Malaria Control and its Discontents:
A Critical Examination of the Emerging Discourse of Seriousness in Development Assistance

A thesis submitted to the University of Manchester for the degree of Doctor of Philosophy in the Faculty of Humanities

2013

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## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of tables</td>
<td>5</td>
</tr>
<tr>
<td>List of figures</td>
<td>6</td>
</tr>
<tr>
<td><strong>Introduction</strong></td>
<td>14</td>
</tr>
<tr>
<td>Methodology</td>
<td>28</td>
</tr>
<tr>
<td>Chapter Outline</td>
<td>32</td>
</tr>
<tr>
<td><strong>Chapter One</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Three Spaces of Power</strong></td>
<td>35</td>
</tr>
<tr>
<td>Introduction</td>
<td>35</td>
</tr>
<tr>
<td>The Multilateral Space</td>
<td>40</td>
</tr>
<tr>
<td>The Semiotic Space</td>
<td>47</td>
</tr>
<tr>
<td>The Development Space</td>
<td>53</td>
</tr>
<tr>
<td>Conclusion</td>
<td>59</td>
</tr>
<tr>
<td><strong>Chapter Two</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Nigeria, Development and Malaria</strong></td>
<td>61</td>
</tr>
<tr>
<td>Introduction</td>
<td>61</td>
</tr>
<tr>
<td>Crude Realities: State, Oil and Politics in Nigeria</td>
<td>65</td>
</tr>
<tr>
<td>Disease and Development: Malaria’s Place in the Rise of Medical Initiatives</td>
<td>80</td>
</tr>
<tr>
<td>Conclusion</td>
<td>86</td>
</tr>
<tr>
<td><strong>Chapter Three</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Background to Malaria Control in Nigeria</strong></td>
<td>89</td>
</tr>
<tr>
<td>Chapter Four</td>
<td>Page</td>
</tr>
<tr>
<td>---------------------------</td>
<td>------</td>
</tr>
<tr>
<td><strong>Malaria Control and the Emerging Discourse of Seriousness</strong></td>
<td></td>
</tr>
<tr>
<td>Introduction</td>
<td>124</td>
</tr>
<tr>
<td>The Political Economy of Long-lasting Nets</td>
<td>126</td>
</tr>
<tr>
<td>The Political Economy of Prequalification</td>
<td>135</td>
</tr>
<tr>
<td>The Political Economy of Rapid Diagnostic Tests</td>
<td>150</td>
</tr>
<tr>
<td>Did You Get the ‘Memoire’? Development Encounters and the Emerging Discourse of Seriousness</td>
<td>155</td>
</tr>
<tr>
<td>Conclusion</td>
<td>170</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter Five</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Malaria Control and the Long Road to Modernity</strong></td>
<td></td>
</tr>
<tr>
<td>Introduction</td>
<td>172</td>
</tr>
<tr>
<td>Toward Orthodoxy: Traditional Medicine and the Question of Relevance</td>
<td>174</td>
</tr>
<tr>
<td>The Science of Ownership</td>
<td>180</td>
</tr>
<tr>
<td>Standardization, Discipline and Alignment: The Epistemic Acquisition of Traditional Medical Knowledge</td>
<td>191</td>
</tr>
</tbody>
</table>
4

Conclusion 201

Chapter Six

Conclusion 203

Bibliography 212

Final Word Count: 79,725
List of Tables

Table 1 - Interview structure for fieldwork conducted in Nigeria 30
Table 2 – Percentage expenditure on defence and health in Nigeria (1960-1970) 104
Table 3 – Reasons for low ITN uptake 130
Table 4 – Therapeutic efficacy of anti-malarial drugs in Nigeria 138
Table 5 – Relative anti-malarial prices 139
Table 6 – Funding for malaria diagnostics, 2004-2009 151
Table 7 – Locally used plants for malaria therapy 179
List of Figures

Figure 1 – Political map of Nigeria (36 states) 65

Figure 2 – Advertisement for leaf logo ACT 165

Figure 3 – Performance-based funding 168
Abstract

Economic production as well as consumption binds many countries together, directly and indirectly. And for this reason, the way one country or a set of countries develop has regional and global ramifications. The case of the Third World is one in which many countries are trying to develop at the same time, and it presents a real potential for distorting global production and consumption patterns. This potentiality compels developed countries to try and organise the way the development of Third World countries progresses. What it also means is that although financial investments are essential to international development, political power remains its activating ingredient. As such, this dissertation is about how the operation of what may be termed 'development power' is organised, and what the organising principles are.

The operation of development power is organised on the basis of assistance; countries trying to develop are not left to their own devices. Assistance is so compellingly available it can be regarded as imposed. Assistance creates a role for developed countries in the affairs of developing countries and this in itself operates as an anchor for instrumental power.

The chief organising principle is the maintenance of developing countries as penetrable markets for developed economies. To this end, it is important that the way solutions are provided for identified development problems incorporates material and intellectual production in developed countries. This is a fundamental problematic in international development and it is a problematic that is maintained by power. It is what this dissertation explores.

Focusing on malaria control as a site for the analysis of development assistance, the dissertation intervenes in the malaria control debate at a number of levels: it shows that organised responses to the disease have evolved in accordance with the way the interests of relevant power structures have evolved, making colonial responses characteristically different from postcolonial ones. The dissertation also extends the narrative of development as a discourse by exploring the specific ways the discourse of development is operationalized in the case of malaria control in Nigeria. It concludes that this is done through a connected 'discourse of seriousness.' This is a discourse that compels national actors to act in certain amenable ways in order to demonstrate seriousness to their global counterparts. The dissertation explores the internal techniques by which this is achieved.
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Acknowledgement

My sincere gratitude goes to my family, whose patience throughout the time it has taken to do this PhD has been quite tremendous. I could not have completed this work without the great deal of understanding shown by my wife Ezi and our two children Emy and Ije.

I am also very grateful to my Supervisor, Dr Steven Pierce who spotted a potential in me that even I had missed. Throughout the PhD he dedicated himself very resolutely to bringing out the best he was always certain I could give. Whatever the high points of this work, they are as much a vindication of Dr Pierce’s steadfastness as they are of mine. I of course take responsibility for the low points and can only hope he is not too disappointed.

I also want to thank other senior academics who have lent their support in various ways. I particularly thank Professor Steve Reyna for never failing to let me know the various little ways I apparently was ‘proving I could do it’ and for constantly pledging his support in every way that he could. His unique approach to banishing self-doubt gave me much of the fillip I needed to find stability in those early years. I am thankful to Professor Peter Gatrell for an early introduction to the works of Tim Mitchell and Sandra Sufian. These works gave me an early appreciation of the possibility of interdisciplinary research into malaria control at a time when it had started to seem like a bad idea for anyone without a background in medicine or public health. I would also like to thank the Department of History for the opportunity I have had to teach and the support I have received from the various Course Unit Directors I have worked with. I extend profound thanks to Dr Chris Godden, Dr Lawrence Brown, Dr Anindita Gosh and Dr Max Jones all of the Department of History, University of Manchester and Professor Tony Redmond, HCRI Deputy Director, for all their support.

Throughout this PhD I received tremendous support from the Humanitarian and Conflict Response Institute (HCRI) and for this I especially owe a debt of gratitude to Jenny Peterson (Director of Postgraduate Research) and Rebecca Whitehead (Institute Manager). At those times when it seemed impossible to carry on, they are the two people who were always committed to making it possible again. I really cannot thank them enough.
Support and Cooperation for the fieldwork was also received from numerous organisations, Nigerian and global. I would like to specially thank the Roll Back Malaria Secretariat in Dakar, Senegal for its role in facilitating access to its Nigeria programme. Special thanks also go to the World Bank (Booster Programme) in Nigeria and for the cooperation I received from its Abuja office. The World Health Organisation was very supportive and I am particularly thankful that the scheduling of interviews was flexible enough to accommodate the way I had to juggle my time in the field.

Fieldwork would simply have been impossible without the support and cooperation I received from the Federal Ministry of Health and the National Malaria Control Programme (NMCP) in Abuja. Ethical constraints prevent me from mentioning names but I would like to thank all the officers in these two institutions that put up with my daily presence for several weeks and who most of all, through interviews and data provided, were indispensable to the actualization of this work. I also extend this token of gratitude to other organisations and bodies, public and private, which also supported me in their own capacities. To the following, I owe a huge debt of gratitude: SUNMAP (Support to Nigeria’s Malaria Programme); Clinton Health Access Initiative (CHAI); Society for Family Health (SFH); National Institute for Pharmaceutical Research and Development (NIPRD); College of Medicine, University of Lagos; University College Hospital, Ibadan; Medical Office, Badagry Local Government; Roll Back Malaria Programme, Badagry; Badagry Medical Centre, Ajara Badagry; Cipla Evans (Pharmaceuticals) Nigeria Limited; National Association of Nigerian Traditional Medicine Practitioners; and the National Bureau of Statistics (NBS), Abuja Nigeria.

Finally I would like to thank all my colleagues at HCRI and the Department of History for all their contributions to how important ideas were formed and for the constructive critiques that refined those ideas. I am grateful to all of them for travelling this long road with me and for making this a worthwhile enterprise.
Dedication

This dissertation is dedicated to the memory of my late father, John Ojimiwe, whose unflinching commitment to doing everything it would take to give me a descent education was a constant declaration even to his last days.
The Author

I studied Political Science and was awarded a Bachelor of Science degree by the University of Lagos in Nigeria. I later did a Master’s degree in Politics and Contemporary History at the University of Salford in Greater Manchester. My Master’s research was a study of the executive mayoralty system, titled ‘Elected Mayors and Local Government: A case study of the Mayoralty of London’. The dissertation was based on interviews with officials of the London Assembly and available secondary material.

Field research for this PhD dissertation was conducted at a number of sites in Nigeria which included the Federal Ministry of Health in the country, the Nigerian Malaria Control Programme Headquarters in the capital Abuja, the University College Hospital Lagos and the University College Hospital Ibadan, the National Archives Ibadan and international organisations based in the country such as the World Bank and the World Health Organisation.

I have attended several conferences organised by the Humanitarian and Conflict Response Institute, University of Manchester and I have also delivered tutorials to undergraduates in the History department. In 2010 I worked as Teaching Assistant and taught on a History module titled “Globalization in Historical Perspective”. I am also teaching as Graduate Assistant in the second semester of the 2012/2013 academic year for the “Colonial Encounters” module in the History department.
Introduction

This dissertation was conceived as an inquiry into the nature of international development assistance rendered by developed donor countries and organisations to developing countries. The location of the research is Nigeria and, as malaria control is one of the most visible contexts of development assistance to that country it provides the primary focus of enquiry. The artemisinin combination therapy (ACT) drug distribution programme, the insecticidal net distribution programme, and the case being made for malaria rapid diagnostic test deployment are the case studies that the research mainly focuses on.

These case studies serve as windows into explorations of more fundamental policy and governance issues that are of historical and anthropological concern. The research uses malaria control case studies as a prism through which issues of international development engagement with Nigeria are elaborated in more detail. By its nature therefore, it is inter-disciplinary and the problematics dealt with throughout the dissertation are drawn from the disciplines of history, anthropology and global health governance. The analysis of the colonial background to malaria control done in chapter three provides a view of the historical antecedents to the current events taking place within malaria control as a field and allows the assignment of appropriate interpretations to these events. The structures of power embedded in reporting methods as well as the epistemological payload that are transported by programme reports and other guidance instruments within international development organisations also come under focus.

These probes reveal how development assistance is instrumentalized by networks of global governance with the effect that developing countries remain amenable to particular forms of economic, social and political organisation. At multiple points in the dissertation, theoretical proposals are put forward as frameworks for advancing our understanding of development policy. Salient among these are the ‘discourse of seriousness’ elaborated in chapter four and the ‘three spaces of power’ which theoretically underpins the dissertation in chapter one. The former deals with how the insistence by donor countries and their agents that recipient countries demonstrate ‘seriousness’ in development assistance transactions is more than a mere requirement for exhibiting commitment; it encodes within itself a system of control that actually
ends up constituting the operationalizing format for the discourse of development much vaunted within post-development theory.¹ The latter separates development praxis into its component elements and submits that development works as we know it because of the dominance of global networks of power in each of three spaces, namely the multilateral space, the semiotic space and the development space. A further breakdown of the chapter format is given below but first, by way of introducing the interest in malaria, I will briefly describe the nature of the disease and its manifestation, borrowing from an apt description given on the Médecins Sans Frontières (MSF) website. I will then proceed to describe the research project itself and its methodology. According to MSF:

Malaria is a parasitic infection transmitted from person to person by the bite of infected female Anopheles mosquitoes. These mosquitoes usually bite from around dusk to dawn. Once transferred to the human body, the infection travels to the liver where it multiplies and then enters the red blood cells. Inside the red blood cells the parasites multiply rapidly until they burst, releasing even more parasites into the blood stream. There are four main species of the malaria parasite: *Plasmodium falciparum*, *Plasmodium malariae*, *Plasmodium vivax* and *Plasmodium ovale*. *P. falciparum* is the main cause of severe clinical malaria and death. Malaria begins as a flu-like illness, with symptoms first occurring 9-14 days after infection. Symptoms include fever (typical cycles of fever, shaking chills, and drenching sweats may develop), joint pain, headaches, frequent vomiting, convulsions and coma. If simple malaria is left untreated, it can become severe – around eight million malaria cases progress to severe malaria annually. Death from malaria may be due to brain damage (cerebral malaria), or damage to vital organs.²

The above description of malaria leaves no one in doubt that malaria is a serious disease with a debility profile that is matched only by a handful of other diseases. It becomes even scarier to imagine that the global incidence of the disease, as reported in the World Malaria report of 2011 was 216 million episodes in 2010 with an estimated 655,000 resulting in deaths. 81% of cases were reported in Africa and approximately 86% of

¹ The discourse of development is extensively discussed in the works of Ferguson, 1990; Escobar, 1984, 1995; Hobart, 1993; Gardner and Lewis, 1996; Fairhead, 2000; and Mills, 1999
cases of global malaria deaths occurred in children under 5 years of age (WHO, 2011: xiii). With the 2012 report declaring that Democratic Republic of Congo and Nigeria together account for greater than 40% of the estimated global deaths, the severity of the disease in Nigeria comes into even sharper focus (WHO, 2012a: 62).

The 2011 report also identified that malaria specific mortality has been reduced in Africa overall by 33% in the decade from 2000 to 2010 (WHO, 2011: xiii). This may seem huge but if one begins to pick through individual countries and also break the statistics down to annual rates a picture may emerge that would suggest malaria is defying the huge global expenditure on its control (Easterly, 2006: 4). This situation rightly provokes questions of effectiveness with regard to the approaches adopted so far. Also, administrative deficiencies and the lack of requisite technological capability have been identified as significant issues relating, almost peculiarly, to Africa in the global fight against malaria (Oaks, 1991: 43). At one level therefore, this research seeks to examine how the very conceptualization of the problem, as borne out by the way prevention programmes are designed and implemented, may constitute a limitation to the prospects of success in the fight against malaria.

The research intervenes at a number of levels in the debate surrounding malaria control and the role of international development organisations and NGOs. First it treats the problem of malaria control as distinct from the fundamental problem of the malaria disease. So rather than rely on biomedical approaches for constructing a view of the problem and its enormity, the dissertation discusses malaria control as a problem of development or under-development. It targets its enquiry at the actors and factors that combine to shape malaria control into its present mould. It does so by scrutinizing the role that international organisations and other external actors play in assisting with the control of malaria. It also looks at the role that the Nigerian state plays in facilitating the agenda of these external actors.

