facilities ought to serve *less* people but should instead focus on quality, aiming to employ one basic health worker per 10,000 people.[72] This committee also held that the priority should shift from maintaining highly specialized medical education programs (resulting in a lower number of future healthcare professionals) to normalizing a broader, perhaps shorter education for a greater pool of potential healthcare professionals among students in all scientific fields.[73] The idealistic nature of the Bhore and CDP reports had likely convinced those on the Mudaliar Committee to recommend a *slowing* in the expansion of PHC facilities and expenditure. In retrospect, scholars deem this recommendation as a turning point for the worse in Indian PHC. The changes implemented in accordance with the Mudaliar Committee's findings greatly slowed the trajectory not only of

[68] Pandve, and Pandve. "Primary Healthcare System in India." p.125, and Powell-Jackson, Acharya, Mills, "An Assessment of the Quality of Primary Health Care in India." p.54
[69] Pandve, and Pandve. "Primary Healthcare System in India." p.127
[70] Deodhar, "Primary Health Care in India." p.78 and Nundy, "Primary Health Care in India" p.31 and Bajpai and Goyal. "Primary Health Care in India: Coverage and Quality Issues," p. 23
[71] Pandve, and Pandve. "Primary Healthcare System in India." p.126, and Deodhar, "Primary Health Care in India." p. 78, 79
[72] Government of India Ministry of Health, *Report of The Health Survey and Planning Committee, "*Mudaliar Committee" p. 21
[73] Government of India Ministry of Health, *"*Mudaliar Committee" p. 28, 310

Indian PHC, but also of Indian development in general.[74] This recommendation (and subsequent adoption by the Indian government) led to the chronic overburdening of PHC facilities in terms of professional-to-patient ratios, as well as the chronic underequipment of PHC facilities with medicines, technology, and staff. For example, the number of PHC facilities exploded from 725 in 1956 to 2,800 in 1961 and 4,631 in 1966, but only increased by under 1,000 in the 5-year plans thereafter.[75] Additionally, expenditure on health was decreased from Rs.540 million in the second 5-year plan to only Rs.148.3 million in the third 5-year plan.[76] These examples indicate that the recommended tightening and slowing of health development in India in the second 5-year plan planted the seeds for a lopsided health system: one in which health might still be socially prioritized, but would lack the facilities to support a growing population.

The third- and fourth 5-year plans are not regarded as significantly impactful, although the 1967 Jungwalla Committee did seek to make health services a joint effort between upper government and local leadership, while the 1973 Katar Singh Committee established employment norms for health workers.[77] Neither 5-year plan saw recommendations to revert India's health plan to the pre-Mudaliar situation in terms of health spending and facility expansion.

During the fifth 5-year plan from 1974-79, India's entire PHC system would be overhauled to reflect a multipurpose, rather than unipurpose structure. This resulted in the training (or retraining) of healthcare workers – each of whom would be expected to serve a greater population but also be responsible for several healthcare tasks, rather than to be a specialist in one task. This was designed to mitigate the problems of understaffing and the overlarge burden on the falling number of healthcare workers.[78] This was also introduced along with initiatives to ensure that health workers would be fairly and regularly compensated.[79] In 1976, the Srivastava Committee recommended an expedited implementation of the multipurpose worker scheme and sought to actualize a three-tier health plan for rural communities which would include village-based volunteers, paramedical intermediaries and PHC medical and referral services.[80] This committee also recommended an improvement of health knowledge

[74] Deodhar, "Primary Health Care in India." p.79
[75] Ibid. p.80
[76] Deodhar, "Primary Health Care in India." p.81
[77] Pandve, and Pandve. "Primary Healthcare System in India." p.126, and Katar Singh Committee Report 1973, p. 13-18
[78] Government of India Ministry of Health and Family Planning, *Report of the Group on Medical Education and Support Manpower*, "Srivastava Committee" pp. 17-19
[79] Deodhar, "Primary Health Care in India." pp.85, 92
[80] Ibid. p.86

throughout integrated sectors by bringing together health professionals, students and teachers, while also seeking to improve the referral system within and among facilities.[81] As a result of these recommendations, 1977 saw the launch of the Rural Health Scheme, which involved the training of community members in healthcare and the linking of existing hubs of medical knowledge with rural communities.[82]

At this stage in Indian health development, the country participated in the Alma-Ata Conference which would reinforce the importance of a focus on PHC, but would also indicate global support for such an outlook. Still, while the recommendations of this 5-year plan were well-intentioned and wise, given their focus on the involvement of and focus on rural communities, the damage had already been done in the 1960s – and had not been undone. Therefore, any subsequent attempts at healthcare reform could only go so far. After the expansion of PHC in the 1960s was significantly contained, subsequent plans in the 1960s and 70s appeared to only respond to the failures caused by the second 5-year plan, rather than an attempt to further the aims of the Bhore Committee and the CDP. Only with the fifth 5-year plan did India appear to return to its health roots, but by that point, the damage had been done.

The flame of PHC would continue to burn for the next few years, but by 1983, it was clear that no sweeping reform could – or would – resolve the flailing health system, especially in rural communities. Despite an affirmation by the Indian Council for Social Science Research and the Indian Council for Medical Research in 1979 and 1980 that most health issues facing India could be resolved at the PHC level, and that this could only happen if the underserved rural communities were brought in on the development and planning of customized health strategies,[83] and despite a 1983 policy suggestion that a greater share of government spending on health ought to be assigned to PHC, the improvement of the Indian health system lost its battle to the industrial and economic concerns of the 1980s and 1990s.

Lessons from the Structural Development Plans

Implementation of PHC norms and ideals reflecting the Alma-Ata declaration by Indian states and territories have been inconsistent and irregular, which is reflected in the many (often

[81] Pandve, and Pandve. "Primary Healthcare System in India." p.126 and Government of India "Srivastava Committee" pp.29, 35, 41-42

[82] Ibid. p.126

[83] Deodhar, "Primary Health Care in India." p.88: Community involvement was minimal, a consequence of the rigid health structure and of operational difficulties: "In the community development project, the panchayats or the zilla parishads (the local authorities at the village and district levels) had very little or nothing to do with the health programmes run by the governments in most of the states."

disjointed) schemes concocted by the Government of India – schemes which quickly developed the reputation of being altered every five or ten years. Just when a state or territory began to implementing policies, the national framework could shift – all the while, health problems that plagued India from its independence, like vaccination, malnutrition and easily-curable diseases persisted, leading one Indian scholar to remark that "the enormity of the unfinished tasks is mind-boggling."[84]

While the Bhore Committee and the CDP's recommendations and passion for implementing a strong PHC system were laudable, they, too, had their faults. Even during the First and Second 5-year plans from 1951 to 1961, where health was ostensibly core and key to national development, "less than 5% of the total revenue was invested in health."[85] In health terms, it was understood that development of PHC would follow a vertical, rather than horizontal integration model. This meant that the health of the nation would only be attributable to the strength and actions of the healthcare sector, rather than other sectors.[86] Such an arrangement has been called "vertical," while a "horizontal" arrangement would tie the success of healthcare to other sectors.[87] It was not until the fifth 5-year plan that "policy-makers suddenly realized that health had to be addressed alongside other development programmes" and that the recommendations of committees in previous 5-year plans had perhaps stunted the development of India's PHC system.[88] It was at this time that the Alma-Ata declaration was signed and ratified by India, and a shift toward decentralizing and integrating healthcare along with other developmental areas began to take hold. Yet lobbies emerged which questioned the viability of the PHC approach and questioned the financial setbacks that such an approach could yield.[89] This ultimately resulted in verticality replacing horizontality once more. By 1980, the Indian health system was clearly lacking in two areas which *continues to be the case.* These two areas, which greatly contributed to the persistently low widespread public opinion of the health system, are the availability of medicine and the state of overall financing.

In discussing the availability of medicine in 1980, Deodhar expressed a belief that "there is a need for a clear-cut drug policy and a National Drug Authority to implement it" and that the prominence and prevalence of international drugs in India would soon represent a greater cost to the system than a benefit.[90] His recommendation was therefore not only to reduce

[84] Jacob, "Public Health in India and the Developing World: Beyond Medicine and Primary Healthcare." p.562
[85] Nundy, "Primary Health Care in India" p.32
[86] Ibid. p.32
[87] Nundy, "Primary Health Care in India" p.33
[88] Ibid. p.32
[89] Ibid. p.33
[90] Deodhar, "Primary Health Care in India." p.95

the number of foreign drugs in Indian markets, but also to create generic versions domestically. This would prove to be a prophetic remark, as a current struggle not only for Indian, but for nearly all PHC systems in LMICs, is the hardship they face in terms of establishing a legal market for generic medications (generics), given existing international trade law on intellectual property (IP) and the WTO's dispute settlement mechanism, which makes the establishment of generics markets in LMICs difficult to achieve.[91] On health financing, Deodhar writes that "total investment in health services should be substantially increased; health expenditures should rise by 8% to 9% per year . . . and reach about 6% of GNP by the year 2000."[92] It is well documented that Indian public expenditure on health was far below this ideal *well after* 2000, signaling that this message failed to reach the Indian Government to the meaningful degree envisaged by PHC policy advisers.

The focus on care turned into a focus on cure once more, and ever since the seventh 5-year plan (1985-1990), the most popularly accepted solution to the weakness in the PHC system was simply to transfer manpower, funding, and patronage to the private sector –including the encouragement of private initiatives, clinics and hospitals. Additionally, the focus remained disease-driven, rather than human-driven, with HIV/AIDS, tuberculosis (TB) and Malaria control dominating discourse. Not until the *tenth* 5-year plan (2002-2007) did India begin a shift back toward Public PHC with the creation of the National Rural Health Mission (NRHM) – but this shift was rather feeble and instead of an upswing for Indian public health, it represented a case of noble words and meagre deeds.[93] At his time of writing in 1980, Deodhar astutely recommended approaching health from three angles: integrating health into overall development, improving education in the areas of health, environment and nutrition, and keeping the focus on serving the underserved and impoverished, writing that ". . .the existing exotic, top-down, elite-oriented, urban-biased, centralized, and bureaucratic system, which

[91] Health systems have not only been negatively impacted by global economic shifts. Even legal norms and agreements have arguably made it more difficult for health systems in LMICs to operate effectively and affordably. An example of this is the WTO's TRIPS (Trade Related Intellectual Property Rights) agreement. Such an agreement has made the legal use of branded medications and medical equipment far more expensive for LMICs whose companies or representatives do not hold the intellectual property rights for them – often materials which are considered the global medical standard. While the implementation of this agreement has generated the creation of generic medicines industries in impacted LMICs (like India), these "generics" must also be approved for market sale and use – a process which is time consuming, and which reinforces a degree of market exclusivity for expensive, foreign products, according to Benatar, Sanders and Gill (p.455) The WTO dispute settlement mechanism could also negatively impact LMIC health sectors due to its cross-retaliation clause and the subjective nature of "likeness."

[92] Deodhar, "Primary Health Care in India." p.96

[93] Nundy, "Primary Health Care in India" p.33, and People's Health Movement, "B4: Dysfunctional Health Systems: Case Studies from China, India, US" p.105

overemphasises the curative aspects, large urban hospitals, doctors and drugs, should be replaced by the alternative model of health care services. . ."[94] Unfortunately, Deodhar's prescriptions would come at the dawn of the neoliberal global development period – and given his perspective that healthcare is a public good – would fall on deaf ears in the following two decades.

The Indian PHC System in the Neoliberal Era

Coverage and Quality Shortcomings

Upon the shift toward neoliberalism in the West, India, which sought to strengthen its role in the international market and enable its economy to keep up with its growing population, was heavily influenced by restructuring suggestions the likes of the Washington consensus. However, many improvements India was able to make to its financial sector, the neoliberal economic reforms of 1991 worsened the outlook for public health in India. Notions of "fiscal discipline" among government bodies led to a culture of imposing expenditure compressions on healthcare and other "soft sectors."[95] In the initial aftermath of these economic reforms the solution to almost every sectoral ill was "decentralization, in the sense of devolution of political, administrative and fiscal decision-making power to local governments" which, as of the amendments to the Indian Constitution in 1992, were awarded more power to self-govern.[96] This meant that, for the first time, "scheduled castes, tribes and other minorities [were] guaranteed proportionate representation."[97] However positive such changes promised to be, the reality which followed objectively lowered the effectiveness and accessibility of India's PHC system.