At another level the dissertation engages in a historical ethnography of malaria control, taking a longitudinal look at the forms it has taken over a number of phases in the past and comparing that to the current state of affairs.³ It shows that organised responses to

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³ Histories of malaria have been written from various perspectives, with many exploring how the disease shaped population histories over time. See for example Cueto (2007); Sallares (2002); Scheidel (2001); Humphreys (2001). Others have focused on its role in wars – see Slater (2009) and Bell (2010). Yet others such as Mitchell (2002) and Sufian (2007) have looked critically at the immutable politics of malaria control. Mitchell identifies political and social relations as closely tied to disease control in Egypt.
the disease have evolved in accordance with the way the interests of relevant power elites have evolved. Colonial responses were therefore characteristically distinct from postcolonial ones, although the common threads linking both periods are the strong political undercurrents that always define the responses. As scholars have demonstrated elsewhere in Africa, health management is intrinsically political and is very much influenced by complex sets of political decisions (Feierman and Janzen, 1992: 5). Packard (2007) has also drawn from the social history of the disease and argued that malaria is a disease of development:

Patterns of agricultural production in tropical and subtropical regions of Africa, Latin America, Asia and the Pacific during the nineteenth and early twentieth centuries…tended to be undercapitalized, used few technical inputs, relied on the extensive use of human labour, and were marked by significant inequalities in the ownership of land (Packard, 2007: 84)

According to Packard, apart from increasing the intensity and distribution of malaria transmission, these patterns of production have meant that in many parts of the world limited resources limit the growth potential that might have enabled them escape the burden of the disease. Poverty also produces a set of socio-economic circumstances such as mass rural-urban migration, poor urban housing and sanitation conditions that increase the endemic nature of the disease. If malaria is a disease of development, it becomes incumbent that the wide range of socio-economic circumstances that accentuate it be addressed as part of the response to the disease. This represents one of its current conceptual problems: the socio-political and socio-economic conjuncture at which it occurs are largely overlooked. Packard expressed it succinctly when he argued that:

The history of malaria tells us that malaria cannot be understood or eliminated independently of changes in the societal forces that drive it…the array of biomedical weapons mobilized in the war against malaria needs to be joined with efforts to understand and improve the social and economic conditions that drive the epidemiology of the disease. Only by making this connection, by learning the

He stresses the importance of understanding the interaction of medical, economic, military and political approaches to development. Similarly Sufian looks at characterisations of Palestine by Zionist elements for whom Palestine is best represented as a diseased land in desperate need of the kind of intervention Jewish farmers are curiously able to provide.
lessons of history, will we be able finally to stop the dying and to silence the wailing (Packard, 2007: xvii).

Packard’s approach was to identify the problems inherent in concentrating malaria control efforts on ‘the proximate cause of the disease – parasites and mosquitoes’ (Packard, 2007: 117). He thus puts significant focus on the social and economic conditions that also shape the epidemiology of the disease.

Taking the logic of Packard’s approach more or less as a point of departure, the dissertation intends to extend it by showing some of those socio-political dimensions of malaria control in Nigeria and developing theoretical frameworks for understanding them. It therefore also intervenes in the debate on malaria, at the level of explanation and theorization by extending the narrative of development as a discourse. Much has been made of the discourse of development by anthropologists such as Ferguson (1990) and Escobar (1995). In various cases of development assistance, the nature of assistance has quite often been based on a need to modernize very rudimentary and inefficient ways of doing things in local contexts. For development to function therefore, it disables any view of development that is in opposition to the modernisation project. By extension, the dissertation explores the specific ways the discourse of development is operationalized in the case of malaria control in Nigeria, and concludes that this is done through a connected ‘discourse of seriousness.’ This is a discourse that compels national actors to act in certain amenable ways in order to demonstrate seriousness to their global counterparts.

By relying on the kinds of methodological shifts that started to emerge strongly in medical anthropology from the 50s and 60s (Fleck and Ianni, 1958; Scotch, 1963) the dissertation explores how the interplay between national actors and their global counterparts produces new ways of understanding disease control in the twenty first century. These methodological shifts in the research into diseases have heightened from the 70s as anthropologists responded to the need to change the prevailing view of causality in the management of diseases. By 1978 a joint document was issued by WHO and UNICEF with new guidelines for global healthcare, especially in African countries (WHO and UNICEF, 1978). The guidelines, among other things, called for a community involvement as well as a focus on prevention of disease. As a result of this
paradigm shift, medical anthropology became increasingly integrated into epidemiology at such a rate that it is perhaps an inseparable part of how disease is understood today.

Collaborative research and interdisciplinary borrowing increased in the 1970s and anthropologists focused more on cultural and behavioural influences on parasitic disease risk and prevalence (Trostle and Sommerfeld, 1996). Following this, there was a wave of works aimed at exploring the utility of anthropological variables such as religion (Levin, 1994); maternal education (Lindenbaum, 1990); stress (Dressler, 1990); medication consumption (Trostle, 1988), to the understanding of illness and disease. Such studies were able to deliver useful contributions to how disease is perceived and the broader sense in which it affects lives. Hence it was possible to design more targeted approaches to managing the health of communities. Through the works of scholars such as Nations (1986) and Frankenberg (1993), it was possible, for instance, to deconstruct epidemiologically constructed oppositions between diseased and disease-free.

‘Anthropologists argue that such dichotomies both obscure the real truth about disease risk… and mislead those potentially at risk into believing that because they do not fall into an “identified risk group” for a disease, they are immune to that disease’ (Trostle and Sommerfeld, 1996: 263).

What medical anthropology has thus done for the way disease and illnesses are researched and studied, has been to show more of their socio-cultural bases and, for that matter, socio-cultural outcomes. It is in this regard that Horacio Fabrega’s definition of medical anthropology becomes relevant:

A medical anthropological inquiry… (a) Elucidates the factors, mechanisms, and processes that play a role in or influence the way in which individuals and groups are affected by and respond to illness and disease, and (b) examines these problems with an emphasis on patterns of behaviour. (Fabrega, 1971:167)

This definition by Fabrega is broadly representative of how medical anthropology is understood in the literature. For example, in keeping with the broad socio-cultural anchor intrinsic to the field, Baer et al (2003: 3) define it as concerning itself ‘with the many factors that contribute to disease or illness and with the ways that various human populations respond to disease or illness’. Also, Scheder (1988) and Singer (1986; 1995) are two of the leading anthropologists that have articulated theoretical positions,
within the field, that fall under the rubric of critical medical anthropology but have, in the way it is defined, retained its linkage to:

A theoretical and practical effort to understand and respond to issues and problems of health, illness, and treatment in terms of the interaction between the macro level of political economy, the national level of political and class structure, the institutional level of the health care system, the community level of popular and folk beliefs and actions, the micro level of illness experience, behaviour, and meaning, human physiology, and environmental factors (Singer, 1995: 81)

Critical medical anthropology thus extends medical anthropology to the extent that it casts a spotlight on power as central to the understanding of disease and public health policy. Ultimately, the continuous struggle with public health management in most of Africa has meant that efforts by conventional medical anthropologists to broaden views of illness, disease causation and epidemiology in culture area studies do not completely explain the range of issues that come together to produce public health failure on the continent. It therefore becomes vital that we cast our gaze beyond these ethnographies of disease and consider additional explanations as we attempt to understand the struggle with disease control in places such as Nigeria.

The anthropology of transnational power or the anthropology of international institutions is certainly one that is germane to how disease is managed in the Third World today. It shows there is a set of social and linguistic practices emanating from the global institutional level which have direct and sometimes indirect impacts on national political, economic and cultural terrains. These practices manifest in the way that funding provides a degree of power to donors to set the international development agenda for the countries they assist and the way in which they rationalize such agenda. In the end, most donor countries and institutions end up with a bureaucratic construction of the development needs of developing countries and as such, render assistance in specifically predetermined ways (Ferguson, 1990).

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4 Debates about the ‘Third World’ as a contested terminology are rife and they generate several related analyses which have not formed part of the focus in this dissertation. Use of the term at several points in the dissertation is purely interchangeable with ‘developing countries’. For the etymology of the term as well as the critiques it has evoked, see Peter Worsley, 1979; Joseph Love, 2007; Vicky Randall, 2004; S.D. Muni, 1979.
Throughout the dissertation, such actors are referred to as the ‘development establishment’. This is connected to the fact that one of the objectives in the dissertation is to cast a spotlight on the arena of operation where this ‘establishment’ encounters the state in Nigeria. Making this kind of distinction suggests a hierarchy in the machinery of development in which the top echelon constitutes ‘the establishment’ and actors on the lower rungs constitute what Elias and Scotson (1965) might have called ‘the outsiders’.

The category of actors taken as constitutive of an establishment in various social contexts is often regarded as identified by Henry Fairlie in 1955. Although Fairlie was not the first to use the term ‘the establishment’ in the same context as he did in 1955, since the publication of his column in *The Spectator* in September of that year the term has become much more firmly entrenched in popular lexicon. Today the expression is much more commonly used to refer to the locus of real rather than imagined power. Fairlie used the term to express the fact that power is not merely rooted in officialdom; it is located as well as exercised from a number of established bases. According to him, ‘by the “Establishment” I do not mean only the centres of official power – though they are certainly part of it – but rather the whole matrix of official and social relations within which power is exercised’ (Fairlie and McCarter, 2010: 8) Fairlie’s ‘establishment’ is therefore wide ranging; it includes members of social as well as professional classes such as judges, top civil servants, the monarchy, politicians etc. who are able to contribute to, or influence, the way power is organised.

‘The establishment’ in the context of international development is linked to the need to keep the project of modernization central to development. The ‘development establishment’ is used in this dissertation to refer to those actors within the development community whose overriding purpose is to ensure that the agenda of modernization is maintained. This invariably entails regimes of rationalization and discourses that position modernization as indispensable to development. It is also ultimately woven into a standard understanding of development. Developing countries that stick to this view of development appear more serious about development than those that take a contending view. Seriousness therefore acquires a discursive character of its own, a character which has hardly been touched on in the literature. This dissertation proposes a framework for the theoretical understanding of seriousness as a discourse.
The role of the development establishment is not to locate and sanction any contention with the standard view of development. Rather it is to reduce the scope for political contention; in other words, to depoliticize the universal understanding of development by bureaucratizing it. This is what Ferguson (1990) calls the anti-politics machine - the supposedly apolitical machinery of development intervention that is designed to deliver development by fixing technical deficiencies. As Ferguson puts it in the case of Lesotho:

At the end of this involved process of theoretical construction, Lesotho can be represented in “development” discourse as a nation of farmers, not wage labourers; a country with a geography, but no history; with people, but no classes; values, but no structures; administrators, but no rulers; bureaucracy, but no politics. Political and structural causes of poverty in Lesotho are systematically erased and replaced with technical ones, and the “modern,” capitalist industrialized nature of the society is systematically understated or concealed (Ferguson, 1990: 66).

This technical-bureaucratic construction of Lesotho’s poverty obscures the role of power in the manipulation of subjects and how their behaviour and responses are disciplined. Instead it provides and emphasizes a set of scientific rationale for accepting bureaucratic changes meant to deliver development. This dissertation takes the view that this kind of bureaucratisation is possible because of the concerted operation of international development and the established power structures that support it. The development establishment is thus made up of those actors within the political hierarchies in many donor countries, the top echelons of many international organisations, especially the United Nations agencies, top NGOs and INGOS, some international relations experts, some anthropologists especially the ones hired by international organisations to provide academic rationale for the way international development is organised, and all other actors in various capacities in and outside developing countries whose rhetoric and action are calculated to maintain a certain order of things as far as development is concerned.

One of the things the development establishment is thus able to do, in terms of deciding the trend of international development is to export and promote the deployment of what Stephen Reyna refers to as ‘travelling models.’ Travelling models, according to him, are
‘procedural and cultural plans of how to do something done elsewhere’ (Reyna, 2007). They often fail because they are in contradiction to local realities and their failure leaves dystopia in their wake. A chief problematic in the way international development operates is therefore that it carries on with the deployment of these travelling models as though there were no such contradictions. Some of the peculiar local conditions that shape Nigeria’s ‘developmentability’ will be discussed in the course of the dissertation but there is one that is quite relevant at this point - the missing history of malaria control.

An interesting discovery that emerged while gathering material for the chapter three of the dissertation was that the history of malaria control is not very visible even to the current officials in charge of control programmes in Nigeria. In my interviews many of them were not able to say much about the history of malaria control in the country, and a good number of them blamed it on the lack of proper records and a general attitude on the part of relevant authorities of not regarding this as a problem. So in a sense the history of malaria in Nigeria is ‘missing’. But it is not missing in the sense of having disappeared; it is missing in the sense of not being deliberately collated and consciously articulated or codified as a guidance instrument. The problem is not so much that there is no history; the way history is written is quite often determined by many aspects of record keeping: what records are kept; in what volume they are kept; how the records are kept (storage conditions and the organisation of records); access control strategies for disseminating the records etc. The aggregation of all these elements certainly paints a picture. It paints a picture for instance of how a society perceives its collective future and what narratives are considered compellingly worth preserving for posterity. As Foucault pointed out in *The Archaeology of Knowledge* ‘history is one way in which a society recognizes and develops a mass of documentation with which it is inextricably linked’ (p.7). There is therefore a nationally strategic rationale not just for documenting praxis but for documenting it in a particular way and for making the documentation accessible to a consciously determined extent.

The way Nigeria treats the documented history of malaria control was explained to me in a number of intriguing ways. One participant told me that although more recently the country appears to be realizing the importance of records this is coming rather late in the day:
Until very recently records were always kept in files and folders which over time either become old or get torn…with health records you start generating them from the community onward to the local government, to the state and so on. The channel is long but we don’t have a defined way of sending it. Ideally the channel is from the community to collate records and send to the ward; the ward collates and sends to the local government; local governments send to the states and they send to the federal. We used to have record officers at those levels but when you go in, the record officer will tell you he doesn’t have stationeries and he doesn’t have money to send. Recently we started dialoguing with Intel: they are using e-technology but that is still an on-going thing. Everybody now realizes that record keeping is crucial, especially when you go to international forums and then you see that when they show records of different African states, for Nigeria they put nil; you know you have records but those records are not there. It’s nil [laughter] and then the way we generate the record is bad. The person at the state will sit down and, because of certain things, will decide to just fill up things. So you have, I tell you, very unreliable data many times for various reasons. At a point I used to go on supervision to states and local governments and then that’s when you are able to find out how those things happen: people formulate records for different reasons depending on what they hope to achieve. So we are thinking if we’ll be able to introduce the electronic system of record keeping it will help. And then record must also be in consonance with feedback. Even the faithful ones that keep records and send records do not get any feedback. So, in time, you don’t see the essence of sending the records, it doesn’t impact on what you do; it doesn’t mean anything whether you do send or not, so with time you get fatigued and stop doing it.  