In this period, India's growth rate increased demographically and economically, but the state of its healthcare system was hardly better in 2004 than it was in the 1980s. By 2004, life expectancy in India was only 64.45 and a lopsided sex ratio of 927 women to every 1,000 men reflected long-standing gender biases but also failures to cater to the health concerns of women.[98] Infant and maternal mortality had not improved greatly since the 1980s, representing

[94] Deodhar, "Primary Health Care in India." pp.89, 94
[95] People's Health Movement, "B4: Dysfunctional Health Systems" p.105: "soft sectors" can here be used as a synonym for sectors of "low politics."
[96] Bajpai, and Goyal. "Primary Health Care in India: Coverage and Quality Issues," p.23
[97] Ibid, p.24
[98] Bajpai, and Goyal. "Primary Health Care in India: Coverage and Quality Issues," pp.3, 6, 7

a 20-year near-stagnation of progress: 407 maternal deaths per 100,000 live births on average in India in 2000 was among the worst in the world.[99] Most births in India also took place in unsanitary conditions rather than well-outfitted hospitals or care centers as a consequence of the lack of accessibility of health centers/lack of emergency transport services.[100]

Nearly half of all teenage girls and women between the ages of 15 and 49 suffered from anemia in 2004. In most cases, this could have easily been reversed through the prescription of low-cost iron or other regiments. Instead, such medicines are only sporadically available. This is only one example of an easily treatable problem that had gone untreated, which could possibly contribute to problems related to infant and maternal mortality if left untreated.[101] Tuberculosis (TB) was another such problem, which in 2004 was "a 100 percent curable disease and require[d] relatively simple and inexpensive interventions." Despite this, the National Tuberculosis Programme (developed as early as 1962) was ineffective due to lack of funds and patchy and disorganized management. Not until the Revised National Tuberculosis Control Programme was implemented in 1993 did India begin to see significant reversals in TB.[102]

Health and poverty represented a vicious cycle. Scholars Nirupam Bajpai and Sangeeta Goyal express this in a simple cause-and-effect loop: where health improves, poverty diminishes. Where health declines, poverty increases. Where poverty increases, health declines, and where poverty declines, health increases.[103] This suggests that, given the high burden of disease in both rural and urban areas, India's economic growth and poverty reduction schemes were prevented from reaching their fullest potential. Without adequate health, there could be no uniform or sustainable growth in other sectors.

From the late 1980s to 2005, the PHC system struggled both with coverage and with quality. While the PHC system was large, it was generally ineffective. In 1998, there were 137,006 sub-centers, 23,179 PHC centers and 2,913 community health centers (CHCs). The structure was nested: on average, one PHC center was meant to oversee 6 sub-centers, whereas each CHC could be referred the patients from up to 4 PHC centers. This number of facilities was healthy for a LMIC, but despite their presence, accessibility and coverage desperately lacked. In the same year, only 13% of rural people could access PHC facilities, 33% could access sub-centers, only 9.6% could access hospitals and 28.3% could access dispensaries or

[99] Bajpai, and Goyal. "Primary Health Care in India: Coverage and Quality Issues," p.9
[100] Ibid.
[101] Ibid.
[102] Ibid. p.11
[103] Ibid. p.4

clinics.[104] The most prominent reason for low attendance of these PHC facilities was the distance from a potential patient's home, and across India in 1999, the average number of PHC centers by villages was under 50%.[105]

Concerns also arose regarding medical staff and trained professionals. The problem of insufficient number of staff has plagued the public PHC system in India since before the 1980s. Given this personnel shortage, it became commonplace for doctors, nurses, and others to choose to work in urban, rather than rural areas, leading to an urban-rural imbalance in trained staff. The most striking consequence of this was that some of the most rural facilities stood vacant by 1996, a year in which "as many as 4,281 of 29,699 doctors posts sanctioned remained unfulfilled in rural health institutions."[106]

While "quality" is hard to define objectively, several scholars have conducted studies by which to assess this characteristic in Indian PHC – and while their definitions may vary, their conclusions do not: at the turn of the century, Indian PHC was of extremely low quality given benchmark factors like GDP and population growth. From state to state, PHC facilities offered inconsistent degrees of basic infrastructure like consistent electrical power, running water, refrigeration devices, telephones and even sterilization tools for surgical equipment and wounds.[107] In a 1999 survey, it was found that only between 15% and 77% of PHC facilities had these individual items.[108] Iron tablets, contraceptives and vaccines were only found in 15%, 56% and 61% of PHC facilities respectively.[109] There was also an overwhelming lack of quality control within the system. Doctors seldom had their competence reassessed once they entered the system – a consequence of the loosely regulated nature of the public health sector and the lack of trained medical staff. This may also stem from the Mudaliar Committee's recommendations, which seemed more concerned by bringing more professionals into the system rather than ensuring these professionals' credentials were trackable and verifiable – in

[104] Bajpai, and Goyal. "Primary Health Care in India: Coverage and Quality Issues," p.14
[105] Ibid. p.14
[106] Ibid. p.15
[107] Ibid. p.16
[108] Ibid. pp.16, 17:
> "77 percent of PHCs had an infant weighing machine, 65 percent had a deep freezer, 60 percent had an autoclave and a steam sterilizer drum and only 16 percent had a refrigerator. Fewer than 20 percent had equipment required for medical termination of a pregnancy. Most lacked essential drugs: only around 15 percent had stocks of iron and folic tablets, 56 percent had contraceptives and 61 percent had vaccines."

[109] Ibid. p.17

other words, a prioritization of quantity over quality.[110] By 2004, The Medical Council of India had *not* devised a list of standards by which the competence of doctors could be reassessed.[111]

Shortcomings in coverage and quality are easily illustrated by medical and survey data, but such shortcomings can also be seen in patient perception. Most thought negatively of the PHC system in India as late as 2004 not only because medicines were lacking and facilities were far away, but also because "often the primary health care facility is not open during the hours and days it is supposed to be functioning or the health worker(s) maintaining the facility are not available."[112] The latter of these problems is known as worker absenteeism, and it was as high as 43% among doctors across states in 2003.[113] There was also no evidence that absenteeism followed a specific pattern, so potential patients were understandably unwilling to navigate all the way to the nearest facility to potentially be faced with the absence of necessary medication, or for the doctor or health professional to be unexpectedly absent. Simply too many unknowns and uncertainties were present in an average rural patient's cost-benefit calculation to even attend a medical facility. No wonder PHC facility use in India only hovered in the 20-30% range by the 2010s.[114]

The public also perceived PHC facilities and the services they provided to be of low quality. A consequence of these shortcomings was that most Indian households (both urban and rural) relied on the private healthcare sector for care in the neoliberal period – and funding reflects this trend. Even though India boasted a large public health system on paper, the most used (private) system was made up of "80 percent of all qualified doctors, 75 percent of dispensaries and 60 percent of hospitals" in 2005.[115] This resulted in a peculiar situation in which the wealthy as well as the middle- and low- income gravitated toward the use of private health care relatively evenly. Both groups believed that a paid service would be of significantly higher quality, but only the former group could afford such services. An OPP could mean the difference between living adequately and being cast into poverty or extreme poverty.[116] This fed further wealth inequalities throughout India, especially in urban areas. Thus, the new, private-contribution-centered health system came to define Indian PHC.

[110] Government of India Ministry of Health, *"*Mudaliar Committee" p.29
[111] Ibid.
[112] Bajpai, and Goyal. "Primary Health Care in India: Coverage and Quality Issues," p.17
[113] Ibid.
[114] People's Health Movement: "B4: Dysfunctional Health Systems: Case Studies from China, India, US" p.109
[115] Bajpai, and Goyal. "Primary Health Care in India: Coverage and Quality Issues," p.19
[116] Ibid. p.30

India was (and still is) known to have a large public health sector, but it functioned so badly in this period that, beneath the facade of widespread public healthcare exists a widening and deepening problem – people from all walks of economic life turning to private healthcare – which is unregulated and comes with massive out of pocket commitments. The impact of OPP payments has been "catastrophic," especially to the rural and urban poor alike, who often find themselves weighing healthcare against expenditures necessary to maintain daily life.[117]

Health spending in India (in all sectors) was only about 4.9% of GDP in 2000. Of this, less than 1% was spent on public, primary health. This included expenditures from the central government (a measly 0.13%), the state governments (0.72%) and the local governments (0.10%).[118] Expenditure on health as part of GDP has been declining slowly in India since 1985. Since then, the central government has not contributed more than 1.61% of its total expenditure and state governments have not paid more than 6.49% of their total expenditures.[119] This is significant because other countries *in a lower income bracket than India in 2004*, like Bhutan, spent much more (10% of GDP) on health.[120] This reinforces findings from a 2010 study which concluded that more money does not necessarily mean more allocation of that money to primary health system reform.[121] In 2000, OPPs accounted for a staggering 82.2% of total health expenditures.[122] Clearly, a culture of privatization had taken over as the public PHC system was ignored by policymakers and distrusted by the most needy.

The prognosis for the PHC system under a new, neoliberalism-influenced Indian economic order was not initially negative. In 1995, PHC facilities and dispensaries came under the control of village panchayats (local governments) in a move toward decentralization. In this move, "the transfer of authority to local government bodies in general had resulted in greater flow of funds to these bodies, more autonomy over spending decisions, faster project implementation, less corruption, and greater advocacy of preventive and curative care."[123] Yet, while in 2004 it was projected that decentralization might increase the *quantity* of services available to patients in PHC facilities, it was unknown what effect this change would have on *quality*. The result of this beyond 2004 was unfortunate: the increase of power in local elites

[117] People's Health Movement, "B4: Dysfunctional Health Systems" p.105
[118] Bajpai, and Goyal. "Primary Health Care in India: Coverage and Quality Issues," p. 20 and People's Health Movement, "B4: Dysfunctional Health Systems" p.105
[119] Bajpai, and Goyal. "Primary Health Care in India: Coverage and Quality Issues," pp.39, 20
[120] Ibid. p.29
[121] Lu, Schneider, Gubbins et.al., "Public Financing of Health in Developing Countries: A Cross-National Systemic Analysis"
[122] Bajpai, and Goyal. "Primary Health Care in India: Coverage and Quality Issues," p.21)
[123] Ibid. p.24

heading the panchayats, especially in rural or poor areas resulted in a significant increase in rent-seeking behavior, in which funds were either diverted to other local needs, or funds were misappropriated by local elites.[124] Despite this 1995 shift, health was still formally a state responsibility under the Constitution of India, which meant the central government still had an outsized influence on, and responsibility for, budgeting and planning. While some degree of power may have been transferred to local elites, the state still determined the direction of the paltry government funds to each region. Unsurprisingly, the state at large was unaware of the specific needs of each region on the local or district level. This, combined with insufficient public funding to public PHC *in general*, rendered efforts by states or territories to control PHC ineffective. [125]

At the end of the phase of "programmatic neoliberal blindness," the overemphasis on "pro-rich," cure-based health, rather than a pro-majority, care-based approach was stronger than ever.[126] It is now known that the low public expenditure on healthcare put undue burdens on households – especially low-income ones. To put this into perspective, the average household expenditure on healthcare (in OPP payments) increased from Rs 16.78 per month to Rs 41.83 per month between 1994 and 2005.[127] Urban centers tend to boast increased household incomes and increased abilities to field higher OPP expenses. This would have been especially true of the time between the late 1980s and the early 2000s, when Indian development along the lines of western economic models was set into motion. Yet despite this, the percentage of households which reported having OPP healthcare expenses in rural and urban households were strikingly similar: in 1994, 55-60% of both urban and rural households reported OPP expenses, and in 2005, that number had risen to 65% in both groups. Additionally, per capita public spending on healthcare was equal to USD$5-$6, while private spending stood at nearly USD$20 per capita. Because of this, "the number of people pushed below the poverty line . . . because of catastrophic OPP expenses incurred on health care [rose] from about 26 million in 1993/94 to 39 million in 2004/05."[128]

This has been a positive feedback loop with decidedly negative consequences: a lack of sufficient household finances (which may stem from overlarge OPP payments) has been a major contributor to the ill electing *not* to seeking treatment in health facilities of any kind. It is also known that, despite several public and private insurance schemes emerging in India in

[124] Bajpai, and Goyal. "Primary Health Care in India: Coverage and Quality Issues,".p.26
[125] Ibid. p.23
[126] Ibid. p.21
[127] People's Health Movement, "B4: Dysfunctional Health Systems" p.106
[128] Ibid. p.107

the last few decades, they only covered about a quarter of the country's population in 2010, signaling that many people had fallen through the cracks – either because they could not pay, or because they did not meet the rather rigid requirements of insurance schemes for particular groups, like the rural poor.[129]

The Indian government did respond to this by attempting to channel the Alma-Ata declaration through the establishment of the NRHM in 2005. This mission was intended to increase central government involvement, as well as investment, in rural PHC. Yet, this was also largely ineffective and almost 15 years had passed before anything was done to correct the failures of Indian PHC that existed even before the NRHM.[130] Of the neoliberal period, it can be said that "the primary health care system in India is dysfunctional. While extensive, it is wasteful, inefficient and delivers very low quality health services, so much so that the private sector has become the de facto provider of health services in India."[131] Aside from critiques by contemporary scholars that the unreasonably low level of state funding illustrates that "health has never been a political priority," India has been rightly accused of implementing a budgetary and funding structure which "remain[s] archaic, obsolete, and resistant to change." [132]

Contemporary PHC (2010s and Onward)

The "neoliberal blindness" phase has arguably ended as LMICs like India have discovered the debts and worsening inequalities that such measures have brought about. Still, such a realization has not prevented the problems which began under the pre-neoliberal committee system and were exacerbated by the distraction of neoliberalism, from being comprehensively solved. In the beginning of India's formal PHC journey after independence, the health problems facing it were "insanitary conditions; malnutrition and undernutrition leading to high infant and maternal mortality rates; inadequacy of the existing medical and preventive health organizations; lack of general and health education; unemployment and poverty that produced adverse effects on health and resulted in inadequate nutrition; improper housing and lack of medical care."[133] Data from the last decade indicates that India still struggles with many of the problems on this list to a degree unexpected of a country which has proven itself able to grow in other sectors.

[129] People's Health Movement, "B4: Dysfunctional Health Systems" p.109
[130] Lahariya, "Health & Wellness Centers to Strengthen Primary Health Care in India" p.919
[131] Bajpai, and Goyal. "Primary Health Care in India: Coverage and Quality Issues," p.28
[132] People's Health Movement, "B4: Dysfunctional Health Systems" p.104, and Bajpai, and Goyal. "Primary Health Care in India: Coverage and Quality Issues," p.30
[133] Nundy, "Primary Health Care in India" p.32

Coverage and Quality in Contemporary India

India still struggles to combat common illnesses and diseases across the board, from diabetes to cancers, to mental health. A mortality problem also persists – life expectancy is not ideal in many states and territories, and this is a clear reflection of wealth and status, signalling deep-set inequalities in the country.[134] Further research is required to examine the reasons for inter-state differences in health statistics regarding mortality, where for example in Kerala a state in southwestern India, the life expectancy for both men and women is 74 years – above the national average of 70.8 – while it is only 56 years in Madhya Pradesh, a centrally located state.[135]

In a 2013 study on PHC centers across Indian states and territories which used a statistical model to attempt the measurement of PHC center quality by examining the center's functionality based on certain characteristics and resources,, it was found that the average quality of care in PHCs (Primary Health Centers) was 52% out of 100%, showing that India still has much to improve.[136] Still, some states' quality scores were significantly better than others, indicating persistent inequities in health are related not only to geography but also income, caste, religion, gender, wealth and education.[137]

Of the 28 states and territories, 10 were broadly found to be low-performing and 18 to be high-performing according to national indicators in the NRHM and the difference between low- and high-performing states was highest in the domains of equipment and essential medicines.[138] Several PHC centers were found to have a quality of care so low, that they barely functioned. The non-functioning centers in high-performing states were classified as outliers given the remaining data, while those in low-performing states are close enough to the mean not to be considered outliers. Most generally, districts in southern India have better PHC quality than districts in Northern India: the 3 lowest-performing areas by district are West Bengal, Uttar Pradesh, and the territory Manipur.[139] Generally, NGO-managed PHC centers are of

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[134] Pandve, and Pandve. "Primary Healthcare System in India" p.126

[135] Powell-Jackson, Acharya, Mills, "An Assessment of the Quality of Primary Health Care in India." p.58, and World Health Organization, Country Data on India. https://data.who.int/countries/356

[136] Ibid. p.53, 56:
Key to the achievement of successful PHC in this study were 6 factors: Availability of services, Number of active clinical staff, Percentage of staff with training in the past 5 years, Basic infrastructure, Equipment, and essential medicines. Each of these broad categories or "domains" contained a number of specific characteristics (like presence of antivenom for snake bites in the "essential medicines" domain), that would be individually evaluated and contributed to the ultimate percentage of quality.

[137] Powell-Jackson, Acharya, Mills, "An Assessment of the Quality of Primary Health Care in India." p.53

[138] Ibid. pp.55, 56

[139] Ibid. p.56

slightly better quality than Government-managed PHC centers, and infant mortality – a significant problem throughout India – was found to be significantly lessened if the PHC had adequate equipment and was functionally available to provide services for 24 hours – two further domains through which quality was assessed.[140] The highest quality PHC centers were urban and had large catchment populations.[141]

Throughout India, access to medical education remains one of the most competitive in the world. In 2021, only 90,825 seats at Indian Medical Colleges for MBBS degrees were made available to over 1.6 million applicants – half of whom passed the national entrance exam, NEET.[142] One Indian report estimated that "almost 90 per cent of the students who clear NEET will not get into a medical college in India," which indicates that "for 5 medical seats in India, there are 100 people competing."[143] The large margin of students who are rejected yet have passed the NEET wish to pursue medicine must therefore study medicine abroad, which comes with its own unique challenges. First, students that choose to remain and practice in the country of their education rather than return to India contribute to the massive brain drain from the Indian health system, while medical graduates who return to India with their foreign degrees must first pass another exam to practice in India to register with the National Health Commission. Before 2022, Indian students returning from foreign medical schools had to sit the Foreign Medical Graduate Exam (FMGE) which was largely comprised of conceptual questions that many considered to be easier than the NEET. Recently, however, the Indian government has conceptualized a new examination system called the National Exit Test (NExT) which is also to be given to final year(s) medical students already studying in India. The NExT is based on clinical, rather than conceptual questions, which many feel gives an unfair advantage to the comparatively small cohort of India-educated students.[144] This shift in examination structure also has the potential to shrink the pool of eligible practitioners despite all having earned comparable degrees. As one medical institute director insisted, "the NExT exam will increase the difficulty level, as most students would fail to qualify. Every year, around 40,000-50,000 graduates appear for the exam and their pass percentage is just 9-18%."[145]

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[140] Powell-Jackson, Acharya, Mills, "An Assessment of the Quality of Primary Health Care in India." p.57

[141] Ibid.: a catchment population is the amount of people in the vicinity of a hospital or facility that can reasonably be covered by that facility - this can transcend city lines or even district lines.

[142] Benu, Parvathi. "Competition, fewer seats sending Indians abroad for medical education" – the total number of applicants who sat the NEET entrance exam was 1,614,777. Only 870,075 passed the exam.

[143] Pandey, Puniti. "Evaluating foreign medical graduates based on clinical questions is unfair." *The Times of India*

[144] Ibid.

[145] Ibid.

One student from the city of Thiruvananthapuram in the southern state of Kerala where the general state of PHC is considered to be above average, insinuated that many doctors who work in a public capacity also run private practices on the side – in some cases, out of their public clinics before or after official hours – due to the profitability of private healthcare.[146]

The domestic discrepancies from state-to-state have clearly impacted India's regional standing in terms of health. Apart from Pakistan, India has fallen to the bottom in health terms and "social indicators" relative to its other South Asian counterparts, including Bhutan and Nepal. This is despite its income growth relative to these same countries.[147] In another study from 2013, it was found that India's nationwide numbers on child mortality, sanitation, and vaccination "lag behind that of substantially poorer Bangladesh," leading to the conclusion that India must be facing a domestic healthcare crisis.[148] Yet in 2014, India cut its healthcare budget by a further 16%, suggesting that the problem is not considered of "high politics" on the policymaking level.[149]

Even still, recommendations and reports are still published which compare ideal coverage with current and projected population levels. In an ideal scenario PHC subcenters, PHC centers and CHCs are equipped to treat 5,000, 30,000 and 120,000 people respectively. Not only are the actual numbers of patients higher *in all categories* in rural areas, but India's population of 1.21 billion in 2011 suggested that the rural health survey's recommendation of an additional 3,800 PHC facilities was a dramatic *underestimate* of the reality. If the recommendation were accurate to the projected population growth, the recommendation ought to have reflected an additional 27,700 PHC facilities.[150] The 2011 best-case scenario of PHC facilities therefore purports to increase as India's population increases, yet India – especially

[146] This student was not officially interviewed for this thesis and wishes to remain anonymous. Indian news sources corroborate this position. In the aftermath of Indian legal proceedings which reinforced the legality of government doctors engaging in private practices, Justices dealing with the case commented: "It would be preposterous, in our view, to hold that if a doctor charges fee for [privately] extending medical help and is doing that by way of his professional duty, the same would amount to illegal gratification as that would be against even plain common sense." Since this perceived legal issue was taken to the Supreme Court, the practice of providing private care in addition to state/government-funded care is clearly a widespread practice. (Quote from Venkatesan, J., *The Hindu,* "Private practice by government doctors no criminal offence: court")

[147] Schrecker, "The State and Global Health" p.282

[148] Ibid. pp.282, 284:
The "Bangladesh Paradox" represents the reality that Bangladesh boasts better healthcare prospects than expected based on its poverty. Despite its elevated child malnutrition rates,, Bangladesh has a "strongly equity-oriented approach to health system design" which the author hinted could be the explanation for this peculiarity.

[149] Ibid. p.283

[150] Pandve, and Pandve. "Primary Healthcare System in India" pp.126, 127

rural India – would still suffer from an inflated underservice problem if those 3,800 additional facilities were created and equipped with the resources and staff needed to serve patients.

Another large, yet understudied problem is the existing rigidity of the health system's structure does not allow for significant departure from officially recognized committee findings or state practices that would perhaps better serve individual rural communities. The "large diversity in India calls for local adaptation of the basic healthcare package and its delivery mechanism," though what this would entail would depend on local conditions and would require extensive additional research to be done in or on each state. [151]

Public Perception and the Intersectionality of PHC

As in the neoliberal period, patients experienced with the contemporary PHC system are generally unhappy with the state of services across India, complaining about rudeness in health workers and even discrimination based on ethnicity, caste and gender.[152] A 2012 study found that Indian women *not* considered poor experienced higher levels of "non-treatment" than their male counterparts of similar income – and even males of lower income – "because poor men can leverage their gender to overcome low economic status."[153] In 2016, another study discovered that more women in rural than urban India opted for hysterectomies to deal with reproductive and gynecological problems *that did not necessarily require such invasive or irreversible treatment* due to the stigma around having such problems.[154] Considering that the use of sanitary napkins has only been widespread in India since around 2012 – and that the country still faces high rates of insanitary menstrual procedures, especially in rural areas, such gendered differences in PHC coverage are appalling but not altogether unexpected.[155]

Aside from gendered coverage problems, Indians consider a number of other shortcomings to contribute to their negative perception of the PHC system – especially the state-run, public system. First, many consider that public health policymakers assume "medicine has all the answers" while turning a blind eye to the complex interconnected web of

[151] Pandve, and Pandve. "Primary Healthcare System in India" p.127
[152] Ibid. p.126
[153] Shawar and Ruger, "The Politics of Global Health Inequalities" p.70, quoted from Sen, Gita and Adita Iyer, "Who Gains, Who Loses and How: Leveraging Gender and Class Intersections to Secure Health Entitlements," 2012
[154] Ibid. p.64, quoted from Desai, Sapna. "Pragmatic Prevention, Permanent Solution: Women's Experiences with Hysterectomy in Rural India" 2016
[155] Garg, Goyal and Gupta. "India moves towards menstrual hygiene: subsidized sanitary napkins for rural adolescent girls-issues and challenges." p.769

social and economic factors that lead to (persistent) health concerns, like poverty, low education, discrimination against certain castes and women, infant mortality, and social security.[156] This feeds into another complaint that has persisted since Deodhar's writing: that primary care is often morphed into curative care, which weakens not only the reputation of public health in general, but establishes the image of public and primary health as a sector which solely deals health emergencies like pandemics, while the private sector – which is not affordable for all – deals with care.[157] Along with this comes an assumption that health problems can be dealt with in the short-term, as health policymakers consider the best solutions to be immediate and curative in nature, rather than long-term and with care in mind – emergency sells, and emergency *convinces* policymakers to generate and support curative policies that (for example) call for the rapid eradication of Covid-19 while neglecting persistent iron deficiencies in nearly half of India's female population.[158] In the words of one Indian scholar, "the need for permanent health solutions is forgotten" in the contemporary PHC system.[159]