I wanted to know what the practice was with people who have been in their roles for a long time and have accumulated a lot of knowledge. I asked whether when they leave their role they write things like memoirs or diaries relating to anything or documents that they generated while they were in office. The response was quick; almost as though the question was expected:

Ideally by civil service rules, when you are leaving a desk you are supposed to do a hand-over note detailing what you’ve done on your desk, what you inherited and

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5 Interview 15, Federal Ministry of Health official, Abuja, Nigeria, 18/10/2011
what you are leaving with, your achievements, your challenges, your recommendation. But like I said, those things most times are written on paper and stored in files which either get torn over time or just disappear. Let me not go into the reasons they disappear but they do get disappeared over time and anything can happen. And, you know, when you go to where you store papers and you have this huge brown looking paper files, they put you off and you won’t want to look at anything. But, you know, if we are able to implement the e-system it will help. You know, all you do is to update what’s on the system and have it backed-up and I hope we get that through honestly. But that has been the problem with record keeping: the lack of feedback, the system of storing and even the personnel that will fill in the data are issues.

As these comments indicate, this kind of resignation to the devalued importance of historical records decontextualizes bureaucratic practice; objectives are loosely set and not firmly evaluated. Many of the officials I spoke to in Nigeria did not relate to the history of malaria control as an aspect that is necessary for understanding or dealing with the present. Memories of how malaria was controlled in the past were easily dispensed with as pertaining to the exigencies of the past; the present dictates its own approach and performing well in the present requires a complete focus on current approaches. At no point was any approach rationalized on the basis of lessons drawn from past experience. This is a problematic attitude in the sense that where history is reduced in this way it is stripped of its essential facility as a medium by which a population is constantly regenerating itself. The way the history of any process is managed indicates the way its future relevance and utility is perceived. This attitude was further confirmed when I asked a separate official why the issue of data management or documentation did not appear to be priority; he responded with an interesting anecdote:

Who will initiate it? You are a Nigerian; you know the system. When you go to our hospitals now, they give you a card as you come in; they say the card costs fifty Naira and you pay. They give you a piece of paper that says fever and so, so and so; another person pays the same; fifty Naira. In a week’s time when you come to the same hospital they say card is fifty Naira and you pay again. Their understanding of that card is as a resource, a money generator [as opposed to a

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6 ‘Brown looking paper files’ in this context refers to paper that have depreciated over very long periods of time
7 Interview 15.
data generator];

‘Let us add this fifty Naira to what we are going to get;’ nobody does it because they want records. And once it gets to a certain level they take everything and burn; that’s the system we are operating in Nigeria.

These comments indicate the setting to which I was confined in trying to give a background to malaria control. A point by point detail of what can be taken as contemporary practice within the country was quite an uphill task. Of the three periods I looked at for chapter three--; data was far more readily available on the colonial period and the period since the Roll Back Malaria partnership (1998/2000) than on the period from independence to the late 90s, covering the time when Nigeria was more or less controlling malaria on its own. Interviews such as the ones described above reveal so much about the socio-cultural as well as socio-economic and political constraints that underpin disease control in countries like Nigeria and did, in a way, help to refine my research questions as I embarked on this study.

Another element relating to the research setting and how to traverse layers of officialdom is in the selection of key participants. Most of the partner organisations involved in malaria control in Nigeria have a designated focal person for malaria control. This focal person would usually be an indigenous official who operates as the face of that institution in practically all matters regarding malaria control. One of such participants explained the role of the focal person to me as thus:

I was engaged through the Global Fund to support malaria implementation, provide technical assistance and advice to the national and state malaria control programmes. For the states, there are six of us, national professional officers on malaria and we are strategically placed at the different geo-political zones…with the national malaria control programme, essentially what we do is to provide technical assistance, technical support in terms of capacity building, surveillance…and information sharing; being able to capture gaps and flagging such gaps for immediate intervention and giving directions on ideals of how to implement, or using algorithms and guidelines. Again one of the major tasks we are expected to do is to ensure, more or less, that a country as much as is possible

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8 Words in italics are mine
9 Paper records are often burned in this way in order to free up storage space. Interview 2, National Malaria Control Programme (NMCP) Official, Abuja, Nigeria, 18/08/2011
aligns with the global strategy in malaria control in the context of adoption of guidelines and policies, though adapting to the local context.\textsuperscript{10}

This elaboration of the focal person’s work perhaps indicates why they are often indigenous officials who have been inculcated into the partner organisation’s mind set. The national professional officers (as this participant referred to them) are very involved in the everyday operation of local programmes and the way it is implemented by the local bureaucracy. Where there is a misalignment in the direction of the local programme with the objectives of the global programme, it is part of the duty of the focal person to ‘capture’ such developments and restore alignment. The focal persons may be indigenous but their gaze upon indigenous systems is the gaze of the international organisation they represent. To the partner organisation therefore, the role of the focal person is quite an important role, serving more or less as a bridge between it and the local apparatuses of state, other partner organisations and the research community. This is the reason why the likelihood for a researcher researching any such organisation’s role in malaria control is that they are directed to the focal person.

The system of research support as it currently operates in most international organisations is that the researcher makes contact declaring what he is researching and as soon as that is determined he is referred to the focal person. For instance when I contacted the UK’s Department for International Development (DFID) I was promptly referred to SUNMAP in Nigeria.\textsuperscript{11} When I got to Nigeria and interviewed SUNMAP, the programme manager I spoke to was emphatic about SUNMAP not being an organisation per se. He emphasised that it is a project coordinated by a partnership of bodies led by Malaria Consortium. So, DFID would not speak to me and yet SUNMAP could not really speak for DFID. The knowledges produced and distributed by these institutions are produced at higher levels than the focal person. The focal person is thus as much a consumer of those knowledges as anyone else.

In terms of its methodology therefore, the dissertation sought to understand the role of global institutions in setting the malaria control agenda for Nigeria and in maintaining the specific ways in which it is approached. It was necessary not only to investigate the way in which control programmes are reified by institutions such as WHO and the World Bank but to go beyond what is expressed by their representatives and also

\textsuperscript{10} Interview 3, WHO official, UN House, Abuja, Nigeria, 19/08/2011
\textsuperscript{11} Support to Nigeria’s Malaria Programme (SuNMaP)
investigate the way local bureaucratic institutions understand the interface between
global actors rendering assistance and the local disease control environment. The various
data gathering methods were also designed to probe how this understanding feeds into
malaria control policy in Nigeria.

**Methodology**

To a large extent therefore, anthropology informs the interdisciplinary leaning in this
ethnography. Rather than merely focusing on a single-minded culturally located site of
ethnographic research and anchoring its substance and relevance in a contextualization
that links findings to broader anthropological and historical debates, the research
follows a number of strands in a carefully constructed research design; it asks
fundamental conceptual questions from the onset, such as what dynamics of power
combine to structure development into its present mould and how these dynamics are
historically constituted; it then pursues answers to such questions over a multi-layered
physical and metaphysical landscape. It looks more probingly at the Nigerian state, with
a view to understanding how its history and character has defined the way it engages
with the apparatus of international development and vice versa. In other words it locates
Nigeria in a wider world system and studies the ramifications of the encounter between
the two. Multi-sited ethnography is particularly apt for the Nigerian setting because the
country is very large and has quite a complex mix of cultural groups and ethnic
identities. It is made up of about 500 indigenous language groups and it is, by July 2013
estimates, about 174 million in population size. What ends up as policy can often be
determined by the relations and interactions amongst these ethnic groups at different
levels and by the actions produced as multiple actors traverse both local and national
terrains of power.

The country’s rich natural endowment of crude oil is also a factor; although the malaria
problem is significantly present in many non-oil countries, Nigeria’s oil wealth endows
it with several peculiarities, one of which is that it is a major regional power in sub-
Saharan Africa. The vast investment potential brought about by oil and its
transformative impact also mean that the country’s position generates extensive global
interest. Given such complexities therefore, the utility of multi-sited strategies of

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12 Central Intelligence Agency. The World Fact Book - https://www.cia.gov/library/publications/the-
research for studying Nigeria can be gleaned from how Marcus expresses its methodological benefits. According to him, the approach offers:

An opportunity to dislocate the ethnographer from the strong traditional filiation to just one group of subjects among whom fieldwork is done and instead to place her within and between groups in direct, or even indirect and blind opposition…What is often taken for granted in terms of an encompassing moral economy for fieldwork is now actively probed and questioned along with other matters as the anthropologist moves among sites of fieldwork (Marcus, 1998: 20).

It is well suited to research work that seeks ‘to reconfigure the conditions for the study of contemporary cultures and societies’ (Marcus, 1995: 103). Marcus cites the examples, among others, of contemporary media studies, social and cultural studies of science and technology such as Latour (1987), epidemiological studies in medical anthropology such as Balshem (1993) and development studies such as Ferguson (1990) and Escobar (1995) as genres in which multi-sited ethnographic research began to emerge more forcefully.

The dissertation follows Marcus essentially because it intends to focus on the multi-facetted arena of malaria control in Nigeria with a view to scrutinizing the social, historical, economic and politically constituted elements that activate its practice. To this end, I arrived in Nigeria in 2011 to conduct field work in various institutions involved in the anti-malaria campaign within and beyond the Nigerian state. The field work was conducted mostly in Nigeria’s capital city Abuja, where the Federal Ministry of Health and the relevant international bodies are located. As part of the process I conducted in-depth interviews, as shown in the table below, with officials of the Federal Ministry of Health in the country and the National Malaria Control Programme (NMCP). Officials of the World Bank in Nigeria and the World Health Organisation were also interviewed. NGOs and INGOs such as the Society for Family Health were interviewed to get a sense of how malaria control operations were being bridged between the public and private sectors. Participants were also drawn from research institutions such as the National Institute for Pharmaceutical Research and Development (NIPRD) and the Colleges of Medicine at the University of Ibadan and the University of Lagos. Participants at NIPRD were asked to comment on the nature of research into the malaria problem in order to get a sense of how the government of Nigeria perceived the
scale of the problem and balance that against the internal efforts being made to address it.

Table 1 - Interview Structure for Fieldwork Conducted in Nigeria

<table>
<thead>
<tr>
<th>Interviewees</th>
<th>Interviews</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public Health Institutions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Malaria Control Programme (NMCP) officials, Abuja, Nigeria.</td>
<td>8 Interviews</td>
<td>18/08/2011 – 02/11/2011</td>
</tr>
</tbody>
</table>
| Federal Ministry of Health official.

13 The National Malaria Control Programme is also part of the Ministry of Health but semi-autonomous

<table>
<thead>
<tr>
<th><strong>NGOs/INGOs</strong></th>
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</thead>
<tbody>
<tr>
<td>Supporting Nigeria’s Malaria Control Programme (SUNMAP) official, Abuja, Nigeria.</td>
<td>1Interview</td>
<td>15/08/2011</td>
</tr>
<tr>
<td>WHO official, UN House, Abuja, Nigeria.</td>
<td>1 Interview</td>
<td>19/08/2011</td>
</tr>
<tr>
<td>Telephone interview with NGO representative from Society for Family Health (SFH)</td>
<td>1 Interview</td>
<td>19/01/2012</td>
</tr>
<tr>
<td><strong>Research Institutions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmaceutical researchers at the National Institute for Pharmaceutical Research and Development (NIPRD), Abuja, Nigeria.</td>
<td>2 Interviews</td>
<td>31/10/2011 (same day)</td>
</tr>
<tr>
<td>Medical researchers, Lagos University Teaching Hospital (LUTH), Lagos, Nigeria,</td>
<td>2 Interviews</td>
<td>14/09/2011 &amp; 13/10/2011</td>
</tr>
<tr>
<td>Medical researcher, London School of Hygiene and Tropical Medicine (LSHTM), London, UK</td>
<td>1 Interview</td>
<td>25/07/2012</td>
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<tr>
<td><strong>Local Government</strong></td>
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<tr>
<td>Medical administration official, Badagry local government, Lagos, Nigeria.</td>
<td>1 Interview</td>
<td>06/10/2011</td>
</tr>
<tr>
<td>Community health centre official, Badagry, Lagos, Nigeria.</td>
<td>1 Interview</td>
<td>06/10/2011</td>
</tr>
<tr>
<td>Roll Back Malaria (RBM) representative, Badagry local government, Lagos, Nigeria</td>
<td>1 Interview</td>
<td>07/10/2011</td>
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<tr>
<td><strong>Private Sector</strong></td>
<td></td>
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<tr>
<td>Joint interview with two executives of a pharmaceutical company in Lagos, Nigeria</td>
<td>1 Interview</td>
<td>9/11/2011</td>
</tr>
<tr>
<td>Medical doctor at a private hospital in Lagos, Nigeria.</td>
<td>1 Interview</td>
<td>12/10/2011</td>
</tr>
<tr>
<td>Traditional medicine practitioners, Lagos and Abuja, Nigeria,</td>
<td>2 Interviews</td>
<td>15/09/2011 &amp; 02/11/2011</td>
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</table>
In all, twenty-five semi-structured interviews were conducted within the country during fieldwork but interviews did not constitute the only method for understanding the local terrain. The data gathered from these interviews were combined with other sources such as official and archival documents to develop the generalizations that have been made in the dissertation. The College of Medicine, University of Lagos as well as the University College Ibadan were also sites for interviews and document reviews. Archival materials from early colonial administration were retrieved from the National Archives Ibadan as well as the Archives of the John Rylands Library, University of Manchester. I observed the work of the State Support Team (SST) in Lagos during the distribution of Long Lasting Insecticidal Nets (LLIN) in the state during August and September 2011. Commentaries in the press on matters relating to malaria control were also reviewed in order to develop a broad picture of what the local perceptions of the problem were and how it has been tackled over time.

Findings from the interviews conducted with Nigerian officials as well as officials of international organisations revealed a general attitude, at both levels, of perceiving global institutions as fundamentally better placed, in material and intellectual terms, to fix the myriad systemic problems that beset malaria control in the country. There is thus an overwhelming reliance on the global level of operations for the transportation of ideas about how the control of malaria is best approached for the overall benefit of Nigeria. The main thrust of Nigeria’s malaria control efforts as well as the logic that drives them is externally rather than internally generated. For example opportunities that may exist for further developing existing herbal remedies for curing malaria are not given much attention at a national level. The way programmes are run shows a commitment to appearing serious to the external bodies that provide funding to these programmes in order to sustain them. Officials also explained successes recorded in the context of being able to maintain such a level of seriousness. The malaria control environment in Nigeria is thus highly diffused and disaggregated giving prominence to many ‘development partners’ engaged in implementing a large number of programmes. The research setting shaped the exploration and pointed it towards attempting to better understand the conjuncture where global and local interests interact through the following questions:
i. How are the parties in relationships of development best characterized?
ii. What are the underlying interests that unify these parties in the practice of development?
iii. What historical and contemporary factors produce dominance in these relationships and
iv. What are the discourses that help to maintain this dominance?

In the end, the questions that guided the field work were shaped as much by observations of such conditions as they were by what I was able to garner from preliminary interviews. As the research progressed, it became more and more focused on understanding the interface existing between the state in Nigeria and the external actors that constitute the dominant parties in international development transactions and it explored how dominance and acquiescence are maintained in such relationships.

**Chapter Outline**

The questions above are mainly what the dissertation seeks to answer in the six chapters into which it has been structured. The first chapter sets up the theoretical understanding of development that guides the narratives and analyses in the dissertation. It argues that development as we know it is possible because it takes place within three spaces of power namely the ‘multilateral space’; the ‘semiotic space’ and the ‘development space’. The predominance of global entities in each space serves to perpetuate the way development relationships are ordered.