Another source of grievance relates to growing social inequalities and health. Indians perceive an unwillingness to shift the narrative among the wealthy upper classes who are in the best position to influence policy change.[160] This is partly because the health needs of the wealthy are more easily met through both public and private means, but also due to the (in)visibility of poor or underserved patients on the national policymaking level perhaps leading to the false assumptions among uninitiated policymakers that most Indians' health needs *are* being adequately met. Finally, the many who are unsatisfied with the PHC system are confused by and doubtful of the mismatch between the official national narrative and the local reality in terms of international aid: "It does not make national sense to have the basic needs of the majority of the population unmet. However, many international aid agencies prefer to support specific and vertical health programmes for particular diseases,"[161] Aid agencies, donor countries or other entities granting financial assistance might see greater global benefit in terms of reputation by supporting the initiative to eradicate HIV/AIDS rather than to support a push to equip all facilities with sterile surgical equipment. These donors and funders also indirectly reinforce the narrative of cure rather than care, and often "side step the fact that even

[156] Jacob, "Public Health in India and the Developing World." p.562
[157] Ibid. p.562
[158] Ibid.
[159] Ibid.
[160] Ibid.
[161] Ibid. p.563

minimal improvements in the health of populations are determined by social and economic factors, rather than by medical input."[162]

Through these grievances, everyday Indians (as well as the scholars that publish their views) indirectly refer to the problems outlined in the theoretical chapter of this thesis: people are unhappy that power structures and financial means dictate the selective application of adequate healthcare, and people are upset that the health concerns deemed emergencies are more openly and adequately funded by international sources, influencing the national government, than everyday problems.

Aid and Financing

Adding fuel to the fire is India's participation in the aid-giving structure. India focuses its own DAH on the development of health infrastructure in areas key to India's own development: this means regional neighbors, like Nepal, Bhutan, and even Afghanistan (as a response to China's growing influence through the Belt and Road Initiative) receive the most DAH from India as of 2020.[163] India's DAH efforts globally have, from 2009 to 2020, committed US$100 million to countries bilaterally across its regional "backyard" as well as Africa.[164] India was also instrumental in aiding the development of the WHO Framework Convention on Tobacco Control (WHO FCTC), the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and pandemic preparedness efforts globally, which indicates that an international presence on health is of greater immediate importance of the Indian government than filling the gaps in its domestic coverage of everyday health.[165]

Of domestic funding, India's health system was found to be the most privatized of the BRICS countries with 63% of health spending being out of pocket in 2014.[166] Due to the low government investment and the resulting low quality of PHC centers, many rural people – as many as 78% – relied instead on private health providers for healthcare in the same year, which indicates that over a 14-year period, the percentage of reliance on OPP payments only sank by 4.2%.[167], Indeed, "a considerable proportion of healthcare seeking in India is in the (largely

[162] Jacob, "Public Health in India and the Developing World." p.563
[163] Huang, "Emerging Powers and Global Health Governance" p.309, 313
[164] Ibid. p.309
[165] Motari, Nikiema and Kasilo, *et al.,* "The role of intellectual property rights on access to medicines in the WHO African region: 25 years after the TRIPS agreement" pp. 2, 6, 7, 10 and Huang, "Emerging Powers and Global Health Governance" p.306
[166] Huang, "Emerging Powers and Global Health Governance" p.309
[167] Powell-Jackson, Acharya, Mills, "An Assessment of the Quality of Primary Health Care in India." p.58

unregulated) private sector," which represents a continuation of patterns that have now persisted for 2 decades.[168]

Since 2005, the PHC situation in rural India has not changed significantly, because skilled professionals remain scarce, professional absenteeism persists, medicines are often unavailable, and centres lack structure from supervision to monitoring. These findings reinforce a lack of government concern, manifested in a lack of government investment into PHC. Indeed, public health expenditures were as low as 0.94% of India's GDP in 2008 and would only increase minimally in the following years.[169] This level of state expenditure on public health for a lower-middle income country with increasing development in other areas.[170] According to current WHO numbers, India now spends 3% of its GDP on health domestically, which was the conservative national aim in previous years.[171] Yet according to earlier recommendations from the 1980s which idealized India's health contributions at 6% to 8-9% of GDP *by 2000,* it is clear that the country still has space to improve. On the state level, similar gaps between the reality and the ideal have persisted, since the reported average health spending is 5% of state budgets rather than the suggested 8% – a percentage first recommended in 2002.[172]

Success Stories and Potential Solutions

There have been pockets of success throughout India, like Aravind Eye Care System which allows poorer patients' care to be subsidized by wealthier patients' payments; the LifeSpring Hospital System which makes access to reproductive care easier for low-income households (and women), and the Narayana Hrudalaya (NH), an association of medical facilities that has achieved success in providing effective, yet low-cost care.[173] Yet these examples of success have not been adopted nationwide, let alone on a state-wide basis. Yet there has been a renewed effort since 2013 to improve what many regard as the first step to effective PHC: the establishment of facilities. The new (since 2018) Ayushman Bharat Program (ABP) introduced Health and Wellness Centres (HWCs) which would refresh and put a new spin on PHC based on failings of the past. From 2013 to 2018, the idea of HWCs was floated, initiated, designed, budgeted and the first location established in the Central-Eastern state of

[168] Powell-Jackson, Acharya, Mills, "An Assessment of the Quality of Primary Health Care in India." p.58
[169] Ibid.
[170] Ibid.
[171] People's Health Movement, "B4: Dysfunctional Health Systems" p.110, and World Health Organization, Country Data on India. https://data.who.int/countries/356
[172] Lahariya, "Health & Wellness Centers to Strengthen Primary Health Care in India" p.922
[173] Huang, "Emerging Powers and Global Health Governance" p.316

Chhattisgarh. Within one year, 17,149 Ayushman Bharat Health and Wellness Centres (AB-HWCs) were established and functioning across Indian states. AB-HWCs were sometimes established in the same building as former PHC centers or Subcenters, evoking images of new saplings growing from the stumps of felled trees and reinforcing the notion that new facilities need not be established in new buildings. 8,801 PHC centers and 6,795 subcenters were converted in this manner.[174] This exceeded the goal by over 2,000. The emergence of Covid-19 stunted this spectacular trajectory, yet by the end of March 2020, 38,595 HWCs were functioning in India.[175] AB-HWCs are meant to have strengthened infrastructure, streamlined and effective referral mechanisms, plenty of staff with multiple skills and steady compensation, be located closer to communities in need, provide free medicines and general diagnostic testing, involve local communities and employ tele-health and other remote means of health services; clearly intended to fill prior gaps related to accessibility and patient confidence.[176] The live progress tracker on the Ayushman Bharat webpage signals that as of late April 2023, 159,632 HWCs are active in India, which appears to indicate that the goal of 150,000 HWCs by December 2022 had either been reached on time, or had been reached in the few months thereafter, yet it is unknown how functionality is assessed by this website or how often the number is truly refreshed.[177]

To sustain this progress and ensure that perception of this new program remains positive and rural access remains at the forefront of the mission, planners and policymakers should ensure that all salvageable PHC centers in any given geographic area can be made functional simultaneously for (a) the perception of PHC in India to improve regionally and from the bottom-up and (b) so as not to overburden specific PHC centers or AB-HWCs that become functional sooner than others. This consistent with one scholar's remark that ". . . people start attending the government facilities if the facilities are made functional and the services are available in an assured manner, people prefer PHC over complicated and overpowering large hospitals."[178] The AB-HWC formula has been planned to coincide with a greater degree of deregulation from the Government of India, which has been a suggested solution by many scholars writing before the implementation of the HWC system. This decentralization push, however, means that states must step up: they must ensure that the facilities within their borders

[174] Lahariya, "Health & Wellness Centers to Strengthen Primary Health Care in India" p.918
[175] Ibid. p.918
[176] Ibid.
[177] "Ayushman Bharat – Health and Wellness Centres Report Card" at https://ab-hwc.nhp.gov.in/
[178] Lahariya, "Health & Wellness Centers to Strengthen Primary Health Care in India" pp.922, 923

are context-specific in care and services, which likely (or hopefully) will increase the amount of region-specific scholarship on PHC concerns.

Finally, aside from necessitating community involvement from the very start, PHC services need to recast their narratives from "cure" to "care," and to do this, they must offer a range of diagnostic services like yearly check-ups and screenings for common illnesses, rather than being content only to treat a problem that is known or suspected by the patient.[179] Covid-19 did slow down the rollout of AB-HWCs, but it was a blessing in disguise. It showed India the need for comprehensive health "education on hand washing, cough etiquettes, personal hygiene and physical distancing." [180] It also made possible the intensification of telehealth initiatives and the legalization of over-the-phone prescription and at-home delivery of medicines, which could completely change the game for rural people who choose not to attend PHCs due to the potential commute.

As the narrative shifts and the need for specialist practitioners is reinforced, so too should the accountability within health facilities be encouraged. This can be done through creating independent agencies at the district, rather than state level, to oversee the health processes on a micro level.[181] Finally, and perhaps most generally, the lesson India's PHC trajectory has taught has been one on the importance of integration. That is, it would be a mistake to continue to view PHC in a vacuum, and to blame the inefficacies of the PHC system on the health sector alone. PHC should be defined as a method of care within a network of other branches of the health system which are in urgent need of top-down structural changes which are intended to lead to bottom-up engagement and strengthening.[182] Policymakers should also be conscious of the PHC system's placement within a network of other systems – most noticeably, economics and finance, but also physical infrastructure, rural development, and perhaps most pressingly, domestic and even global policy.

[179] Lahariya, "Health & Wellness Centers to Strengthen Primary Health Care in India" pp. 922, 923
[180] Ibid. p.925
[181] Pandve, and Pandve. "Primary Healthcare System in India" p.127
[182] Ibid.

Case 2: Nigeria

Nigeria was chosen to be the second case study in this thesis due to its outward similarities to India: a rapidly growing economy despite threats of worsening poverty, a rapidly growing population, lower-middle income status according to the World Bank, an ethnically and lingually diverse population spread across several states, and finally a commitment to PHC stemming from the pre-neoliberal period.[183] The greatest difficulty in using Nigeria as a case study stems from a lack of consistent data and scholarship. Relative to India, the available resources with which to study the trajectory of Nigerian PHC are limited. Far more prevalent are studies on health emergencies like pandemics or epidemics like HIV/AIDS. While Nigeria's growth – both demographically and economically – is smaller than India's, Nigeria nonetheless represents a growing power and influence in its own region (Sub-Saharan Africa), much like India's role in South Asia.

Before the state of Nigeria's contemporary PHC system can be described and analyzed, this thesis will offer a brief historical overview of Nigerian development under colonial rule, Nigeria in its initial years of independence, and a description of the Nigerian structure of government as it pertains to health matters. Then some ideas and hypotheses from former Nigerian Health Minister and activist Olikoye Ransome-Kuti will be used to set the tone for the intended trajectory of the Nigerian PHC system, and Nigeria's independent history will be broken up into four "waves" of PHC development, with the fourth and final wave being the contemporary period. This fourth and final wave will be analyzed in its own subsequent subchapter, followed by some potential solutions.

Political and/or Economic Transformations (Mid-20th Century Onward)

Before full Independence was gained on the first of October 1960, Nigeria existed under British colonial rule since its colonization in 1884. While concepts in India like *Arogya* are traceable and remain popular, even in the 1950s, very little scholarship existed on pre-colonial Nigerian health, save for some hypotheses that approaches to health would have been different across the four kingdoms (Dahomey, Fulani, Yoruba and Hausa), and that they would likely not have been classed as medical procedures in the Western sense.[184] Moreover, the vast majority of early (mid-20th-century) scholarship on Nigerian health concerns itself with post-independence health matters and is written from a non-Nigerian perspective, making any theory

[183] According to a World Bank factsheet, Nigeria's economy is predicted to grow by 2.9% each year until 2025, but the number of Nigerians below the national poverty line is also expected to rise by 13 million.
[184] Patterson, "Disease and Medicine in African History: A Bibliographical Essay.", pp.143, 146, 147

of Nigerian health *before* the colonial period (or even during it, in rural settings) incredibly elusive – if such texts even exist. What is known, however, are the broad impacts of colonial structures on Nigerian society, as well as some health data from around independence. These indicate that, as one scholar writing in 1961 wrote, "the major purpose of British rule . . . [in] Nigeria for almost one hundred years was not primarily that of tutoring and freeing the natives," indicating that health – along with education and political involvement – would have been low on the checklist of British colonial priorities.[185]

In the early decades of the 20th century, a deep sense of resentment had already built up among Nigerians against colonialism and the British rule, with its overt white supremacy and its policies of "separateness . . . in all spheres of social life" which had contributed to massive inequalities.[186] By the 1940s, "job opportunities and promotion for Nigerians were limited," which included leadership roles in the public sphere including government positions, and achieving high rank in private organizations.[187] The realm of education did not go untouched by inequalities either. Despite the 1934 establishment of the Yaba Higher College, a medical school aimed at educating Nigerians, the institution was not granted university status and therefore only awarded diplomas instead of full degrees, which limited the job prospects for its graduates in the medical field.[188] While this is only one example of the colonial impact on education, the same would be true for other institutions, including those related to politics and administration, resulting in a lopsided degree of Nigerian representation in government, even after Britain began to loosen its grip on Nigeria beginning in the 1940s and 50s.[189]

Upon independence of the "biggest free black nation in the world" in 1960, the priority was not immediately health-focused, as ingrained structural issues of lacking local representation on the political level persisted.[190] American scholar Edward K. Weaver, writing in 1961, asserts that Nigerian priorities were neither Western nor Eastern (given the Cold War context), but instead were focused on being a voice and example of strength within the African context.[191] At independence, Nigeria was estimated to have been made up of *more than* nine regional (but sometimes overlapping) tribes, three major religious groups, and a significant

[185] Weaver, "What Nigerian Independence Means." p.151
[186] Odegowi, "From Conquest to Independence: The Nigerian Colonial Experience" p.23
[187] Odegowi, "From Conquest to Independence" p. 24
[188] Ibid.
[189] Ibid. pp.24, 27
[190] Weaver, "What Nigerian Independence Means." p.146
[191] Ibid. p.147

minority population of non-Africans – all speaking a selection of more than 250 languages.[192] Despite the potential for disunity that could arise from this, an independent Nigeria viewed this diversity as "a source of unique strength [and unity]" as well as nurturing a productive sense of developmental competition.[193] In the political arena, power was derived from "tribal traditions and the local potentates" who may be western educated, but who may instead be influenced by "the ancient ways" and viewed in a religious, rather than secular, context.[194] At independence, illiteracy levels rested at around 85%.[195] In terms of health, Weaver summarizes the numbers best:

> "Nigeria comes into independence with, in 1960, only 107 government hospitals with 9,544 beds - there are 118 private hospitals with 6,775 beds, and 225 "other" hospitals with 16,301 beds; there are only 958 registered medical practitioners in all Nigeria, fewer than 40 dentists and only two places where eyeglasses may be properly secured."

Additionally, 1958 data indicated that the most prevalent causes of death were overwhelmingly health related. From most to least prevalent, these were "bronchitis and the pneumonias," followed by malaria, dysenteries, (most likely) heart disease, tuberculosis, measles, motor vehicle accidents, whooping cough and cancers. In the large and urban city of Lagos, more than half of all deaths in 1958 occurred in children under 4 years of age – signaling a high infant mortality rate.[196] Weaver concludes his health overview by stating that "major killers in this modern city are amenable to prevention, control, cure and treatment with modern health services, drugs and hospital care," but that a high level of social inequalities exist that make treatment access to many impossible.[197] This brief health overview indicates that initial health prospects in Nigeria were grim. If urban and modern cities like Lagos, for example, faced such high rates of infant mortality and such low rates of medical care in general, what steps were taken before and after Alma-Ata to solve these problems?

Health Background (Mid-20th Century Onward)

Writing in 1987, former Nigerian Health Minister Ransome-Kuti wrote that in the decades around independence, cultural and social factors were not seen to be potential determinants of ill health and disease in Nigeria. Additionally, the practices of traditional

[192] Weaver, "What Nigerian Independence Means." pp.148, 149
[193] Ibid. p.149
[194] Ibid. p.150
[195] Ibid. p. 151
[196] Ibid.
[197] Ibid.

healers, like feeding children mixtures with cow urine to cure tetanus or pouring cold water over babies' heads to resuscitate them were often more harmful to health than helpful – yet they were widely considered effective methods of treatment.[198] Ransome-Kuti suggests it was the creation of a global health movement in the early 1970s which spurred Nigeria forward on its path to comprehensive PHC. Yet, with this global shift toward health improvement came a great difficulty for developing countries like Nigeria – the pressure and expectation "to assimilate very quickly the new ways of doing things," without testing them or measuring them against previously-accepted health norms and practices. An unreasonable degree of blind trust was asked of developing countries. Even if Western health approaches could be more effective than existing Nigerian ones, Ransome-Kuti stated that the roots of distrust of Western institutions arose from this global pressure and the lack of time and space Nigeria was given to balance Western medical practices with traditional ones.[199] Thus, in Nigeria and elsewhere, where there was "no tradition of scientific thought or method" and "phenomena may [have been] attributed to gods and the spirits of ancestors," changes were expected to come about within the span of mere decades.[200] Here, power structures facilitated through international relations disregarded local and even national needs in the interest of the homogenization of *doing* health. Another problem anticipated by Ransome-Kuti was one of lacking multi-sector involvement. It is now known that horizontality – or the inclusion of health in all sectors – is vital to the implementation and sustainability of health systems. But in Nigeria before the 1970s, "there was no government or community participation" in health, indicating not only a persistent verticality in Nigerian health, but also that a model which ignores the politics of health is ineffective.[201]

Finally in the mid-70s, there was a first push focused on increasing the availability of everyday healthcare. This First Wave, from 1975 to 1980, saw the establishment of the Basic Health Services Scheme (BHSS) within Nigeria's Third National Development Plan which stretched from 1975 to 1979. Under this scheme, 20 clinics were set up across each local government area (LGA) and would be supported by 4 PHC centers.[202] Additionally, mobile clinics were established, intending to serve 150,000 people each, though it is also unclear how many of these mobile clinics were created. The pitfalls of this wave are relatively clear to see

[198] Ransome-Kuti, "Finding the right road to health" p. 161
[199] Ibid.p.161
[200] Ibid.
[201] Ibid.p.162
[202] Aigbiremolen, Alenoghena, Eboreime et.al., "Primary Health Care in Nigeria," p.36: It is unclear whether there were 4 of these for each state or 4 in total, though it is interpreted that the former is true.

in retrospect. The lack of clear reporting on the success of this plan creates some confusion as to the total number of PHC centers and mobile clinics which indeed resulted from this wave. This lack of clarity, given Nigeria's continued population growth, indicates that PHC coverage in this wave would be patchy at best. Moreover, local communities were *not* involved in the planning and implementation of health schemes in this wave, indicating a persistent lack of horizontality and bottom-up support and acceptance.[203]

Ransome-Kuti, who had been educated in both Nigeria and England, would come to stand at the helm of new policies in the early 1980s which aimed to make "compulsory the recording of maternal deaths and [encourage] the continuous nationwide vaccination." He also "pioneered [an] effective HIV/AIDS campaign."[204] In 1985 he was promoted to Health Minister and was keen on implementing the aims of the Alma-Ata declaration in Nigeria. PHC based on Alma-Ata being adopted in 52 LGAs is testament to this.[205] Ransome-Kuti argued that any health-related initiative, like his expanded program on immunization, could only be sustained if "anchored to primary health care systems such as were advocated at Alma-Ata in 1978."[206] From this conviction stemmed the Second Wave (1986 – 1992).

Under the guidance of Ransome-Kuti, PHC was intensified in this wave. 52 LGAs would implement PHC models within their health systems, including within the clinics that had been established in the previous wave of development. These models would ease in the achievement of the 8 components of PHC: *public education, nutrition, clean water and sanitation, immunization, disease control and prevention, accessible treatment and availability and dispersal of medicines.* Under this system, Nigeria reported an 80% immunization coverage of children under 5 and focused on involving communities in the health reform process.[207] This wave can be considered as the most successful of the three historical waves. Still, PHC as a concept was not officially adopted in Nigerian policy until 1988 under that year's National Health Policy declaration.[208]

Another argument Ransome-Kuti made during this wave was that no country – and therefore no national health strategy – can be identical. While HICs certainly represented a catalogue of health system role models, the country implementing said models would have

[203] Aigbiremolen, Alenoghena, Eboreime et.al., "Primary Health Care in Nigeria," p.41
[204] Aregbeshola and Khan. "Primary Health Care in Nigeria."p.1
[205] Ibid. p.1
[206] Ransome-Kuti, "Finding the right road to health" p.162
[207] Aigbiremolen, Alenoghena, Eboreime et.al., "Primary Health Care in Nigeria," p.36
[208] Ibid. p.36

inherently different circumstances, problems and needs than its role model. Ransome-Kuti argued that ". . . it is possible to train health personnel to serve the needs of a particular country. . . . developing countries, now more than ever before, must learn the meaning of self-reliance and put it into practice. . . we must identify our goals clearly and realistically and pursue them with great purpose, and we must refuse to accept aid that would thwart them."[209] This statement references aid from HICs that might seek to strengthen the military or political connections, rather than domestic circumstances. Yet despite Ransome-Kuti's diplomatic pattern of writing, by 1987, Nigeria has already been contending with targeted aid, symptomatic of a neoliberal global economy. Like Deodhar's warnings on India, Ransome-Kuti's wise advice to scrutinize aid and its intentions would fall on deaf ears.

Here it is important to briefly describe the 3 tiers of Nigerian government and their *intended* role in PHC upkeep. These are the federal, state, and local governments. Each should have some formal degree of responsibility for the healthcare system. The federal government devises and implements policy, assists with technical and planning strategies, implements the integration of the National Health Policy on the state level, and creates and strengthening health-related information initiatives. Additionally, the federal government carries out surveillance of diseases, the regulation of drugs and medicines, the training of health professionals and the management of vaccines.[210] State governments comprise of many parts, including State Hospital Management Board(s), State Ministries of Health, and Local Government Areas (LGAs). General hospitals, which fall under the category of secondary health facilities, are meant to be supported and controlled by the state governments. Sometimes, the state also influences the control of tertiary hospitals and some PHC facilities.[211] LGAs oversee PHC facilities inside their borders and provide hygiene, sanitation, and other community health services.[212]

The Third Wave, from 1992-2001, is perhaps a greater negative turning point for Nigerian PHC than existing scholarship indicates. The National Primary Healthcare Development Agency (NPHCDA) was created in 1992, along with the Ward Health System (WHS) which allowed local governments to control PHC rather than the state, as was mandated

[209] Ransome-Kuti, "Finding the right road to health" p.163
[210] Gyuse, Ayuk, and Okeke, "Facilitators and Barriers to Effective Primary Health Care in Nigeria." p.1
[211] Ibid. p.1
[212] Ibid.

by the military government.[213] While decentralization could have benefitted the PHC system if it meant a greater level of autonomy by local communities backed by the requisite funding, the reality reflected a different motive. In this stage, the focus appeared to shift to disease rather than people and accessibility, with the Ward Minimum Health Care Package (WMHCP) establishing minimum baselines for disease prevention above all else.[214] Still, this disease prevention-oriented scheme was well aligned with the Millennium Development Goals (MDGs) set for Nigeria, which indicated a prioritization of global messaging rather than local needs.