Chapter two further explores existing literature on development as well as on Nigeria and its public health situation in order to get a sense of the state of debate on Nigeria and also how socially and politically problematic a biomedical problem such as malaria can be in the context of a country like Nigeria. What is revealed from this exploration is that many of the contemporary hindrances to controlling the malaria burden in Nigeria stem from the country’s socio-political history, and the challenges posed by this historical dimension need to be factored into any analysis of the problem in order to fully understand how best to study it.

In chapter three a background is given to malaria control in Nigeria. Its evolution is traced through three stages namely the early colonial stage during which it received a large dose of attention as a result of the obstacle the disease posed to the colonial
operation; the immediate post-colonial stage of relative inertia in which Nigeria, like
many other endemic countries, dealt with the problem almost entirely through a case by
case management with chloroquine administration. Global involvement in control
efforts was extremely limited at this stage; and the current stage of widespread
partnerships organised between external actors and country actors. Local perceptions of
the utility of these partnerships and the operational benefits they bring to the process are
also explored.

In chapter four I critically examine the interface between the machinery of international
development and the machinery of state in Nigeria as it relates to malaria control. The
chapter argues that the requirement of international development that countries in receipt
of assistance should demonstrate a degree of ‘seriousness’ in order to justify continued
assistance is not as transparent as may be imagined. Seriousness is instrumentalized as
part of a discourse with its own internal rules designed to regulate and control the way
developing countries think about development. This position is elaborated using three
case studies: the system of prequalification for the supply of approved artemisinin
combination therapy (ACT drugs); the distribution of Long Lasting Insecticidal Nets
(LLINs) and the roll out of Rapid Diagnostic Tests. The way programmes are
implemented in each case exposes a system of dominance and subservience in which the
Nigerian state is unable to harvest the economic potential that these programmes really
offer beyond their usefulness as public health interventions. This situation is also not
politically contested for the same reason of keeping up the appearance of seriousness.

Chapter five focuses on the continuing overlap between orthodox medicine and
traditional medicine in Nigeria and the latter’s struggle to make the transition into
orthodoxy. Many traditional medicine practitioners claim that malaria as a disease has
been with Africans long before the colonial encounter. They say that traditional
methods of curing and managing malaria in pre-colonial times were effective and have
survived through the ages and should be integrated into Nigeria’s current malaria
control strategies. The official government line however is that traditional medicine is
unrefined and needs to be subjected to rigorous testing before it can be integrated. This
has generated a serious debate about the place of traditional medicine in Nigeria’s
healthcare delivery. This chapter will consider this debate as part of a consideration of
the sociological and historical disconnect between the nature of the malaria problem in
Nigeria and the external actors driving the response to it.
Chapter six concludes the dissertation by considering the contributions that the empirical narratives in the previous chapters have made to the study of development assistance to Nigeria. The findings from the research will be analysed and used as the foundation for building the case that the problem of controlling malaria in Nigeria is most usefully dealt with if conceived as a conjuncture between technical as well as socio-political realities.
Chapter One

Three Spaces of Power

Introduction

Li (2007) has referred to development as ‘the will to improve’ while Cowen and Shenton (1995: 32) express it as ‘a means to create order out of the social disorder of rapid urbanization, poverty and unemployment’. But development has varied meanings and perhaps a pointer to the varied use of the word is the fact that the Oxford English Dictionary has more than ten variations if its definition. Two of them are of particular interest to this chapter; in one, the dictionary defines development as ‘the economic advancement of a region or people, especially one currently under-developed’ and in the other it is defined as a ‘gradual advancement through progressive stages, growth from within’. They are germane because they assign to the word those meanings it is associated with in the practice of international development; the meanings that set it apart from its usage with reference to the organic growth of living organisms or its usage in, for example, property development. Development has thus also been defined in current literature as ‘the process of making progress or improvement in terms of income, employment, living standard, self-reliance, equality, freedom, and sustainability (Haque, 2004; UNDP, 2003).

There are however ways in which these definitions are problematic; by emphasizing underdevelopment and by qualifying advancement as occurring through ‘progressive stages’ the definitions evoke a desire for further clarity. As one seeks to clarify definitions such as these, questions such as how a country is understood as underdeveloped or what elements are constitutive of those ‘progressive stages’ immediately become relevant.

The way in which these questions have been answered in sections of the literature links development invariably to power or the hegemonic influence of powerful states. Arturo

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2 OED Online.
Escobar (1995), for example, critiqued development as a mode of thinking that endorses and entrenches particularly Western economic practices and, to that extent, international development aggregates those institutional practices that allow what is understood in Western economic models as development to function.

Gustavo Esteva (1992) traced the political coinage of the word to President Harry Truman’s inaugural speech in 1949 and argues that the meaning of development was changed by the context in which Truman used the word ‘underdevelopment’ when, in reference to the perceived role of the United States in the emerging world order, he declared ‘we must embark on a bold new program for making the benefits of our scientific advances and industrial progress available for the improvement and growth of underdeveloped areas’ (p.1).

Truman was calling for a programme of intervention, by areas of the world where ‘scientific advances and industrial progress’ had been achieved, in areas of the world that were perceived as ‘underdeveloped’. Development thus became a practice that set a group of developed countries apart from a set of undeveloped or underdeveloped others. Internationalizing this dynamic also meant that the involvement of the former in the affairs of the latter confirmed their respective stations in the global spectrum of ‘progress’. The desire to develop became equated with a desire to move further up this spectrum and become more like those countries already developed. This invariably created a role for the latter and as Esteva put it, Truman created a ‘euphemism, used ever since to allude either directly or inadvertently to the era of American hegemony’ (Esteva, 1992: 2).

Such critiques of development create a necessity to more closely scrutinize its operation even in situations such as malaria control in Nigeria where the assistance it renders is reported as saving lives (WHO, 2011: xiii). This chapter will therefore set up a theoretical framework that contextualizes development by linking it to the global operation of power and thereby reveal international development assistance in Nigeria’s malaria control as analytically problematic. It is also a useful framework for interpreting the empirical narrative from the fieldwork in Nigeria.

In developing this contextual framework, what immediately presented itself as a challenge was how to label the frames of reference. The question was whether to think of them as spaces in as Lefebvre (1991) did or whether it would be better to think of
them as discourses. This question was necessary because it is not intuitively obvious that multilateralism, for instance, is the same sort of thing as semiotics. As such it became important to end up with a term that bound them together in a general frame of reference. Tempting as it was to retain, discourse was very quickly discarded. This was largely due to the difficulty sensed in being able to draw together those sets of practises where the constitutive elements are largely symbolic. Also what I have conceived here as a development space is different from the idea of development discourse as elaborated in post-development literature. There was hence a conscious effort to move away from making the two concepts appear interchangeable.

The conceptual register of space was adequate for this purpose. It is also an already generously invoked term in the literature and has been employed in referencing various sets of common elements, especially in the discussion of encounters between global and national terrains. Importantly, the concept of space does not come with the analytic compulsion to identify what Foucault called ‘rules of formation’ - the ‘conditions of existence but also of co-existence, maintenance, modification and disappearance in a given discursive division’ (Foucault, 1972: 42). Ferguson for example invokes the term several times in *Global Shadows* (2006) in relation, for example, to ‘national economic spaces’ (p.13); ‘the space of politics’ (p.14) ‘lawless spaces’ (p.41). In his discussion of how global dimensions of knowledge and knowing are represented and reproduced in Africa, Ferguson uses ‘space’ as somewhat interchangeable with arena, so that ‘national economic spaces’ refer to nation-wide economic practice as opposed to localized domains where, for instance, warlords may hold sway and conduct their own forms of economic organisation in disregard of the state and ‘lawless spaces’ refers to those areas in Africa that are characterized or have been characterized by war, such as Liberia and Sierra Leone.

John Allen (2003) attempts a more geographical use of the terms by pointing out how spatial dynamics of reach and proximity shape the character and practice of power. He thus argues for a view of power that recognizes that ‘although much of what we understand of power stems from its relational effects, its basic configuration, whether mainly political, cultural or economic in shape, is drawn from the manner in which resources are mobilized and deployed over variable spans of space and time’ (p.95).
Space, as a way of expressing different forms of boundaries, is thus invoked with a number of connotations in the literature and, following Lefebvre (1991), Agnew and Corbridge describe the distinctions that make it possible to apply the concept of space in such a variety of ways. According to them, Lefebvre’s distinction between ‘spatial practices’ and ‘representations of space’:

Is helpful in understanding the nature of the connections between geopolitical orders and the discursive representations of space implicit in the practises of foreign policy. Spatial practices refer to the material and physical flows, interactions, and movements that occur in and across space as fundamental features of economic production and social reproduction. Representations of space involve all of the concepts, naming practices, and geographical codes used to talk about and understand spatial practices (Agnew and Corbridge, 1995: 7)

Agnew and Corbridge’s summation of the broad connotation of space is useful for understanding its application in the literature, but it is with regard to what they have referred to as ‘interactions and movements that occur’ between global actors and national actors that I use the concept. I identify three spaces of power on the basis that the affinities between particular practices are what bind them together in a common space, namely ‘the multilateral space’, ‘the semiotic space’ and the ‘development space’. Matters of international cooperation and of common international standards and conventions for example are constitutive of the multilateral space while matters relating to the way in which global power is represented, symbolized or rationalized form what I have called the semiotic space. Finally, the development space harbours those practices devoted to how national and international politics is organised to ensure that the objectives of international development retains its primacy in the relationships between both national and global fields of politics.

International development as a practice is very active on the African continent and it is possible to group its activities by typologies so that they can ultimately be said to occur in distinct spaces as I have pointed out above. In its respective spaces of operation, international development in Africa encompasses every measure that is instituted to help move the continent along a modernizing trajectory. This modernizing mission is supported by a narrative on Africa that is quite often a narrative of a failing continent in desperate need of rescuing. The knowledge of Africa that is distributed is of a continent
plagued by the most profound forms of human malaise at the same time as it lacks the resourcefulness and the capacity to change its own condition. This narrative of failure that Africa presents as well as represents to the world underscores the interaction between global and national structures of power, binding the two into perpetual negotiations of a way out of the African malady. These interactions take several forms, one of which is international development. The trouble however is that the narrative is hardly ever updated. The modernization project does not intermittently review Africa’s place so that the continent can be relocated along the continuum of modernity; instead, the narrative of gloom, crisis and failure is permanent. Progress is recorded in Africa but is often discussed in the context of the achievements of international development efforts rather than any sort of socio-economic engineering that happens outside that scope. In much the same way as the narrative of racial inferiority served as a legitimizing narrative for colonization, the narrative of failure serves to legitimate development interventions in Africa. The perpetuation of this narrative is therefore necessary for the sustenance of the mechanisms of international development.

Ferguson points out in Global Shadows, how some anthropologists have attempted to rescue Africa from undifferentiated narratives of the continent, and have gone as far as citing the homogenous category of ‘Africa’ as empirically problematic (Ferguson, 2006: 3). But what is possibly not studied enough is what gives this narrative of ‘African crisis’ its permanence or how that permanence is maintained. This chapter proposes that the dominance of global actors in each of the three observable spaces of power identified above is what perpetuates the narrative on Africa. If the African narrative is to change therefore, that change will have to emerge from new hybrids of power.

As the operations of international organisations in areas such as malaria control amply demonstrate, development is not just a single-minded archetype that supports the ideological engagement of the West with the developing world. It has been constructed and operated as an inevitable aspect of a world order that is constantly renewing itself to produce, as well as accommodate particular forms of change in international relations and the global economy. The site of operation for international development is not really the physical locations within the countries where it is active; it is the metaphysical site of encounter between the elite in developing countries and the development establishment. The encounter between the two produces the interestingly varied formations we refer to as development. A proper understanding of these
formations compels an antecedent understanding of the nature of the encounter itself, i.e. what necessitates it, what facilitates it and what maintains it.

The theoretical framework that is offered in this chapter is one that regards the development encounter as a universe of practices, made up of distinct but overlapping spaces of power namely the multilateral space in which the behaviour of countries is expectedly defined by the fact that they are bound to others by common principles; the semiotic space where idealism, rationality and symbolisms are framed in such a way that they also influence and define behaviour; and the development space where the ultimate operation of international development becomes visible. One common element of this universe of praxis is that the relationships within each of the subsets and the standards that they enforce compel actors to demonstrate a seriousness about developing by approaching development in particular ways. The semiotic space, example, is a space of symbolisms; it constantly provides renewable sets of rationalities and potential states of attainment to which national authorities can aspire if serious. Also, within the multilateral space, it is practically a forgone conclusion that seriousness imposes on every country (including powerful ones) the need to subjugate itself to the multilateral agenda. While this makes the constraints of multilateralism appear even-handed, the political economy of many sub-Saharan African countries, especially given their dependency on Western sources of funding, compels them to appear to be demonstrating a more intense seriousness. A country like Nigeria also tenaciously adheres to multilateral agendas partly because of its own internal fragility. Being able to appear and be seen as a serious member of a multilateral network of responsible states becomes a useful source of legitimacy.

**The Multilateral Space**

Formed in the wake of the Second World War and against the historical antecedent of a failed League of Nations, the most urgent task for the United Nations Organisation was how to engineer a spirit of internationalism and cooperation; a spirit that will define and regulate the action of member nations within a political sphere that is trans-national by virtue of being multi-lateral. The logic was that global security and international peace was best assured if nations agreed to be bound by a common understanding and by conventions and treaties. What emerged out of this internationalism is a global order that placed a high premium on the vital role played by multilateral institutions.
Responsible international behaviour became defined by how agreeable relevant multilateral institutions deemed it; and the opposite is often true if such action is condemned at this level.

There is therefore a very strong multilateral culture that regulates the action of states and imposes or demands ‘responsible’ behaviour. Even hegemonic states are engulfed in this culture. The refusal of the United States for instance to sign the Kyoto agreement is still viewed by many as irresponsible. But while a country like the U.S may be able to get away with this kind of action, smaller states are hard put to attempt that level of obstinacy without fear of some form of consequence. For a country trying to develop within this multilateral space, such a limitation can be quite a handicap. The example was given in chapter four, for instance, of how the EU announced that it was going to ban all agricultural exports from Uganda if the country made good its intention to resume the use of the internationally banned chemical DDT in vector control against malaria.

The multilateral system by its nature is made up of diverse states and a multiplicity of sub-systems; attempts are thus constantly being made globally to standardize practice, define processes as well as common terminologies and determine minimally acceptable quality (in the case of manufacturing) as those that conform with internationally agreed ‘good manufacturing practises’ (GMP). With such international standards it is often the case that the standards that are mirrored are the standards already attained in advanced economies, thereby leaving small countries trying to develop at a disadvantage. They also find that they are locked in the embrace of a multilateral system that can be quite punitive when it is defied. This leaves them with very little choice but to align themselves with whatever is internationally endorsed.

Often this will mean that small countries are unable to focus internally generated capacity on a problem and hope that the challenges they face in dealing with that problem will prompt them into new ways of thinking about it and hence improved capacity to deal with it. They are persuaded that allowing in multiple external agencies to deal with the problem is a better approach. Again, an example is given in chapter four of how the GMP has been instrumentalized as a tool for keeping Nigerian pharmaceutical companies out of the approved malaria drugs market; a situation they are unhappy about but are somewhat helpless against.
As an idea that brings a number of countries together, multilateralism probably even predates the League of Nations but it has become a much more relevant discussion in the contemporaneous post-Cold War context in which the unilateral action of the United States, especially under the second Bush administration has tended to confirm worries about a unipolar power balance (or imbalance). In this regard, a country’s embrace of multilateralism can demonstrate its willingness to tailor its actions according to the tenets of cooperation with other countries, especially where such actions may have transnational ramifications. Going it alone or even suggestions of going it alone may therefore be seen as irresponsible behaviour in this context.