In this wave of development, 500 new health centers were established and were often headed by community representatives rather than solely by state powers. Yet despite significant effort to reorient Nigerian healthcare schemes towards local involvement and community influence being aligned with Alma-Ata, this sudden "devolution" of healthcare from the federal level to the local government level had an overall negative impact on the trajectory of health development. For one, local government in this period controlled the fewest resources and the "lowest technical capacity" of any government level.[215] In other words, LGAs were given all the responsibility but none of the technical or financial support. Moreover, this process of devolution was far more sustainable under a military dictatorship, which was challenged in 1999 when democracy was established and a certain degree of downward pressure on LGAs but also support disappeared.[216]

The three waves of historical PHC development after independence illustrate a well-meaning process which was badly executed, especially for the rural poor. As in India, the First Wave represented a phase of idealistic progress whose results – only patchily documented – indicate a failure to reach initial goals. The Second Wave was perhaps most effective due to the changes in perception of PHC. Ransome-Kuti was able to convince powers on the political level that PHC could be successful in Nigeria, *by Nigerians.* Yet, his campaign and time as Health Minister were unable to solve the prevailing problems of verticality in Nigerian health – both in terms of sectoral responsibility-sharing and the involvement of local people in determining their own health journeys. The Third Wave loosely followed Ransome-Kuti's prescription of decentralization yet did not support this step with aid to the LGAs hastily made

[213] Aigbiremolen, Alenoghena, Eboreime et.al., "Primary Health Care in Nigeria," p.37, and The Lancet, "Obituary: Olikoye Ransome-Kuti" p.175.
[214] Aigbiremolen, Alenoghena, Eboreime et.al., "Primary Health Care in Nigeria," p.37
[215] Ibid. p. 37
[216] Ibid.

responsible for the country's PHC. Add to this the inconsistent nature of the Nigerian political structure, and the picture of a nation's health left on the back burner emerges.

In 2000, Nigeria ranked among the worst in the world in terms of healthcare, coming 187th out of 191 in a WHO ranking. By 2002, after the end of the Third Wave, 63.1% of respondents in a study conducted the same year reported that they used PHC services frequently, but a third of these also admitted to having also used drug shops or "hawkers" to treat their ailments when PHC services proved to only address certain issues or did not provide adequate treatment (or education on the necessity of such a treatment).[217] Of the features rated most constraining to a participant's choice to use PHC services, the top two chosen were cost as well as waiting time.[218] These complaints indicate that PHC was more expensive than the average person could comfortably afford, and that well-equipped, well-staffed and accessible facilities were too few in number. These perceived shortcomings also indicate a lack of horizontality at the end of the Third Wave, especially in terms of general health and hygiene knowledge in the rural public on, for example, the importance of visiting a general healthcare specialist at least once a year, following prescribed treatments until a medical professional deems the problem resolved, and understanding the basic functional differences between legally prescribed drugs and drugs sold on the street. This same 2002 study found that the more educated the person, the more likely they were to use PHC services: 19% with no formal education indicated they did not use PHC services, while only 3.6% with a tertiary education reported the same.[219]

At the end of the Third Wave, perception of PHC in Nigeria was also addressed by this study. Key informants in the health sector in rural Nigeria were asked to evaluate PHC services and their use by the public. According to these informants, most people in the community were ignorant about what purposes PHC facilities served, and therefore do not elect to go, instead opting to buy medications at drug markets or from hawkers, or would attempt to self-treat, especially among the uneducated or the marginally educated.[220] The unavailability of drugs and medications also made PHC facilities less attractive to those seeking treatments, and reflected the poor quality of PHC facilities in general.[221] The reason for the general practice of visiting medicine hawkers stemmed from the fact that most people in the region were poor

[217] Sule, Ijadunola and Onayade, et.al, "Utilization of primary health care facilities: Lessons from a rural community in southwest Nigeria." p.100
[218] Sule, Ijadunola and Onayade, et.al, "Utilization of primary health care facilities" p. 100
[219] Ibid. p.100: 9.3% with primary education and 4.6% with secondary education did not attend.
[220] Ibid. p.102
[221] Ibid.

subsistence farmers who could not afford the standard prices of medicines or services at PHC facilities. By 2004, OPP spending in Nigeria was "one of the largest [in terms of] total household expenditure in developing countries" at the equivalent of USD$22.50 per household, or 8.7% of total household expenditures.[222] Finally, and as in India, the lack of availability of healthcare personnel – most prominently doctors – dissuaded people from waiting for appointments at PHC facilities.[223] Wages among medical personnel were low – in some cases, only 25% of that of their Western counterparts, which one study asserts contributed to a brain drain of as many as 21,000 Nigerian doctors electing to work abroad in 2012.[224]

Current PHC Situation – Fourth Republic, Fourth Wave

By 2016, Nigerian citizens numbered in the 182 million, and by 2020, Nigeria's total population numbered over 208 million.[225] Nigeria remains mostly rural and agrarian, punctuated by large, urban cities. Nigeria's population consists of over 374 ethnic groups which speak 5 main languages, and the life expectancy has risen from an average of 54.5 to 62.2 from 2016 to 2020, though when adjusted for disability, this number falls to around 39.[226] The official unemployment rate stood at 14% in 2016, though is estimated to be much higher as the youth unemployment rate hovered around 47% in the same year, suggesting that a vast number would experience a decline in their standard of living after an unexpected OPP.[227] To put this into perspective, Nigeria's population is considered young, which means a large portion of the population is 15 years old or under.[228]

The NPHCDA established in the Third Wave experienced an upswing in republican Nigeria. Routine immunization efforts were restarted (for example: through the National Routine Immunization Strategic Plan from 2013-15), as well as certain initiatives against polio and infant and mother mortality.[229] This all occurred through a reintegration of PHC on the national government level and through the creation of new systems, like the National Health Management Information System (NHMIS) and the Quarterly Primary Healthcare Planning and Reviews process, which would observe healthcare processes and report on whether 6

[222] Obansa, and Orimisan, "Health Care Financing in Nigeria: Prospects and Challenges," p. 224
[223] Sule, Ijadunola and Onayade, et.al, "Utilization of primary health care facilities" p. 102
[224] Obansa, and Orimisan, "Health Care Financing in Nigeria: Prospects and Challenges," p. 224
[225] World Health Organization, Country Data on Nigeria: https://data.who.int/countries/566
[226] Gyuse, Ayuk, and Okeke, "Facilitators and Barriers to Effective Primary Health Care in Nigeria" p.2
[227] Ibid. p.1,
[228] United Nations, "World Population prospects 2022" https://population.un.org/wpp/Graphs/DemographicProfiles/Pyramid/566 (refer to figure IV)
[229] Aigbiremolen, Alenoghena, Eboreime et.al., "Primary Health Care in Nigeria" p.40

"determinants of PHC outcomes" including "availability of commodities, human resources and geographical accessibility, . . . initial utilization, continuity and quality of coverage" were being met.[230] Yet a big problem persists: the acceptance and implementation of such systems by each of Nigeria's 36 states. Despite all having received training on this methodology of PHC and the tracing of its effectiveness, as of 2013, only 3 states (Lagos, Kaduna and Nasarawa) had institutionalized any of these nationally devised measures, laying bare the difficulties of coordinating effective community involvement while maintaining national leadership of health matters.[231] In 2013, the PHC Under One Roof initiative was launched with the aim of integrating all states, but this is still underway and far from complete. Despite significant moves in the right direction, "the quality of routine health data in Nigeria still leaves much to be desired" as late as 2014 and these problems were "further complicated by the poor private sector compliance."[232]

In a 2016 study, 48 facilities from 6 rural states in each geographical zone were randomly chosen, and a selection of their services related to PHC judged from a scale of "fully compliant"/100% to "not applicable"/0% The average scores fell between 38% and 51% in terms of compliance. [233] Among the most valuable findings to the study were those related to technical support and leadership structures. Among the best performing PHC facilities, community support was high, and staff were focused on providing technical support and increasing the effective capacity of their facility. Even though all facilities were assigned a Ward Development Committee (WDC), only those which "offered support to the facility in various forms inclusive of recruiting cleaning and security staff" were most compliant.[234] The study also revealed a possible widespread "lack of adequate drug administration, guiding procedures and monitoring" after nearly all examined facilities neglected to maintain and implement guidelines for the treatment and management of local or regional concerns, like malaria.[235] Additionally, across the board, there were "deficiencies . . . in the security of patients and staff, infection control, waste management, occupational health and fire safety," all of which are capital intensive categories and "beyond the capacity" of the facilities to implement on their own.[236]

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[230] Aigbiremolen, Alenoghena, Eboreime et.al., "Primary Health Care in Nigeria" p.39
[231] Ibid.
[232] Ibid. p.40
[233] Ugo, Ezinne and Modupe, et.al., "Improving Quality of Care in Primary Health-Care Facilities in Rural Nigeria: Successes and Challenges." pp.2, 3
[234] Ugo, Ezinne and Modupe, et.al., "Improving Quality of Care in Primary Health-Care Facilities in Rural Nigeria" p.4
[235] Ibid.
[236] Ibid.

In a 2017 study of PHC effectiveness, the Nigerian system was labelled "appalling with only about 20% of the 30,000 PHC facilities . . . working."[237] This was due to inadequacies in staffing, inadequate equipment, poor distribution of professionals, insufficient healthcare services, inferior infrastructure, and low medical supply. Part of this contemporary weakness can be traced back to the devolution of the PHC system to LGAs in the 1980s which continued well into the 1990s. Despite the presence of the PHC Under One Roof policy and others, as of 2017, the effects of these initiatives were not yet widely felt. Meanwhile, the underperformance of the PHC system has led to a significant outflow of patients to the secondary and tertiary health facilities – an eventuality for which these kinds of health facilities were unprepared and therefore overburdened.[238] Not only have inadequacies in the PHC system put undue pressure on secondary and tertiary health systems, but they have also increased the tendencies to gravitate either towards the private healthcare sector or to spiritual healers. "The private sector includes for-profit services, faith-based non-profit services and corporate-based services."[239] Even though 85.5% of Nigerian health facilities are ostensibly based on PHC, basic healthcare coverage struggles to reach those in rural areas – either due to spotty coverage or due to inadequacies in existing healthcare facilities.[240]

Financing and Failures to Reach the Poor

A perceived problem on the level of political commitment – and a factor which is too often considered the sole cause of PHC failure in Nigeria – is that Nigerian politicians and policymakers do not see health as a fundamental human right. This is reflected in a practical example: despite Nigerian leaders signing the 2001 Abuja Declaration on (among other goals) allocating 15% of the annual budget to improving health and the health sector, such action had not ever been implemented as of 2017.[241] There is even some suspicion about *why* the healthcare sector is stagnating (according to the current SDG Nigeria factsheet) given increasing oil wealth in the country since 1980.[242] This speaks not only to low political motivation to advance PHC, but also to possible corruption and misallocation of funds, since the existing monetary inputs would be assumed to yield better outputs than has been the case.[243]

[237] Aregbeshola, Samson, and Khan. "Primary Health Care in Nigeria" p.1
[238] Ibid. p.2
[239] Gyuse, Ayuk, and Okeke, "Facilitators and Barriers to Effective Primary Health Care in Nigeria." p.1
[240] Ugo, Ezinne and Modupe, et.al., "Improving Quality of Care in Primary Health-Care Facilities in Rural Nigeria" p.1
[241] Aregbeshola, Samson, and Khan. "Primary Health Care in Nigeria" p.2
[242] Gyuse, Ayuk, and Okeke, "Facilitators and Barriers to Effective Primary Health Care in Nigeria." p.2
[243] Ibid. p.2

The International Finance Corporation (IFC) increased its engagement with Nigeria in preparation to meet the MDGs, but its fund program, Health in Africa Investments, which were meant to alleviate healthcare concerns for the most underserved, displayed poor progress. National targets as well as international goals, like the Millennium Development Goals, remained unmet. In 2014, only 25% of infants under 1 year old were fully immunized.[244] Nigeria "bears 14% of the entire global maternal mortality burden," and yet, the Africa Health Fund invested significantly in the first Nigerian in vitro fertilization (IVF) center intended to treat infertility problems. IVF is a notoriously expensive procedure and does nothing to solve the maternal mortality problem that those unable to afford IVF would be more likely to experience.[245]

If such financing measures achieved anything, it was to lay bare the problem that very little health funding likely reaches the poor. While it has proven a challenge to trace funding to confirm that it is indeed *not* reaching its target audience, the poor outlook of rural health in Nigeria should be some indication that the money flowing in is not trickling all the way down as intended. In 2014, Health In Africa (HiA) investments most overwhelmingly went to "expensive, high-end, urban hospitals offering tertiary care to African countries' wealthiest citizens and expatriates . . . those rich enough to seek care overseas as health tourists."[246]

In one review of the basis of inadequate health and healthcare in Sub-Saharan Africa, "unequal and unjust economic and political relations between Nigeria and advanced countries, the neo-liberal economic policies of the Nigerian state, pervasive corruption, Very low government spending on health [and] High out-of-pocket expenditure" appeared prominently within a sea of interconnected reasons for the "comatose" nature of the Nigerian health system.[247] In terms of corruption, this study reinforces other findings that the widespread use of alternative or illegal drug markets tarnishes the health system – but rather than placing blame on patients or facilities, the study's authors suggest that such diversion of medicines is so rampant – and profitable – that even health professionals or government fund allocators could be 'in on it', citing an example of a health minister privately sharing – rather than allocating as intended – the equivalent of USD$650,700 in health sector funds.[248] In sum, internal conflict, corruption, profusion of agencies leading to stunted decision-making processes

[244]Gyuse, Ayuk, and Okeke, "Facilitators and Barriers to Effective Primary Health Care in Nigeria." p.2
[245] People's Health Movement, "D6: The International Finance Corporation's 'Health in Africa' initiative" p.312
[246] Ibid.
[247] Obansa, and Orimisan, "Health Care Financing in Nigeria: Prospects and Challenges," pp.222, 223
[248] Ibid. p. 224

(bureaucracy), low political motivation, inequities that favor urban areas to the detriment of the larger rural majorities, bad working conditions, ineffective distribution of healthcare professionals, including brain-drain, and poor functioning of training centers are most commonly cited as "the problem" – indicating that the multidisciplinary hypothesis related to neoliberalism, financing blunders and corruption holds weight, but also that horizontality must be featured in any future solutions. [249]

Potential Solutions Proposed by Nigerian Scholars

Several Nigerian scholars take issue with the control of the health system. PHC, considered by Ugo et.al., to be "the most important and consequential level of health care," remains functionally under the primary auspices of the LGAs – the weakest level of government. This is the case because ". . . LGAs lack adequate funding, manpower, and effective reporting lines, resulting in poor coordination and integration between levels of care and a weak and disorganized health system . . ."[250] Consequently, many have proposed an idealistic solution: that local and community-level involvement must be strengthened through community mobilization, underpinned by practical political commitment, which can be shown through funding and top-down support, which includes the maintenance of health infrastructure, adequate training of professionals, and a focus on obtaining and maintaining the best possible quality of medical materials and technology.[251] Given the intersectoral mix of problems, however, it could be difficult to set such a plan into motion.

Scholars like Aregbeshola, Samson and Khan, suggest that the primary and foremost problem with Nigerian healthcare policy is the lack of political will and engagement. A growing number believe that if the government strengthens its approach to improving healthcare (and indeed, presiding fully over these improvements), that the Nigerian health system could swing back on track with Ransome-Kuti's initiatives launched in the 1980s.[252] Yet two large potential hurdles exist that, if gone unaddressed, could result in a failure to launch in even the most well-meaning changes. The first hurdle would be the renewed disregard of community and local leadership in policy conception and implementation. This would potentially increase the longevity of stagnating health policy in the future, as local communities

[249] Gyuse, Ayuk, and Okeke, "Facilitators and Barriers to Effective Primary Health Care in Nigeria." p.3
[250] Ugo, Ezinne and Modupe, et.al., "Improving Quality of Care in Primary Health-Care Facilities in Rural Nigeria" p.5
[251] Aigbiremolen, Alenoghena, Eboreime et.al., "Primary Health Care in Nigeria" pp. 40, 41
[252] Aregbeshola, Samson, and Khan. "Primary Health Care in Nigeria"

struggle to come to terms with implementing national policies that may not be right or sensical to them and their needs. The second hurdle would be the indelible stain of neoliberalism that has, in the last decades, become ingrained in the parts of Nigerian society which hold the most power. It is perhaps misguided and overly pessimistic to think that the very presence of neoliberalism will prevent successful PHC from emerging in the developing context. But the norms that have been established on the level of financing and funding – and even *outside* the health sector entirely, like the pressure to innovate and grow economically – make high government expenditure and donations and funding to non-emergencies seem unappealing to existing power structures.

Ransome-Kuti's 1987 vision of Nigerian health was one in which Nigerians determine the scope and direction of their health systems – systems which prioritize PHC and are supported not only by local engagement, but by the state itself. In his ideal model, Nigeria would create health frameworks based on established science and data, but not necessarily based on the health systems of developed countries. Now the question remains: is such a system possible, or has the concept and practice of health been so thoroughly globalized that the independent roots of Nigeria's failing PHC system cannot be untangled from it?

Conclusions

It is important to remember that the two cases chosen for this thesis cover countries that are growing influences in their respective regions. These countries are not voiceless or powerless; not fully beholden to policy prescriptions of HICs. Yet their failures in establishing comprehensive, effective PHC speaks to greater ills which cannot *only* be blamed on the countries themselves – nor is the international system completely at fault. As stated in the introductory chapter, in health, an area which is as far-reaching and embedded in other sectors, there can be no single area of fault and no single catalyst for failure. This is a conclusion which is true everywhere – one need only look as far as the considerable private and OPP spending within the US health system to understand this.[253] What makes the cases of India and Nigeria important is their placement as top influencers in the developing world. It is estimated that 80% of the 35 million annual deaths attributable to noncommunicable diseases happen in lower- to lower-middle income countries, and India and Nigeria stand at the top of this category in terms

[253] According to the US CDC, in 2019, private health spending and OPP payments combined accounted for 45.6% of total healthcare spending. Additional studies indicate that as many as 44% of US inhabitants cannot afford healthcare, though it is unknown how much of this is related to PHC.

of influence.[254] That indicates that a shift in the delivery of PHC unlike anything established in the developed world could emerge here. As public health scholar Yanzhong Huang wrote, emerging countries, led by the BRICS, could have the opportunity to be gamechangers in global health policy, and perhaps bring about a new era of PHC.[255] However, the decisive shift back towards securitization in international affairs suggests that the developing world will face renewed difficulties achieving such a feat.

The efforts of current institutional bodies at the global level, like the WHO, are easily hampered by funding and financial issues, and their suggestions are therefore easily "sidestepped" by other international agencies like the World Bank, or even individual lender countries or organizations, who are more likely to (over)fund those areas deemed to be health emergencies.[256] When finances *are* allocated to PHC matters in LMICs, internal governance problems make the money difficult to trace, make it prone to rent seeking behavior or allocate it overwhelmingly to urban areas.

It is difficult to address the often-idealistic nature of proposed solutions – like heavy bottom-up involvement from underserved rural populations or even a "global south" health policy takeover – when there exists no clear enforcement mechanism to date. Even though a thesis like this cannot not offer actionable solutions and guides to achieve them, it *can* shed some light on the complex nature of the problem. Existing scholarship on the failures of PHC have often remained bound by one level of analysis, with the rise of neoliberalism in global health policy in one corner, and domestic political problems stemming from post-colonial insecurities and low government engagement on the other. By combining these internal and external factors, the root of the problem becomes clearer. To remove the weed, one must know where the root begins. In both India and Nigeria, the story of failure is fundamentally top-down. In both cases, independence heralded an era which challenged both countries to shake off colonial baggage that left health, but also finance and political structure, in shambles. In both cases, health found its place in political discourse, but priorities in the developing context had simply shifted elsewhere by the time health committees began to make recommendations: their economies had to be fixed – and the developed world came prepared with an answer – and answer which broadly took the shape of neoliberalism and appeared to be any LMICs ticket to "developed" status. The economic reforms adopted by both countries did not primarily target their health sectors, but they did cement certain values and processes which would have a

[254] Shawar and Ruger, "The Politics of Global Health Inequalities" p.60
[255] Huang, "Emerging Powers and Global Health Governance" p.312
[256] Ibid." p.305

profound negative impact on the unity and focus with which domestic policymakers could have dealt with PHC policy. These values and procedures included the securitization of (certain kinds of) healthcare and the consequent prioritization of illnesses deemed emergencies by lender countries, the rise of OPPs as a permanent fixture in PHC, and the continued casting-off of healthcare concerns from "high politics" in the interest of market development or increasing security. By the 2010s, several studies and reports had drawn similar conclusions, which indicated that domestic health spending *fell* after international funding rose, but also that "the lower the per capita income in a country, the larger the proportion of healthcare that is financed out-of-pocket, leading to a pernicious poverty trap."[257]

Ultimately, the failure to establish sustainable PHC in India and Nigeria *despite consistent efforts to do so* represents greater systemic challenges that most LMICs likely face, which include certain downward pressures – initially from the international system and then from domestic power holders – that drive health out of high politics. In this way, the only thing to "trickle down" was neoliberalism itself, rather than the financial backing promised to the urban and rural poor. Despite this, all hope is not lost. Movements have emerged in the last decade which have sought to develop historically Indian or broadly African ideas and philosophies on society and governance, which includes health. The inclusion of *Arogya* in the title or mission statements of some of India's post-COVID health initiatives reflect this shift, as does the increasing amount of scholarship on African solidarity in the realm of scholarship and higher education. While doubtful that nationalism can solve either country's PHC problem – or any PHC problem among LMICs – perhaps it is instead a shift away from doctrine of Western origin that can free up some national roadblocks to comprehensive PHC.

On the other hand, the perceived permanence of global economic and political expectations cannot be ignored. Just because international health aid focuses overwhelmingly on health emergencies rather than PHC, does not mean that aid is unnecessary. A decisive domestic policy shift in any LMIC could potentially threaten its ability to receive aid or loans, especially if those policy shifts appear to be non- or anti-neoliberal. At its most basic, the PHC problem in the developing world reflects the idea that even – or *especially* – on the global level, it is difficult to justify a national sea change in *any* area, even health. Thus, if PHC, as hoped, ever *does* come to play a greater role in high politics, established systems – which clearly do not work everywhere – may become even harder to escape. New bright spots in developing

[257] Lu, Schneider and Gubbins, et.al, "Public Financing of Health in Developing Countries" p.1382, and Schrecker, "The State and Global Health" p.282

countries' PHC processes, like the Jamkhed Comprehensive Rural Health Plan or the Imo State Health Insurance Agency, indicate that slow change for the better is possible, but whether these are sustainable in the long term, only the future can tell.

Bibliography

Acemoglu, Daron, Simon Johnson, and James A. Robinson, "Reversal of Fortune: Geography and Institutions in the Making of the Modern World Income Distribution," Quarterly Journal of Economics, Vol. CXVII (2002), pp. 1231–94

Aginam, Obijiofor, "The Global Politics of Neglected Tropical Diseases" In *The Oxford Handbook of Global Health Politics*, edited by Colin McInnes, Kelley Lee and Jeremy Youde, 569-582. New York: Oxford University Press, 2020.

Aguwamba, Sunday M., O.R.Ogbeifun and Ehijiele Ekienabor, "Impact of World Bank, International Development Association and International Finance Corporation on the Nigerian Economy (1990-2010)" in *International Journal of Scientific and Research publications*, Vol. 6, Iss. 6 (2016): 632-630, ISSN 2250-3153

Aigbiremolen A.O., I. Alenoghena, Ejemai Eboreime et.al., "Primary Health Care in Nigeria: From Conceptualization to Implementation" *Journal of Medical and Applied Biosciences* 6 no. 2(2014): 35-43 https://www.researchgate.net/publication/269703981_Primary_Health_Care_in_Nigeria_From_Conceptualization_to_Implementation

Aregbeshola, Bolaji Samson, and Samina Mohsin Khan. "Primary Health Care in Nigeria: 24 Years after Olikoye Ransome-Kuti's Leadership." *Frontiers in Public Health* 5 (March 13, 2017). https://doi.org/10.3389/fpubh.2017.00048.

Bajpai, Nirupam, and Sangeeta Goyal. "Primary Health Care in India: Coverage and Quality Issues," *Center on Globalization and Sustainable Development*. (2004): 1-39. https://doi.org/10.7916/D8RF5T96.

Benatar, Solomon, David Sanders and Stephen Gill, "The Global politics of Healthcare Reform" In *The Oxford Handbook of Global Health Politics*, edited by Colin McInnes, Kelley Lee and Jeremy Youde, 445-468. New York: Oxford University Press, 2020.

Benu, Parvathi. "Competition, fewer seats sending Indians abroad for medical education" *The Hindu* March 4, 2022 https://www.thehindubusinessline.com/data-stories/data-focus/data-focus-close-to-90-per-cent-of-students-who-clear-neet-cannot-get-a-medical-seat-in-india/article65189606.ece

Centers for Disease Control and Prevention, "Health Care Expenditures 2009-2019" Accessed April 27, 2023. https://www.cdc.gov/nchs/hus/topics/health-care-expenditures.htm - featured-charts

Chukwuani, Chinyere Mercellina, Akindeji Olugboji, Edward Erdorga Akuto, et.al., "Baseline Survey of the Primary Healthcare System in South Eastern Nigeria" *Health Policy* 77 (2006) 181-201. https://pubmed.ncbi.nlm.nih.gov/16107291/

Deodhar, N. S. "Primary Health Care in India." *Journal of Public Health Policy* 3, no. 1 (1982): 76–99. https://doi.org/10.2307/3342068.