Multilateralism is however not strictly limited to this kind of security connotation. Its definition by former UN Secretary-General Javier Pérez de Cuéllar (1987) shows it can be much more encompassing: ‘by multilateralism I mean a common effort by the international community, based on the principles of the United Nations Charter, to address in a pragmatic manner the world's many needs and problems, so that the entire human family can realize its full potential.’ This definition is probably the most often quoted definition of multilateralism and it provides the sense in which the multilateral space can be seen as that space within which the relentless effort by developed countries to help poorer countries along particular trajectories finds its most empowering logic. Multilateralism imposes a moral duty on developed countries to help poorer countries develop; a duty to help humanity realize its full potential, and one might add ‘in spite of itself’. This is because the fact that the process involves a multiplicity of actors necessitates standardization of practice and where there is conflict there is an insistence that the standards are upheld in the interest of multilateralism. It is, by this token, possible to regard the arena of operation that multilateralism offers to international development as an instrumental one.

Instrumental multilateralism can therefore be taken as one that renders national interests subservient to multilateral interests; one in which neo-liberal Western values are garbed in the cloak of universality to forestall political contestation. This kind of distinction is possible because persuasion and diplomacy is often the mode of getting powerful countries to conform to multilateral agendas while small countries are often subjected to multilateralism by the threat or the direct application of sanctions. Under these conditions it is nearly impossible to develop any other way but the multilateral way.
Alilio and others (2004) showed two things in their article on multilateral research projects in malaria control: one was that malaria control failed during the period before the early 90s when it was enacted as part of national primary healthcare systems in respective countries. The second was that its resurgence was possible because of multilateral efforts mustered to deal with the problem much more decisively. They also described the process of multilateral action that set the stage for the current global approach to malaria control:

In 1992, the Ministerial Conference on Malaria in Amsterdam enunciated a Global Malaria Control Strategy, which was endorsed by The Economic and Social Council of the United Nations in 1994. The World Health Assembly passed a resolution on controlling malaria in Africa in May 1996, and the Organization of African Unity made declarations on malaria in Harare, Zimbabwe in 1997 and in Ouagadougou, Burkina Faso in 1998. In 1996, the African Regional Office of the WHO became increasingly attentive to malaria and launched the African Initiative for Malaria Control (AIM). AIM contributed $9 million in 1997 and 1998 for accelerated implementation of malaria control activities in 10 countries in the region, and provided the foundation for the eventual launch of Roll Back Malaria in 1998. In 1997, the MIM Malaria was established by African and northern country partners with focus on strengthening research capacity in Africa. The heads of African States conference was held in April 2000 in Abuja, Nigeria, which declared the goal of reducing malaria deaths by half by the year 2010 (Alilio et.al. 2004: 269)

The rapidity with which movement was restored to malaria control, not just in one but many countries simultaneously in the eight years from 1992 to 2000 is testament to how much difference is made when the might of global health institutions is put behind national health systems in their efforts to tackle health as part of the development problems they face. Many of the countries dealing with the malaria problem are poor countries and will indeed struggle to control it on their own. The great thing therefore about international development is its humanitarian undertone. However, when the humanitarian involvement of external actors becomes a permanent feature of statehood as is the case in Nigeria and most African countries, it evokes a different question: are global actors overly empowered to create a space of multilateral operation around any problem that they choose, just by defining the problem as requiring a multilateral
response? It would appear that all it takes is for any Africa specific problem to be injected into multilateral debates on Africa and the response to that problem invariably transcends the continent. Not only so, but the continent also becomes subservient in how that response is articulated.

This tendency is quite visible in the way global institutions seized the initiative on malaria control. Things progressed very quickly from the initial Multilateral Initiative on Malaria (MIM) meeting in 1992 to the setting up of the Roll Back Malaria (RBM) in 1998 and by 2000 African heads of state were declaring a commitment at their Abuja meeting to creating ‘an enabling environment in our countries which will permit increased participation of international partners in our malaria control actions’ (WHO/CDS/RBM, 2000). As a further demonstration of their seriousness, they pledged ‘to reduce or waive taxes and tariffs for mosquito nets and materials, insecticides, anti-malarial drugs and other recommended goods and services that are needed for malaria control strategies’ (WHO/CDS/RBM, 2000). This is an example of how development’s multilateral space is created. The legitimacy accorded by multilateralism to political and socio-economic action originating from global centres of power precludes national authorities from questioning the economic impact such actions exert on the domestic economy. They refrain from questioning whether the trade-off between what is received in development assistance and what is lost through the opening up of the economy to foreign companies, who get access under the umbrella of the programme of disease control, is one that is commensurate to the situation.

It is not unusual for action and rhetoric to be at variance in African politics. After the pronouncements at the Abuja Summit, only about half of African countries kept to the promise. This, in a sense, is understandable as these countries are too poor to afford a vacillation with tax receipts. Not surprisingly however, the action of the ‘errant’ countries was condemned as unserious. A naming and shaming strategy was deployed: Louis Da Gama, Director of Malaria Foundation International declared that ‘Africa’s leaders must be held accountable to their promises…they have it in their power to drop the taxes and do more to fight malaria in their countries’ (Megafu, 2002: 56). He then proceeded to name not only the countries that have dropped the taxes but also all those countries who were yet to, demonstrating a patent recourse to the instrumentalization of seriousness as discourse.
The multilateral space of operation within which these events take place does not exist just by virtue of individual countries being members of the UN or WHO. Being members of such organisations connects them to a multilateral network that imposes certain codes of practice, but the network is dormant and operates with a casual regularity until a space for its particular operation is created; until a particular set of problems are given a multilateral colouration. In malaria control for instance, it is part of the regime of Good Manufacturing practises (GMP) that all member countries adhere to the WHO Pesticide Evaluation Scheme (WHOPES). But the experience of indigenous companies in Nigeria trying to meet the WHOPES standard is that it is too stringent and precludes them from playing a more significant role in the control of malaria. It does not help that the standard is continually tightened as the foreign companies who have already secured WHOPES recommendation are able to improve their technologies. At the time when mosquito nets were made of polyester it was possible, even at a post-production stage, to bind the insecticide to the net using chemical binders. Retreatment kits were therefore available separately with the nets. As local companies started to proliferate around schemes that acquired the nets and the chemicals separately and then bound them together in a treatment plant, a new regime emerged that disqualified such nets for public tenders. The reason was because a new technology had become available, which had a better quality of yarn for the nets (Polyethylene). The technology also mixes the insecticide into the polymer used in creating the yarn. ‘The insecticide is therefore distributed inside of the polyethylene yarn as it is made. As the net is washed, insecticide on the surface that may wear off is replaced by fresh insecticide emerging from the yarn’ (USAID Deliver Project, 2007).

This process by which technologies that are remote and inaccessible become the standard within the domestic economy is one that many local companies find frustrating, but one which the tenets of multilateralism constrain the state from addressing. It limits competition by preventing or limiting market entry and it also keeps prices high and limits consumer choice (Coticelli, 2007).

The importance of this paradigm for anthropology therefore is that it reveals how the behaviour of the state in Nigeria is shaped by the fact that it finds itself already enmeshed in deeply-rooted structures of power even before it was born. Its socio-political as well as economic practices have thus been shaped by these very firm structures, the irony being that the state ceases to pursue development in a way that
actually improves the welfare of its population precisely because it is pursuing
development according to an imbued agenda, an agenda made operational mostly
through development assistance.

Development assistance is implemented through national systems and local civil
society, and rationalized not so much as assistance to recipient governments and groups
but as packages meant to support the alleviation of the dire conditions of people in
poorer countries severely affected by problems such as disease, hunger, malnutrition,
poor infrastructure, economic planning deficiencies etc. Basing the need for rendering
these types of assistance on a compelling moral responsibility to act creates a role for
big countries in the affairs of small ones. Fassin refers to this as making possible a
‘humanitarian government’ and argues that the ‘tension between inequality and
solidarity, between a relation of dominance and a relation of assistance is constitutive of
all humanitarian government’ (Fassin, 2012: 1-3). The multilateral environment in
which this encounter takes place encodes a set of Western dominating practices and
systems of rule. It is not as disinterested as it may claim that it is, but rather it is yet
another mutation of much deeper sets of Western political, epistemic and humanitarian
projects.

Multilateralism creates the conditions under which the invasion of domestic political
and socio-economic spaces is accepted as incontestable. For example, at the Abuja
Summit on Roll Back Malaria which took place on the 25th of April 2000, it was
acknowledged by the African heads of state that all African countries have signed and
ratified the Convention on the Right of the Child (CRC). Since this convention
recognizes the right of all children to good health and nutrition, it would have appeared
grossly unserious for any of the African countries present not to give their full backing
to the Roll Back Malaria programme which was designed to roll back mortality due to
malaria; a disease well known to be most severe in children under five. The legitimizing
effect of multilateralism’s humanitarian undertone is therefore such that the idealisms
which it transports are accepted as offering the only way to approach development. It
also creates an opportunity for hegemonic countries such as the United States to ensure
that such affairs are carried out in a way that remains favourable to their own
ideological predispositions. Essentially it allows them to maintain a given global order.
The technique by which this role is organised is through a multilateral system that creates a comity of nations under an umbrella body such as the United Nations with multiple agencies which oversee various functions. So far, as is visible in malaria control, this technique has worked very well in instituting dominant practices on developing countries. I will now turn to a related space of power in which a different set of techniques are at play: the semiotic space.

**The Semiotic Space**

Much is made in this dissertation of how the narrative on Africa portrays the continent in a dim light and of how the representation of its disease status projects an image of a helpless continent in desperate need of rescuing. These are not fabricated representations of Africa; they are the image of Africa held both inside and outside Africa and are backed up in many ways by the reality of the human condition on the continent. The real problem with the narrative is how it is used as a basis for imposing inescapable systems of rule.

The narrative of disease in general and malaria in particular has historically been a very handy way of telling the story of the continent. Even Africa’s economic challenges have been explained in terms of its historical disease situation (Gallup and Sachs, 2001; Acemoglu and Robinson, 2003). International development intervened at the level of making serious efforts at resolving these problems. It can therefore be asserted that in order to keep international development operative, its rationale as well as the narrative that supports it must be rendered visible. This visibility is achieved through a series of semiotic mechanisms that constitute a distinct space of operation organised to project the ideal of development.

Development’s semiotic space is a space of symbolisms and meanings. It is a power-laden space rooted in historical as well as contemporary forms of representing socio-economic reality; it is rooted in the historic efforts by dominant Western countries to construct rationality in their own mould; it is also rooted in the struggle to affect the African’s world outlook, his perception of himself and the world around him, and to institute new ways of tackling socio-economic organisation in relation to the rest of the world. A close examination of this space reveals why the development encounter takes the form that it does: it is a space that harbours entrenched forms of power that shape the way less powerful groups develop a consciousness of reality. In a sense, their
consciousness is colonized as Comaroff and Comaroff (1991) describe it. They in fact argue that the three domains of African life invaded by the civilizing mission were its natural resources, its techniques of production, and its language.

Development as we know it today is often traced back to the establishment of the United Nations and its technical agencies, but the semiotic space into which it was born predates it by very many years. Going back as far as the early encounters between Europe and Africa travel writing made much of representing Africans through Eurocentric lenses. Morgan (1997) for example has shown how gendered notions of European social order were pitched against what was represented in early English Literature as a cultural disorder in Africa, in order to justify access to African labour. A series of symbolisms and texts as well as the meanings assigned to them have thus historically been at the heart of how groups locate themselves in a universe of realities, and hence the way they perceive change. As Thibault put it, ‘ideological formations are constructed in and through the texts and social discourses of a given social group. Meanings are socially made in and through regular and limited patterns of action and interaction in particular discursive formations’ (Thibault, 1991: 204). Social groups therefore become dominant by being able to elaborate their thoughts, value systems and practices over and above those of other groups. This is achieved through various systems of signification through which the practices and value systems of dominant groups become entrenched as standard. Cormaroff and Comaroff (1991), for example, in their historical ethnography among the Southern Tswana show how the late 19th century map of power among the Tswana emerged out of the way in which their consciousness of reality was colonized through the missionary encounter. The enduring effect of colonialism and its missionary adjunct was therefore to gain control over material and semantic practices through which subjects acquire understandings of, and, interpret their everyday life.³

The current development environment is also replete with a series of linguistic and non-linguistic methods of idealizing or disabling particular norms but this is a recent practice. From the earliest evangelical contacts with Africa, through to the institution of Western pedagogy during the colonial period, the effort had constantly been to force Africans to re-imagine reality. The principal way that Christianity achieved this was to ascribe everything that did not fit into a Christian mould to the devil and condemn it as

³ See also John Comaroff and Jean Comaroff, 1993.
evil, meriting only resolute discontinuance. To this extent, missionary Christianisation was a forerunner to colonialism and performed part of the conversion necessary for the subjugation of consciousness. Although separated from the practise of colonial control, Pels has argued that missionaries under colonialism continued to be involved in colonial education: ‘individually, missionaries often resisted collaboration with colonial authorities, but they supported them by education and conversion. For the colonized, education and conversion became technologies of self-control that enabled subordination at the same time that they structured resistance to Christianity, colonialism, and their trappings’ (Pels, 1997: 172)

Underscored by the Western modernity project, the way the encounter between developed and developing countries is represented has continued to evolve in the post-colonial era and largely revolves around rationalizations of a global development agenda; so much so that development has become a fully professionalised practice. Professionalization offers a powerful optic by which development’s semiotic operation is best captured. The way the language of development is constructed and its achievements symbolized are at the very root of professionalization. Escobar (1988: 430) defines the concept of professionalization as ‘a set of techniques and disciplinary practices through which the generation, diffusion, and validation of knowledge are organized, managed, and controlled; in other words, the process by which a politics of truth is created and maintained.’ The effect of professionalization is seen first and foremost in the fact that what development assistance involves is an intervention that proposes to deliver ‘improvements’ to the way things are done in order to achieve better results. It places the benefactor in a powerful position in which he can rely on the operative systems of representation to impose his will. Where for instance institutional weaknesses are cited as the reason malaria control programmes are not working, organisations like the WHO and World Bank are able to present themselves as offering institutional frameworks that are able to supervise particular programmes and strengthen systems in such a way as to produce better results.

Due to the absence or near absence of any institutionalized powers to sanction in this space of operation (unlike the multilateral space), there is more of a reliance on subtle forms of persuasion to elicit conformity. The most potent of these forms is embedded in language use. As will be discussed in chapter four, language is deployed to strategic effect. A system of agenda setting takes place through the direction given to national
policy frameworks by their global counterparts. Global networks set not only the expectation of how the problem should be approached but also how it should be described. Preferred terminologies are infused into the process of thinking about the problem; goals and timeframes are set and they become terms of reference for the programme of assistance. Because all pronouncements evaluating the programmes of assistance are tailored towards, and in many cases confined within, these terms of reference it is often the case that there is a semiotic aggregation that imposes limits on how the responses to these problems can be imagined by national actors and hence on how those responses are fashioned.

The need to control the conceptualization of and the responses to these problems thus gives rise to discourses that deploy language in instrumental ways. The success of such strategies is linked to colonialism’s modernizing project, the great outcome of which has been to successfully imbue many developing countries with languages that are culturally external to them. With such impositions come a shaping of world outlooks and articulation becomes a predictable endeavour. Frantz Fanon put it succinctly when he argued that ‘a man who has a language consequently possesses the world expressed and implied by that language. What we are getting at becomes plain: Mastery of language affords remarkable power’ (Fanon, 1967:18).

Another form of semiotic operation can be seen in the instrumentalist way the severity of the African condition is reported which has the overall effect of goading developing countries along particular trajectories; an example being the alarming way in which malaria on the continent is reported. A stupefying urgency is created, on the basis of this alarm, which makes any form of contestation of malaria control programmes an attempt to undo the achievements that are clearly saving lives and targets such as the Millennium Development Goals (MDG) are further referenced in buttressing this urgency. 4 Statistical data is also often provided to emphasize the severity, for example:

‘In 2010 there were an estimated 216 million cases of malaria, of which 91% were due to *P.falciparum*. The vast majority of cases (81%) were in the African Region…

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4 Millennium Development Goals (MDG) 4 target: By 2015 reduce by two-thirds the mortality rate among children under five; MDG 6 target: By 2015 have halted and begun to reverse the incidence of malaria and other major diseases- See World Malaria Report 2010, p.3
There were an estimated 655,000 malaria deaths worldwide in 2010. It is estimated that 91% of deaths in 2010 were in the African Region.\(^5\)

This kind of alarm has become commonplace in the literature on malaria (Breman et al., 2004; Breman et al., 2007; Packard, 2007: xvi; Oresanya et al., 2008).\(^6\) It follows a familiar pattern: the global scale of the disease is given, the huge proportion in Africa is given and then the severe vulnerability of pregnant women and children under five is stated. It is perhaps the case that sounding the alarm assumed increased urgency especially in the earlier part of this century when the need to change malaria control policies across endemic countries had to be more vigorously pursued. But the malaria alarm, although broadly representative of the scale of the disease on the continent has been sounded across the literature with so much tenacity that it needs to be understood more as a knowledge entity than as a benign set of scientific facts. On one hand it helps to focus the attention of the global community on a major problem that requires very urgent responses. Stressing its severity means that the problem can be prioritized on the global health agenda; donors are persuaded to devote more funds to it and political cooperation in endemic countries is a lot more forthcoming. But on the other hand, the unflinching regularity of its appearance casts the continent in a certain light; a very dim light. Africa is depicted as a problem case; a hot bed of disease endemcity needing very radical measures in order to avoid very severe health catastrophes. This then defines practice in terms of how the continent is set up for particular assistance packages and how those packages are delivered.

Part of the effects of this alarm is that as the range of global practises aimed at controlling malaria increases, the likelihood of political contestation of the relative benefits of particular practices is diminished at the national level. This is essentially because, among other reasons, national governments are inclined to avoid being characterized as unserious about tackling a problem as severe as malaria has clearly been established to be.

A further form of persuasion in this space is the resort to the cult of celebrity to keep the message of malaria control current and visible to all parties involved. An example of this was when the world number four tennis player Andy Murray, the England

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\(^5\) See World Malaria Report 2011, p.73
\(^6\) Perhaps a pointer to its effect is the fact that this dissertation also found a need to sound the alarm in the introduction.
footballer, David Beckham, British Prime Minister, Gordon Brown and the former British athlete Denise Lewis had their picture taken in front of a mosquito net draped on the door of No. 10 Downing Street in April of 2009. This picture was in many of the world’s newspapers and had the effect of sending the message across that all hands were on deck to eradicate malaria. The calibre of the individuals depicted suggested in a powerful way that this was an achievable mission if everyone stayed the course.

This kind of symbolism is also what is at the core of the World Malaria Day celebrations. It is celebrated every year on the 25th of April and superficially, it appears as a celebration of achievements in the fight against malaria. However, like all such special celebrations and ceremonies, it also serves to reinforce the strong meanings and ideological foundations stemming from the global anti-malaria campaign. The literature is replete with the effects to which ceremonies can be deployed (Manning, 1978; Jackson, 1988; Waterman, 1998) and the Malaria Day celebrations are no exception: apart from the parade of celebrities that grace the occasion to give it popular legitimacy, it often serves as a day to resound the rallying call to all parties to stay the course and maintain focus on the approaches that are affirmed as working effectively to deal with the malaria problem. At the 2009 celebration for instance, the UN Secretary-General, Ban Ki-Moon reiterated that the day ‘represents a chance for all of us to make a difference. Whether you are a government, a company, a charity or an individual, you can roll back malaria and help generate broad gains in multiple areas of health and human development.’ The WHO also seized the opportunity of the celebration to announce that the day is ‘a day of determination and optimism as the global community now has enough evidence that this fight can be won if partners collaborate efficiently on community, local, national, regional and at international levels.’ This was in other words, a call for partner countries to maintain or even step-up the course of action that had produced the achievements recorded up to that point.

For developing countries, staying the course is also a way of demonstrating seriousness and hopefully guaranteeing an unhindered stream of development assistance. The characteristics of the semiotic space therefore show that it is the space of operation from which the discourse of seriousness emanates. In other words, it is a discourse that is

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8 The Guardian, “Counting Malaria Out”
9 The discourse of seriousness is more elaborately discoursed in chapter four
possible because the semiotic space sets normative parameters which allow the systematic regulation and control of national reactions to global action. In a lot of ways the semiotic space and the multilateral space are mutually reinforcing and the effects of all the actions and events they make possible are not limited to these spaces but are also visible in what I refer to below as the development space.

**The Development Space**

It is necessary to distinguish between the concept of a development space and the way a closely associated one, the humanitarian space, is widely conceived. Coined by Rony Brauman, the concept of a humanitarian space stemmed out of what he saw as a need ‘to create a space within which the spirit of humanitarian action can be preserved’ (Brauman, 1998: 190). He argued that such a space was needed to ensure the right relationship with the recipient populations for humanitarian assistance. The concept has therefore since become synonymous with calls for the establishment of something of a humanitarian corridor that facilitates the work that humanitarian actors do. It relates to ‘a physical access that international aid agencies and their partners have to populations in need; the aid agencies’ ability to adhere to core principles of humanitarian action; the nature of the “operating environment” that they work in, particularly security considerations; and the ability of populations themselves to reach needed lifesaving assistance and protection’.

Another distinction that needs to be made is between the development space and what Escobar describes, in *Encountering Development*, as the ‘the space of development’. What Escobar does is to present a powerful account of the nature of development and how its roots are anchored in the establishment of the sub-discipline of development economics. It has also evolved in consonance with the evolution of economic models from neo-Keynesian to neo-liberal economics. Instead, what I describe here as the development space explores the characteristics engrained in the field of politics that makes international development possible; those characteristics that, if missing, would render it nearly impossible to operate. It is generally regarded that the combination of the chequered history of Third World countries and the unstable nature of contemporary politics in many of them, acts as a natural fodder for international development, but the problems in these countries do not by themselves constitute undisputable recipes for

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10 Humanitarian Space: Concept, Definitions and Uses, Meeting Summary, Humanitarian Policy Group, Overseas Development Institute, 20th October 2010
external intervention; there is an engineering of politics that ultimately sets each country up as a domain of development practice. The development space is thus simply a constructed arena of politics within which both internal and external relationships are created, which render international development possible.

It is the category of what Lefebvre (1991: 3) called ‘a mental thing or a mental place’ that the concept of a development space belongs. It is somewhat more theoretical than the humanitarian space. Rather than physical locations in either developing countries or donor countries or even the arrangement of tangible processes that have a bearing on the work of international development, it refers more to a metaphysical conjuncture between the elite in developing countries and the international development establishment. It is delineated by a governing ideology that unifies the various networks of power that are involved in international development. This kind of unity may not easily manifest itself in tangible forms but it is a strong force that makes the control of the development operation possible from remote centres of power. Fuelled by the hegemonic character of power in international development and the rentier character of the elite in national centres of power, this conjuncture produces the series of mutually beneficial operations that we commonly refer to as development.¹¹

The range of operations referred to as development are not so referenced strictly because they bring about development or are even expected to do so in all cases. Development is not typically or qualitatively applied to those projects or structural planning decisions that bring about growth and progress; it is in fact flexibly applicable to whatever projects both parties in this power configuration can agree on. Agreement therefore demarcates the frontiers of the development space. Development experts are able to organise whatever project they are interested in extending to particular developing countries and seek agreement for its implementation. Agreement confers the status of a development project on it. This is why it is possible for international development to work backwards from solution to problem.¹² Development programmes are often packaged as standardized solutions that are rolled out to every developing country that signs up to them. Minor adaptations are possible but the core package is delivered insofar as political guarantees are secured for it.

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¹¹ See chapter one for a discussion of Hazem Beblawi’s 1987 work - ‘The Rentier State in the Arab World’
¹² This is an important observation by James Ferguson in The anti-politics machine (1990), pp.69-70.
The development space is therefore one where the intricate sets of relationships that make up the postcolonial state are located. It is not necessarily one that can be compartmentalized as the locus of development work but it is certainly the one that produces those relationships that support development. The Postcolonial state was stillborn to the extent that it was born into spaces of power in which there already existed predominant forces. Collectively this network of forces had a long history and quite a global coverage in the exercise of power; the need to maintain its global reach and its dominance created a compelling need to control the way postcolonial countries imagined their future. Properly conceived, the development of developing countries must incorporate material and intellectual production in developed countries. This view is based on the fact that although community focused development assistance exists, they mainly service small projects of community relevance.\(^{13}\) In general, development intervention often analyses problems besetting national economies in developing countries as requiring further market penetration and the lifting of trade barriers, as we saw with structural adjustment policies in the 1980s.

Although it is rhetorically rationalized as humane and incumbent on developed countries, the pervasiveness of international development assistance has in reality prevented postcolonial countries from learning from the experience of internally generating solutions to their most critical national problems. It also has implications for democracy in the sense that there is a delay in the development of systems of accountability in which citizens assess political performance in terms of a real ability on the part of leadership, to deal efficiently with these problems. In Nigeria as in many postcolonial states, power is exercised by a political class that behaves more or less like caretakers of a hastily formed Nigerian state. The geopolitical entity that is Nigeria is quite a fragile one in which the relationship between government and its citizens is very loosely defined. The expectations of postcolonial development have not been met due to limited capacity and the consequent reliance on external support by the state. This unfortunate situation necessitates the alliances and relationships that make up the development space. It is thus a space in which crucial exchanges take place: donor countries contribute expertise and funding to tackle problems of development while national elites ensure access to markets and an embrace of socio-economic models that

\(^{13}\) An example is the American Ambassador to Nigeria's Special Self-Help (SSH) Program which provides small grants to community development activities in Nigeria. See http://nigeria.usembassy.gov/ambsshp.html (Accessed 30/12/2013)
welcome Western values. This type of exchange is visible, for example, in the way artemisinin drug distribution has been organised in the country.\textsuperscript{14}

The way to understand the role that international development plays in supporting various areas of governmental responsibility in Nigeria is therefore not just to think of it as efforts geared toward supporting the wellbeing of Nigerians but also as one that serves to facilitate the reconstitution of the nature of governance. In contemporary terms, governance at the national level is made globally manifest only if it incorporates elements of global governance. What this means is that developing countries have needs and those needs are met not by becoming more insular but perceivably by embracing a kind of globality that allows external actors to function, in an enhanced capacity, as part of the socio-economic fabric of individual countries. The intervention of these external actors, even though it operates under a variety of motives, is generally defined under the rubric of development. This is convenient because to the extent that governance entails a guarantee of popular wellbeing, demonstrating the inability of Third World countries to do so on their own emphasizes the power as well as the relevance of rich countries. The practice of development must therefore be understood as a technique of power and the deployment of this technique was already visible in the run-up to decolonization.

By the time colonialism was coming to an end and new indigenous administrations were being formed, the colonial state did not simply relinquish all forms of power. Rather, colonial power took on new forms and new techniques were devised to modulate its exercise. One of such techniques is international development. It is studied today from a number of paradigms that are articulated around the nature of change and how best to influence or organize it. From the inception of the discipline in post-war Western social science, the modernization paradigm assumed dominance as US leadership in the post War era was centred on resuscitating a ravaged global economy and keeping the spread of communism in check. As social scientists with different specializations picked up the challenge of theorizing change in the post-war era several explanatory models emerged:

While economists laid out models of how productivity in the late-industrializing world might be stimulated, sociologists and social psychologists studied the group dynamics of change, and political scientists devoted themselves to the problems of

\textsuperscript{14} See chapter four
state and nation-building. Whatever the rough edges, the result was indeed a unified and cumulative agenda for Third World studies (Smith, 1985: p.533).

The largely Western view of emergent states in the decolonization era was one which promoted the notion that supporting their transition would require the passing on of modern approaches to statehood i.e. Western methods of industrial and agricultural production as well as Western approaches to trade. Based on arguments by several proponents of modernization such as Arthur Lewis (1954; 1955); Walt Rostow (1960); Talcott Parsons (1960), the West perceived itself as well-placed to offer these interventions and therefore constructed ideas of modernization around offering development assistance to Third World societies in a way that eases them into Western forms of socio-political and socio-economic organisation. This kind of ethnocentrism was criticized by Randall and Theobald (1985: 33) as failing to recognise that economic dependency on the West had political implications. Appadurai (1996) as well as Rofel (1999) considered the notion of ‘multiple modernity’ which helps to find a place for the Third World within a multi-faceted view of modernity; other scholars have even discussed African modernity as a distinct category (Comaroff and Comaroff, 1993; Larkin, 1997).

Economic stagnation (in spite of attempts at ‘modernizing’) provoked arguments from scholars such as Andre Gunder Frank (1967) and Walter Rodney (1972) that ideas based on modernization were retarding Third World growth instead of developing it. Connected to Marxist theories of imperialism and exploitation, the attempt to explain underdevelopment laid most of the blame on the unfair trade relationships between mass exporters of raw materials represented by Third World countries and Western countries who process these raw goods and flood the former’s markets with finished goods.

Such models were classed as dependency theory but have not really led most proponents of modernization theory to abandon that mode of scholarly thinking on development. The import substitution approach that dependency theory promoted did not work very well in many underdeveloped economies. This was especially so because efforts at industrializing were led, in many cases, by ineffective state bureaucracies that had emerged as the main intermediaries between local and foreign actors. Import substitution also overly relied on the importation of capital-intensive technology which
only served to plunge underdeveloped economies further into dependency (Rowden, 2009: 58).

The impasse between dependency and modernization theories generated other ways of explaining the relationship between developed countries of the West and Third World countries. Scholars inspired by Foucault have argued that "development" is not an obvious and natural set of socio-economic changes that societies go through in sequence. Instead, it is a way of describing policies designed to promote particular kinds of social change while disabling others; it encases development in a discourse that makes particular approaches seem natural and inevitable because of a set of scientific facts rather than something that might be contested politically (Ferguson, 1990; Escobar, 1984, 1995; Hobart, 1993; Gardner and Lewis, 1996; Fairhead, 2000; Mills, 1999). The emphasis of the Foucaultian paradigm is on how particular ways of thinking about subjects is based on carefully constructed unities and continuities between statements and practices that over time become encoded into a discourse.¹⁵ The discourse of development thus emanates from the work of ‘experts’ in the field as well as modernization oriented researchers. But the counter-reckoning to it in Foucaultian literature is that its utility as received wisdom hardly goes beyond validating Western instrumental models of rationality and of development thinking; it therefore constitutes a way of exerting power over the process (by which less developed countries pursue development). For Cooper and Packard (1997: 3) it represents an ‘extension of a universalizing European project into all corners of the globe’.