Garg Rajesh, Shobha Goyal and Sanjeev Gupta. "India moves towards menstrual hygiene: subsidized sanitary napkins for rural adolescent girls-issues and challenges." in Matern Child Health J. 2012 May;16(4): p.767-774. doi: 10.1007/s10995-011-0798-5. PMID: 21505773.

Ghebreyesus, Tedros Adhanom, Henrietta Fore, Yelzhan Birtanov et.al, "Primary health care for the 21st century, universal health coverage, and the Sustainable Development Goals" *The Lancet*, 392(2018): 1371-1372 https://pubmed.ncbi.nlm.nih.gov/30343843/

Government of India, "Ayushman Bharat – Health and Wellness Centres Report Card" Accessed April 24, 2023. https://ab-hwc.nhp.gov.in/

Government of India Ministry of Health, *Report of The Health Survey and Planning Committee, "*Mudaliar Committee" Vol. 1:(1959-1961). Accessed April 11, 2023

Government of India Directorate General of Health Services, *Report of the Committee on Integration of Health Services,* "Jungwalla Committee" (1967), Accessed April 11, 2023

Government of India, *Report of the Committee on Multipurpose Workers Under Health & Family Planning Programms,* "Katar Singh Committee Report" (1973), Accessed April 11, 2024

Government of India Ministry of Health and Family Planning, *Report of the Group on Medical Education and Support Manpower*, "Srivastava Committee" Delhi (1975). Accessed April 11, 2023

Gyuse, Abraham N., Agam E. Ayuk, and McSteve C. Okeke. "Facilitators and Barriers to Effective Primary Health Care in Nigeria." *African Journal of Primary Health Care & Family Medicine* 10, no. 1 (February 22, 2018). https://doi.org/10.4102/phcfm.v10i1.1641.

Harmer, Andrew and Kennedy, Jonathan, "Global health and International Development" In *The Oxford Handbook of Global Health Politics,* edited by Colin McInnes, Kelley Lee and Jeremy Youde, 217-236. New York: Oxford University Press, 2020.

Huang, Yanzhong, "Emerging Powers and Global Health Governance: The Case of BRICS" In *The Oxford Handbook of Global Health Politics,* edited by Colin McInnes, Kelley Lee and Jeremy Youde, 301-324. New York: Oxford University Press, 2020.Countries"

Jacob, K S. "Public Health in India and the Developing World: Beyond Medicine and Primary Healthcare." *Journal of Epidemiology & Community Health* 61, no. 7 (July 1, 2007): 562–63. https://doi.org/10.1136/jech.2006.059048.

Kavanagh, Matthew M., Renu Singh, and Mara Pillinger. "PLAYING POLITICS: The World Health Organization's Response to COVID-19." In *Coronavirus Politics: The Comparative Politics and Policy of COVID-19,* edited by Scott L. Greer, Elizabeth J. King, Elize Massard da Fonseca, and André Peralta-Santos, 34–50. University of Michigan Press, 2021. http://www.jstor.org/stable/10.3998/mpub.11927713.4.

Kornprobst, Markus, and Stephanie Strobl. "Global health: an order struggling to keep up with globalization." *International affairs* vol. 97,5 1541-1558. 6 Sep. 2021, doi:10.1093/ia/iiab092

Labonté, Ronald. "Health in All (Foreign) Policy: Challenges in Achieving Coherence." *Health Promotion International* 29 (2014): i48–58. http://www.jstor.org/stable/45153203.

Lahariya, Chandrakant. "Health & Wellness Centers to Strengthen Primary Health Care in India: Concept, Progress and Ways Forward." *The Indian Journal of Pediatrics* 87, no. 11 (November 2020): 916–29. https://doi.org/10.1007/s12098-020-03359-z.

Lu, Chunling, Matthew T. Schneider, Paul Gubbins, et.al, "Public Financing of Health in Developing Countries: A Cross-National Systematic Analysis" in *The Lancet,* 375 (2010): 1375-1387 https://www.sciencedirect.com/science/article/pii/S0140673610602334

McInnes, Collin, Kelley Lee and Jeremy Youde. "Global health Politics: An Introduction" In *The Oxford Handbook of Global Health Politics,* edited by Colin McInnes, Kelley Lee and Jeremy Youde, 1-17. New York: Oxford University Press, 2020.

Moon, Suerie and Ellen 't Hoen, "The Global politics of Access to Medicines: From 1.0 to 2.0" In *The Oxford Handbook of Global Health Politics,* edited by Colin McInnes, Kelley Lee and Jeremy Youde, 605-626. New York: Oxford University Press, 2020.

Motari, Marion, Jean-Baptiste Nikiema,Ossy M.J. Kasilo, *et al.* "The role of intellectual property rights on access to medicines in the WHO African region: 25 years after the TRIPS agreement" in *BMC Public Health* 21, 490 (2021): 1-19. https://doi.org/10.1186/s12889-021-10374-y

Nundy, Madhurima, "Primary Health Care in India: Review of Policy, Plan and Committee Reports" *NCMH Background Papers – Health Systems in India: Delivery and Financing of Services.* 2005. https://www.researchgate.net/publication/312211554_Primary_Health_Care_in_India_Review_of_Policy_Plan_and_Committee_Reports

Obansa, S.A.J., and Akinnagbe Orimisan, "Health Care Financing in Nigeria: Prospects and Challenges" in *Mediterranean Journal of Social Sciences* Vol 4 no.1 (2013): 221-236 Doi:10.5901/mjss.2013.v4n1p221

"Obituaries: Olikoye Ransome-Kuti" *British Medical Journal,* June 19, 2003. https://doi.org/10.1136/bmj.326.7403.1400

"Obituary: Olikoye Ransome-Kuti" *The Lancet,* 362 (2003) https://doi.org/10.1016/S0140-6736(03)13884-6

Odegowi, Tunde. "From Conquest to Independence: The Nigerian Colonial Experience" in *Historia Actual Online* no.25 (Spring 2011): p.19-29. ISSN 1696-2060

Okeke, Victor. "Towards universal health coverage in Imo" *The Nation Newspaper* April 27, 2023 https://thenationonlineng.net/towards-universal-health-coverage-in-imo/

Pandey, Puniti. "Evaluating foreign medical graduates based on clinical questions is unfair." *The Times of India* May 2021.http://timesofindia.indiatimes.com/articleshow/82452770.cms?utm_source=contentofinterest&utm_medium=text&utm_campaign=cppst

Pandve, Harshal Tukaram, and Tukaram K Pandve. "Primary Healthcare System in India: Evolution and Challenges." *International Journal of Health System and Disaster Management* 1, no. 3 (2013): 125. https://doi.org/10.4103/2347-9019.129126.

Park, Sophie and Ruth Abrams, "Alma-Ata 40th birthday celebrations and the Astana Declaration on Primary Health Care 2018" *British Journal of General Practice,* 69 (2019): 220-221, https://doi.org/10.3399/bjgp19X702293

Patterson, K. David. "Disease and Medicine in African History: A Bibliographical Essay." *History in Africa* 1 (1974): 141–48. doi:10.2307/3171766.

Perry, Henry B., and Jon Rohde. "The Jamkhed Comprehensive Rural Health Project and the Alma-Ata Vision of Primary Health Care." *American Journal of Public Health* 109, no. 5 (May 2019): 699–704. https://doi.org/10.2105/AJPH.2019.304968.

People's Health Movement. "B1: The current discourse on Universal Health Coverage (UHC)," "D3: Private Sector Influence on public health policy," "D4: The TRIPS agreement: two decades of failed promises," "D6: The International Finance Corporation's 'Health in Africa' initiative" in *Global Health Watch 4*, 2014. Accessed January 26, 2023. https://phmovement.org/global-health-watch-4/.

People's Health Movement. "E3: People living with HIV in India: The Struggle for Access" in *Global Health Watch 5,* 2017. Accessed January 26, 2023. https://phmovement.org/download-full-contents-of-ghw5/.

People's Health Movement: "B4: Dysfunctional Health Systems: Case Studies from China, India, US" in *Global Health Watch 3,* 2011. Accessed January 26, 2023. https://phmovement.org/global-health-watch-3/

Powell-Jackson, Timothy, Arnab Acharya, and Anne Mills. "An Assessment of the Quality of Primary Health Care in India." *Economic and Political Weekly* 48, no. 19 (2013): 53–61. http://www.jstor.org/stable/23527344.

Ransome-Kuti, Olikoye. "Finding the right road to health" *World health forum 1987,* 8 no. 2(1987), 161-163. https://apps.who.int/iris/handle/10665/48195

Rushton, Simon. "Security and Health," In *The Oxford Handbook of Global Health Politics,* edited by Colin McInnes, Kelley Lee and Jeremy Youde, 123-142. New York: Oxford University Press, 2020.

Schrecker, Ted. "The State and Global Health" In *The Oxford Handbook of Global Health Politics,* edited by Colin McInnes, Kelley Lee and Jeremy Youde, 281-300. New York: Oxford University Press, 2020.

Shawar, Yusra Ribhi and Jennifer Prah Ruger, "The Politics of Global Health Inequalities: Approaches to Studying the Role of Power" In *The Oxford Handbook of Global Health Politics,* edited by Colin McInnes, Kelley Lee and Jeremy Youde, 59-84. New York: Oxford University Press, 2020.

Starfield, B. “Politics, Primary Healthcare and Health: Was Virchow Right?” *Journal of Epidemiology & Community Health* 65, no. 8 (August 1, 2011): 653–55. https://doi.org/10.1136/jech.2009.102780.

Sule, S.S., K. T. Ijadunola, A. A. Onayade, et.al, “Utilization of primary health care facilities: Lessons from a rural community in southwest Nigeria.” *Nigerian Journal of Medicine* 17, no. 1 (2008) https://pubmed.ncbi.nlm.nih.gov/18390144/

“Sustainable Development Report 2022.” Accessed January 26, 2023. https://dashboards.sdgindex.org/.

Ugo, Okoli, Eze-Ajoku Ezinne, Oludipe Modupe, Spieker Nicole, Ekezie Winifred, and Ohiri Kelechi. “Improving Quality of Care in Primary Health-Care Facilities in Rural Nigeria: Successes and Challenges.” *Health Services Research and Managerial Epidemiology* 3 (January 1, 2016): 233339281666258. https://doi.org/10.1177/2333392816662581.

United Nations, “World Population Prospects 2022” Accessed April 25, 2023. https://population.un.org/wpp/Graphs/DemographicProfiles/Pyramid/566 and https://population.un.org/wpp/Graphs/DemographicProfiles/Pyramid/356

Uzochukwu B, MD Ughasoro, E. Etiaba, et.al., “Health Care Financing in Nigeria: Implications for achieving Universal Health Coverage” in *Nigerian Journal of Clinical Practice* Vol.18, Iss.4 (2015): 437-444, DOI: 10.4103/1119-3077.154196

Venkatesan, J. “Private practice by government doctors no criminal offence: court” *The Hindu*, May 1, 2011 https://www.thehindu.com/sci-tech/health/policy-and-issues/private-practice-by-government-doctors-no-criminal-offence-court/article1981589.ece -:~:text=Private%20practice%20by%20a%20government%20doctor%20cannot%20be,him%20or%20her%2C%20the%20Supreme%20Court%20has%20held.

Weaver, Edward K. “What Nigerian Independence Means.” In *Phylon (1960-)* 22, no. 2 (1961): 146–59. https://doi.org/10.2307/273451.

World Bank, “World Bank Country and Lending Groups” Accessed January 27, 2023. https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups.

World Health Organization, “Constitution of the World Health Organization,” 1946, Accessed April 26, 2023 https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf?ua=1

World Health Organization, “Declaration of Alma-Ata.” Accessed January 26, 2023. https://www.who.int/teams/social-determinants-of-health/declaration-of-alma-ata.

World Health Organization, “Declaration of Astana.” Accessed January 26, 2023. https://www.who.int/publications-detail-redirect/WHO-HIS-SDS-2018.61.

World Health Organization, Country Data on Nigeria and India. Accessed April 25, 2023, https://data.who.int/countries/566 and https://data.who.int/countries/356

World Health Organization, “World Health Statistics 2022” Accessed April 25, 2023. https://www.who.int/news/item/20-05-2022-world-health-statistics-2022