To be sure, these authors do not suggest that development discourse represents a model for guaranteeing the under-development of the Third World. Development actors quite often genuinely believe they are helping, and are able to prove it at least to themselves through reports of specific project initiatives and outcomes. For example, the Global Fund for Aids, Tuberculosis and Malaria generated a great sense of hope of accelerating malaria control in Tanzania when in August 2009 it gave the country $111million for insecticide treated nets.¹⁶ What is often glossed over in such reports however is the long term reversal rate arising from misapplication or low uptake of the bed nets. They also don’t tell us how the approaches prioritized by donors tend to foreclose any independent methods that may prove efficacious. For instance when in 2009, the

¹⁵ See Chapters 2 and 5 of Michel Foucault, The Archaeology of Knowledge.
Chinese Peacekeeping team deployed to Zwedru city in South-eastern Liberia started to suffer unbearable levels of malaria infection, they deployed outdoor electric mosquito killing apparatuses which were found to reduce the rate of infection to zero (Song et.al, 2009). Even if this was viewed in Liberia as a significant alternate approach, it is unlikely that it could have been translated into a control programme that is rolled out at the necessary scale without the donor community prioritizing it as such.

The problem thus seems to be that donors are only making the impact they choose to make. Solutions come as standardized packages which the problem on the ground is often analysed to need. If donors decide to build roads, the situation on the ground is explained as needing roads (Ferguson, 1990: 69-70.); if in malaria riddled countries like Nigeria, development experts want to supply bed nets, then insecticide treated nets, within the logic of development discourse, would easily become the best defence against malaria. But by addressing the problem in such piecemeal and presentist ways, the overall situation of underdevelopment and poverty or the population’s health condition or are not really altered.

The point ultimately made in this section is that international development does not occur simply because the problems it addresses occur in the countries where they do; there are relationships negotiated between groups within and outside each country that actualize the practice.

**Conclusion**

To sum up, it is pertinent at this stage to re-assert the way in which this framework of the three spaces of power helps us to better interpret all the empirical narratives in the dissertation. The framework indicates that development can have different meanings for different groups within and outside Nigeria. It is not a single-minded type of activity: it has its subsets and they each operate in distinct spaces of power working independently to organise and control the distinct parts of development’s total logic, but also working in unison to reinforce that logic in its totality. So if international development can be imagined as an engine, the three spaces of power are its individual parts, namely the multilateral space, the semiotic space and the development space.

Understanding this kind of distinction as the entailment of international development makes it possible to look beyond pronouncements of regional economic growth
performance or statistical reports of number of lives saved by malaria control programmes and attempt to decipher the socio-political dimensions of such reports. For example the Nigerian economy is said to have been growing steadily at an average of 7% over the last decade, showing a really strong performance of 6.8% in the third quarter of 2013.\textsuperscript{17} It is part of the semiotic operation of the global agencies involved in rendering development assistance that this kind of growth pattern is reported globally as great news and it tends to attract investor attention to the Nigerian economy. On the other hand however, a Gallup report shows only 9% of people in the country work full time, with a large number either underemployed or working as casual labourers.\textsuperscript{18} Understanding such discrepancies between rhetoric and reality socio-economic experience in Nigeria demonstrates how ordinary Nigerians and their welfare are not necessarily constitutive of development’s central focus. Discrepancies between rhetoric and reality in Nigeria’s malaria control, especially in the net distribution programme are also discussed further in chapter four.

What follows below is a review of the literature on Nigeria and how contemporary development in the country has been shaped. This serves as a useful background to understanding how the study of malaria control intersects the study of development in Nigeria.

\textsuperscript{17} Xan Rice, “Nigeria sees strong growth but oil account fears rise”, \textit{ft.com} –World, November 18, 2013, http://www.ft.com/cms/s/0/02aa21bc-5063-11e3-9f0d-00144feabdc0.html#axzz2pEJopbsS (Accessed 02/01/2014)

Chapter Two

Nigeria, Development and Malaria

Introduction

Public debates in Nigeria are often marked by strong divergences in how state policies and the impact they are making are seen by government and on the streets, as CNN’s Christiane Amanpour recently found out when the broadcast network spoke to some Nigerian’s on the streets of Lagos.¹ That instance, in which the Nigerians spoken to vehemently disagreed with the president’s earlier assessment that the government’s energy policy was having a positive impact on their standard of living, presented an example of how the imperative of development is given vastly different interpretations at different levels within Nigeria, and also of how Nigerians feel excluded from the public policy making processes.

Understanding this divergence prompts a questioning of the motivations for public policy and how policy makers are incentivized. Politicians are very skilled in advancing a rhetoric that suggests proceeds from the country’s oil resources are being efficiently utilized in a way that benefits the majority of Nigerians. They also often have one or two new, on-going or planned projects to point to as evidence. On the other hand, whenever Nigerians assess their welfare and relate it to the country’s resource endowment, they are often left with no choice but to question where all the money has gone.

Remarkably, when it comes to the public health situation, politicians are often very willing to highlight the problem in detail as the former Minister of state for health, Mohammad Ali Pate, recently did. According to him:

In 2012, I visited several rural communities in north-western Nigeria to assess the impact of our renewed efforts to improve the delivery of basic health services. One of our stops was a settlement of Fulani nomadic pastoralists, located far from

the nearest road in Katsina state. We drove several kilometres into the bush, following cattle tracks. The settlement comprised huts built out of corn stalks. There were several children running around barefoot, with goats roaming freely and a strong stench of animal dung. There was no water, no toilets, no electricity, no school, and no clinic nearby. In such an environment, every day is a struggle between life and death, particularly for children and women. There is a dearth of simple, cost-effective medical interventions that could save children from diarrheal diseases, malaria, or pneumonia. Women lack access to antenatal care and skilled attendance at delivery (Pate, 2013: 35).

Insights such as these may form part of the rhetorical way in which public health development needs are emphasised but they are not new to Nigerians. It is a narrative they are quite familiar with and it was famously (or perhaps infamously) reiterated about 30 years earlier when, to the litany of maladies the country was diagnosed as suffering from, the incoming military government added that ‘health services are in shambles as our hospitals are reduced to mere consulting clinics, without drugs, water and equipment.’

It is reasonable to expect presume Nigerians would much prefer that change is brought to this situation than to be reminded of it recurrently. A thorough discussion of the socio-economic experience of Nigerians can therefore not proceed without an antecedent elaboration of the nature of the state and how its apparent disconnection from popular aspiration impacts on many aspects of life, including public health and its continuous struggle with a myriad of communicable and infectious diseases. Any such discussion follows from the insight provided in the literature on the problems of the state in Nigeria; problems of corruption (Eker, 1981; Apter, 2005; Pierce, 2006; Smith, 2001). An important insight in Pierce’s work for example is that it addresses corruption’s multifaceted and multi-layered meanings in the Nigerian context (Pierce, 2006; forthcoming). This allows an application of corruption to a field such as malaria control without necessarily limiting its meaning to such practices as the embezzlement of money meant for control programmes or the wholesale theft of drugs meant for free distribution. The way such things as regional variations of the problem are understood

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and the way foreign partner presence is spread across different regions in Nigeria can just as well be given a local interpretation that fits under the rubric of corruption.

Economic crisis and structural adjustment also became the rubric under which the decline that characterized the 1980s in Nigeria has been analysed for many aspects of economic and social organisation, including health (Adepoju, 1993; Loewenson, 1993; Forrest, 1986; Olukoshi, 1998; Mkandawire and Olukoshi, 1995). Structural adjustment intersects the discussion of malaria control in Nigeria as a result of the economic crises of the 80s; dwindling oil prices meant the country was unable to service its debts. It thus had to scale back public expenditure and adopt austerity measures. In the austere dispensation, health, as many other sectors, was severely affected.

The problem of political competition and political integration in Nigeria has also been much written about, especially in terms of how these create tensions and impedes the ability of the Nigerian state to function effectively (Mackintosh, 1966; Joseph, 1987; Nnoli, 1978, 1995; Laitin, 1986; Young, 1994, 2002; Ukiwo, 2003; Hoffman and Nolte, 2013). The overall objective in this chapter is however to show how the general problems of statehood shape the nature of the development engagement. Further on in the dissertation (especially in chapters two and three) it shall be shown how this engagement is taking on new forms and how this is borne out in malaria control. To this end, this chapter will review the relevant literature on the state as well as on development and disease control in Africa with particular reference to Nigeria. This is in order to situate the country’s malaria control efforts within an analytical frame that can usefully serve the rest of the dissertation.

The chapter is more expressive of the paradoxes dealt with within the dissertation as a whole: it is about malaria but it’s not medical; it is not a biomedical inquiry into how to tackle the malaria problem. It therefore does not claim to produce any entomological or parasitological proposals for ridding Nigeria of malaria. For instance during the writing of the dissertation scientists announced the possibility of genetically modifying the mosquito vector so that it kills the malaria parasite rather than hosting it for onward transmission to humans (Isaacs et al., 2012). This is a positive development but was not considered essential to the dissertation. The dissertation is about development but not as a linear process. It focuses on development as an idea which constitutes the instrumental platform upon which the engagement of developed Western countries with
developing countries of the South is based. It is also directed at malaria not just as policy analysis or as a report of success and failure; it focuses instead on the control of malaria as an arena of international operation within which particular facets of the development engagement are compartmentalized or confined. What this means is that the development operation is disaggregated to fit a multitude of practices in tailor-made ways. This way, dominant Western countries are able to permeate practically every aspect of life in developing countries through carefully constructed development programmes that fit each aspect. This kind of exercise is possible because of the acquiescence of the state in developing countries like Nigeria, an acquiescence which is in itself a product of a myriad of historical and contemporary factors.

What the chapter does therefore is to set up the general problematics that inform the task that the dissertation as a whole has set for itself. These problematics are produced from the historical crisis of statehood in Nigeria and the intervention of external actors in a bid to ameliorate the effects of crisis. This intervention takes the form of international development and is ostensibly directed at lending assistance in many areas where the state is weak or has demonstrated very little capacity in carrying out its responsibilities to its citizens. Intervening in this way emphasizes a sense in which richer nations feel responsible for poor countries and it is also often justified as necessary for preventing human catastrophes. But this kind of contact in which global centres of power and national authorities become commonly engaged and sometimes unified in practice within particular geographies quite often, in and of itself, produces distinct formations that shape the very crisis it has been created to deal with. The great question with regard to international development therefore is one of how the solution gets absorbed into the problem and becomes situated within it. This is a continually explored theme throughout the dissertation and this chapter reviews the way that this crisis of statehood and the nature of external relationships it produces are understood in existing literature. This serves as a contextual background for understanding malaria control as a case study of development practice.

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3 The crisis of statehood is amply borne out in the various problems encountered by postcolonial Nigeria such as civil war, religious conflicts, poverty, weaknesses in governance structures, economic crises and disease.
Crude Realities: State, Oil and Politics in Nigeria

An exploration of the history of politics in Nigeria is relevant at this point within the context of current global concerns and focus on the malaria problem in every malaria endemic country. Although many of the countries which are most active in the global fight against malaria have long eradicated the problem, they have in the last decade intensified their commitment to dealing with it in those Third World countries in which malaria remains a public health nightmare. This evokes a need to explore the role that the Nigerian state plays in complementing or facilitating these efforts and how its history as a state might define that role.

Fig. 1 – Political Map of Nigeria (36 states)

Source: Nigeria High Commission, UK

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4 The World Malaria Report 2012 declares that ‘international disbursements for malaria control rose steeply from less than US$ 100 million in 2000 to US$ 1.71 billion in 2010 and were estimated to be US$ 1.66 billion in 2011 and US$ 1.84 billion in 2012.’

5 http://www.nigeriahc.org.uk/about-nigeria (accessed 12/06/2013)
The history that this kind of exploration reveals is somewhat chequered and its effect is instructive, to the extent that it continues to impact on Nigeria’s approach to development. For instance, the map above shows the country’s current 36 state structure and the Federal Capital Territory (FCT, Abuja) looking innocuously central. But the political map of Nigeria has not always looked like this and the capital has not always been Abuja. The state structure currently stands at 36 after several iterations of state creation and Abuja came about (officially in December 1991) as an attempt to forge a sense of unity by centralizing the capital. Curiously though, Abuja is only geographically central; politically it falls more within the domain of one of the three major ethnic groups in the country – the Hausa north. The very movement of the capital from Lagos and the many state creation exercises are therefore strong indicators of the myriad of political problems the Nigerian state has been beset with since before and after independence. The territories that are now the modern country of Nigeria actually have tremendous geographical and cultural diversity and very little historically linking all areas together until the beginning of the colonial period which was around the late 19th century.

Geographically, each region in modern-day Nigeria has a predominant ethnic grouping which is culturally and linguistically distinct from the rest of the country. Their histories, socio-political and religious experiences are also differentiated along similar lines. Even the colonial experience was somewhat different. When the two Protectorates of Northern and Southern Nigeria were amalgamated in 1914, it was a strategic move that allowed the funding of the colonial project in the North with resources that accrued from Southern Nigeria (Falola, 1999). The British colonial administration’s system of Indirect Rule also seemed to have been more keenly implemented in the north due probably to its conservatism, and the hierarchical social and religious organisation it already had in place. This prompted Obafemi Awolowo, one of the leading figures in Nigeria’s struggle for independence to write that northern emirs were excessively empowered under colonial rule (Tibenderana, 1988: 68) although the reality points more to a convenient invention of political tradition in a way that suited British and Northern Nigerian elite interests (Ranger, 1983; Pels, 1997; Pierce, 2003).

The differentiated experiences that the north and the south had under colonialism meant that by independence the level of integration between them was insufficient to collectively focus them on a common ideology of development, defined even in its
more liberal terms of modernizing the economy and alleviating poverty.⁶ There has thus always been an apparent north/south dynamic in the way the country has approached development since independence. A pointer to that dynamic appeared in 1953 when Anthony Enahoro moved a motion in the House of Representatives for Nigeria to be self-governing by 1956. The major party in the north, the Northern People’s Congress (NPC) was not willing to go along, fearing hegemony by the south which was politically and educationally more experienced. Ahmadu Bello, the Sardauna of Sokoto and leader of the NPC moved a counter motion defeating Enahoro’s earlier motion by substituting ‘1956’ with the words ‘as soon as practicable’ (Bello, 1962: 118; Orobator, 1987: 302). This north/south dynamic has made it difficult for both parts of the country to forge a consensus on indigenous development. Development has thus remained quite a fluid concept, devoid of a national classification; it takes its more pragmatic meaning from the work of international organisations within the country rendering assistance on a range of matters of statehood including disease control.

The most visible indigenous approach to development has been to repeatedly split the country into smaller administrative units in various state creation exercises that purport to bring government closer to the people and foster grassroots development.⁷ But many of the states created have only really been good at looking like they can play the role of getting government closer to the grassroots while in fact the reality has been that each exercise merely succeeds in enabling new elite groups who are more or less awarded control of a new state. What is therefore discernible is a kind of paradox in which networks of individuals are incentivized to fall back to their bases both as custodians and as guarantors of the long term relevance of each ethnic group, intensifying the unending agitation for the creation of new states and local government areas, while at the same time there is a scramble for the control of power at the centre of national politics. Acquiring control at the national level offers access to a much larger domain of resources and a distributive clout that guarantees enormous personal wealth. What ethnic politics in Nigeria shows is the curious way in which decision makers are incentivized: it is one that defines politicking as tantamount to advancing the personal interests of the individuals that make up the political class. Political energies have been largely exerted on either angling for dominance or forestalling the hegemony of other

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⁶ I return to modernization and development in the next section.
⁷ Nigeria started out at independence as three regions namely Northern, Eastern and Western Regions. The Mid-Western Region was created in 1963 and between then and 1996 there were five state creation exercises in 1967; 76; 87; 91 and 96 to take the state structure to 12, 19, 21, 30 and 36 respectively.
ethnic factions, rather than on bringing development to a broad based majority. With ethnicity defining the order of politics, corruption creating mistrust at several levels and the myriad institutional weaknesses of the state, it is much more easier collaborating with external agencies for development than it is to build a strong internal developmental base, especially as such external agencies constitute a significant source of funding.

In the very difficult consensus building atmosphere the military in Nigeria has often intervened in politics in the guise of playing a stabilizing and modernizing role. Although repressive by nature and lacking popular legitimacy, military governments have tended to justify their foray into power by claiming to stabilize the country against the debilitating effect of ethnic rivalry and also claiming to be better able to arrest the national economic decline. This kind of posturing resonates strongly with modernization thinking. As Huntington (1968; 1991: 50) observed, military intervention in unstable societies is often brought about by the military’s assumption of a modernizing role. It intervenes to prevent the disintegration of society and would in most cases promise economic growth and development. This usually becomes the basis of legitimacy as with the example of Nigeria where people embraced the military government as a better alternative to a kleptocratic civilian government. But in Nigeria the military is a constituency in itself and is not immune to the problems of ethnicity or class. It has its own vested interests and its own survival strategies. As one faction of the elite class it is in competition with other factions. Also, because the military controls the coercive apparatus of state, the ethnic configuration of power within the military is often translated into an equivalent configuration of power among Nigeria’s political elite. Ethnic rivalry has been such a dominant feature of Nigerian politics that acquiring political power at the centre (for military as well as civilian administrations) has always had more potential as a means of furthering the interests of politicians and businessmen from one ethnic group over and above others. Economic growth and development are often promised but there is no agenda for rising above ethnic interests to re-articulate

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8 Nigeria became independent in 1960 and there was a military takeover of power in 1966, which lasted thirteen years. The Civilian government of Shehu Shagari only lasted from 1979 -1983, when, barely three months in, what should have been his second four year term was truncated on New Year’s Eve by the military. Democratic government was not restored until 1999.
existing patterns of external dependency and for fashioning out indigenous ways of developing.  

The military was thus grossly unable to arrest the problems caused by ethnicity in Nigeria or to amend the north-south dynamic referred to above. It was also not effective against a different kind of dynamic, the global-national dynamic which sees national elite classes operating in a subordinate position to global centres of power. It is patently linked to structures of dependency created by colonialism but it is also partly traceable to the malformation of the state itself, which has left it devoid of the ideological unity required to develop an internal consciousness of development. This requisite ideological unity is a separate one from the Socialist or Capitalist kind; it is one that commonly recognises the well-being of the population as intricately linked to the well-being and effective functioning of the state. The disjuncture that arises out of malformation means that the emblems of democratic practise such as voting and a free press do not operate in forms that empower the Nigerian population because politicians are able to bypass those machineries in the pursuit of their narrow interests. It also means that the avenues for citizens to audit and qualify state behaviour are compromised. This generates several associated problems, one of which is the issue of corruption and it has bedevilled all efforts at improving the lot of the Nigerian population. To fully understand the aforementioned global/national dynamic therefore, it is important to also understand how corruption limits the ability of the state to actually deal internally with major problems like disease control. The difficulty that corruption creates manifests in every sphere of life in Nigeria. If any process, public or private, is known to not function efficiently, more often than not, it is traceable to this problem.

With regard to corruption in Africa however, Bayart (1993) has warned against the danger of borrowed paradigms that look at the African situation through the prism of conventional Western conceptualizations. Such views produce a notion of Africa as essentially ill-fated at independence due to the shortcomings of the colonial state. The contemporary manifestation of corruption in this view is thus part of the inevitable outcomes of the malformed postcolonial state. The view that Bayart favours is one that takes cognizance of Africa’s long term history and understands that much of what characterizes African politics today has very little to do with the inflective influence of

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9 The phrase ‘re-articulation of patterns of dependency’ is borrowed from J. Samuel Valenzuela and Arturo Valenzuela (1993: 206).
the colonial state. African politics is based on a unique blend of patron-client relationships which feed into a ‘rush for spoils in which all actors – rich and poor – participate in the world of networks’ (Bayart, 1993: 235).

It becomes even clearer in a later anthology (Bayart et.al. 1999), how Bayart conceives of Africa’s venality. He argues that criminality and kleptocracy in Africa can be explained within the context of ancient practices which are discernible from the continent’s cultural history, myths and folk tales. Africa’s past reveals subtle characterizations that are not far removed from current criminal and corrupt behaviour. Bayart’s argument is that this suggests corruption in Africa is intrinsic to its culture and history. He buttresses this claim by stating that ‘political and economic actors in Africa often demonstrate some of the characteristics of the Trickster of folk tales. This description is said to fit ‘those agents of the process of criminalization who, for example, are active in the drug trade or in financial fraud, whose social profile is at least as ambiguous as that of the Trickster’ (Bayart et.al. 1999: 37).

Some of the responses to Bayart have been, perhaps unfairly, vitriolic. They suggest that he fetishizes and reifies a particularly African mode of politics and the way he invokes history is somewhat perverse. Those who are critical of his view, such as Wiseman (1999) as well as Osaghae (1999) have pointed to its undue parochialism and seriously question the methods used to reach the bold conclusions arrived at in the book. Osaghae pointed out that Bayart failed to establish how criminality is rooted in the history and identity of the African. He found it fortunate that two other chapters in the book contributed by Stephen Ellis and Beatrice Hibou contradict Bayart and make the case that ‘economic decline, forces of liberalization and globalization are at the roots of increasing criminalization of the African state’ (Osaghae, 1999: 465). Much less vitriolic, Olivier de Sardan’s (1999) contribution to this debate is that nothing can be more absurd than attempting to ‘impute corruption in Africa to some kind of African culture’ (p.44). He states further that “‘culturalism’, to the extent that it occasions an excessive homogenization of the way in which practices are perceived, to the extent that it transforms the abstract construction of the researcher into a Subject, to the extent that it deduces from social actions a kind of cultural “tablet of the law”, is indefensible’ (p.44).
The debate generated by Bayart’s position will no doubt continue to receive theoretical attention but worth mentioning here is a fairly recent historicist paradigm that sheds more light on the debate. Following Pierce, one becomes more aware of the faults in the view that corruption was engendered by some sort of Western model that was imposed by colonialism. Reminding us that evidence bears out that British authorities had cause to complain about indigenous governmental corruption as early as 1906, he declares that the idea of a colonialism-inflected malformation of the state in Africa ‘is a rather presentist and model-driven account. The story available through ethnography can be matched with another version entirely’ (Pierce, 2006: 900). The problem that this points out is that the understanding of corruption in Africa is not improved by taking the contemporary problem of the state as some sort of structure that exists only in the present. This is an ahistorical way of looking at it; if one instead historicizes the structure of the Nigerian state a very different account of corruption emerges. Reconciling both accounts is thus the fundamental challenge that Pierce poses in this paradigm as a more useful optic for studying corruption in Nigeria.

The logic contained in this paradigm is a strong one and in response to it, what the rest of the chapter will do is to connect Nigeria’s colonial history to the intensification of corruption rather than to its birth. This also means that it moves further away from Olivier de Sardan’s position that ‘this moral economy is “post-colonial”… fundamentally syncretic [and] in no way reflects on “traditional” or pre-colonial culture’ (Olivier de Sardan, 1999: 26). In fairness though to Olivier de Sardan, it can be said that what at least permits this connection of colonialism to an intensification of corruption is the patent reformation of the relationships of power that the intervention of the colonial state engendered. Also, the modelling of African economies into capitalist dependencies established bureaucratic systems that continue to challenge moral instincts in ways that are manifestly different from pre-colonial forms of political and socio-economic organisation. In particular, the mind-boggling variant of corruption in Nigeria needs to be understood separately from a general understanding of criminality.\(^{10}\) It is all the more troubling because it appears to be deeply embedded in the regular functioning of the state and obstructs the efficient execution of the entire range of programmes

\(^{10}\) Transparency International’s Corruption Perceptions Index (PCI) for 2012 ranks Nigeria as the 35\(^{th}\) most corrupt country out of a total of 176 countries surveyed - http://cpi.transparency.org/cpi2012/results/ (accessed on 14/06/2013)
associated with it, including public health management. Hence it also obstructs the development of effective institutions of state.

The problem of corruption has not been rendered any easier by the transformative impact of oil on the financial logic of the Nigerian state. This is hardly surprising, if the findings in Ross (2001) are anything to go by. In his study of the linkages between natural resource wealth and democratisation, he noted that there was growing evidence ‘that resource wealth itself may harm a country's prospects for development’ (p.328). This is connected to the observably slower rate of economic growth in natural resource rich countries between 1970 and 1990 (Sachs and Warner, 1995) compared to resource poor countries, and also to the higher propensity for civil wars (Collier and Hoeffler, 1998) in the former.

A relevant paradigm which has been advanced for understanding this kind of weakness is Hazem Beblawi’s rentier state. The impact that oil has had in Nigeria has not just been to reveal the fragility of nationhood but to transform the country’s political economy from its early post-colonial emphasis on indigenous production as a means of creating surpluses, into a kind of rentier state in which the major source of revenue accrues from rent paid directly to the state by foreign actors engaged in the domestic economy.\(^{11}\) Between the former and latter situations, the development of the population is more likely to be taken seriously in the former, as the state relied heavily on what the population produced for its own revenue. Under the rentier state, only a micro-segment of the population is required to keep the revenue stream going and the linkages between the interests of the population and the interests of the state are weakened.

The discovery of oil dampened the competition that existed among the regions to develop. Regional leaders in the first republic saw regional populations as forming part of their fabric of power. Development had meaning within the context of keeping this fabric strong and formidable in relative terms. With the emergence of oil as the main revenue earner for Nigeria in the 1970s, the stakes were exponentially increased.\(^{12}\) No

\(^{11}\) For a discussion of the character of rentier states, see Hazem Beblawi (1987)

\(^{12}\) Oil had been discovered in Nigeria as early as 1956 and production started in 1958, but the outbreak of civil war in 1967 limited its economic impact. By the 1970s the Arab-Israeli conflict of 1973 spiked global oil prices and this, in combination with the end of hostilities in Nigeria, ushered in a period of economic boom for the country. The literature on crude oil in Nigeria is fairly vast but Sarah Khan, 1994 is particularly useful for understanding its political economy. See also J.G Frynas, 2000; Odofin, 1979; Nigerian National Petroleum Corporation,
longer did each region have an export revenue profile that could be reckoned with: oil was extracted only from one area of the country and promised huge surpluses. The policy of regional control of resources could no longer be sustained. Indeed in Nigeria many of the contemporary problems of the state have revolved around questions of how to equitably manage the distribution of its common wealth, the most significant being the allocation of federally collected revenue. This was less of an issue in the immediate post-colonial era, when the country depended largely on agricultural commodities for export earnings and each region had a major commodity that earned revenue in its own right. Commodity Marketing Boards were set up by the colonial administration around 1939, to stabilize commodity prices by buying up produce at fixed prices and selling them at international commodity markets at prices that were expected to fluctuate.\textsuperscript{13}

The surpluses accrued by these Marketing Boards became a bargaining chip in the negotiations that preceded the granting of independence. The north feared domination by the educationally and politically more advanced south if the political system was a more fragmented unitary system with a strong central government. They wanted a federal system that guaranteed more autonomy for the regions, which the south was less keen about (Nixon, 1970, pp. 157-158). At the London Constitutional Conference of 1953, agreement was reached that control of the Marketing Boards and their surpluses would pass to the regional governments in a federal system. This marked the beginning of the political clout which the regions were to wield up until the first military coup in 1966. It also accentuated the north/south developmental dynamic arising out of the fact that revenue from Cocoa exports in the West was far in excess of what the other regions were earning (especially the north). According to Helleiner (1970), while the Western region was able to continue to make surpluses that allowed it to lend money to other regions and the Federal government (pp. 132-133), the Northern region actually ran a deficit in the period between 1954 and 1961, paying more to farmers than it earned from their produce (p.125). The Marketing Boards south of the country were also quicker off the block in terms of development investment. The Western region committed a lot more of its surpluses to development programmes and the support of private enterprise while the north preferred to stick to the policy of price stabilization, returning more of its resources to farmers (Nixon, 1970, p.158-159). In more contemporary terms, a carry-

\textsuperscript{13} Nixon (1970) has however argued that the purpose was more to guarantee a steady supply of agricultural raw materials to Britain during the war.
over of the north/south dynamic is visible in the way federalism has produced classes of
states in Nigeria, with hugely different capacities to provide services such as healthcare
and very wide gaps in the health of their populations. For instance the role of the private
sector in the provision of health is significantly higher in southern states such as Lagos
while government remains the predominant provider in the North (World Bank, 2010).

A reassessment of how rent from mineral production was going to be shared between
the regions and the federal government formed part of how Nigeria’s post-colonial
future was negotiated amongst the constituent parts of the country, but increasingly
from the 1970s, the derivation-based formula in which the regions kept a huge chunk of
revenue derived from their domains, was de-emphasized through several iterations of
revenue allocation review, and the revenue from oil is today distributed in a way that
allocates the majority share to the federal government, and the component states receive
grants from the federal purse.\(^1\)

The reformulation of revenue allocation in this way achieved at least two things: first it
made central government more powerful, as opposed to the situation in the first republic
whereby the financial might of the regions made them practically more powerful than
the federal government; secondly it created an intensely competitive struggle among the
country’s politicians for power at the centre, driven more urgently by the desire to
control the huge resources derived from oil. But there was another obvious implication
in the sense that in many states where commercial activity is very low and where the
state government has very limited opportunities for alternative sources of revenue, their
share of the federally allocated revenue is hardly adequate for maintaining even the
semblance of a decent public service infrastructure.

Perhaps due to the pervasive consciousness of the vast revenue profile at the centre, the
states are not sufficiently motivated to develop their revenue earning potential. Instead,
political competition is characterized, in part, by an unrelenting determination by the
states to obtain as much as they possibly can from the federal government purse. And
given the situation with corruption in the country a substantial portion of such monies
are diverted into private accounts rather than spent on development. As Apter
expressed, ‘if, as we have seen, oil represented the lifeblood of the nation, the petro-
state paradoxically expanded by consuming this life blood of the people - sucking back

\(^{14}\) O.C. Uche and C.U. Uche, 2004 is particularly useful for understanding the way revenue allocation in
Nigeria has evolved and its linkages to oil. See also Ekpo, 1994 and Phillips, 1971
the money that it pumped into circulation…The oil may have energized domestic markets through the intensified circulation of money and commodities, but it enervated and undermined the real productive base of Nigeria’ (Apter, 2005: 269). Rather than boost the prospect of development therefore, oil has been referred to as a resource curse having the opposite effect (Sachs and Warner, 1995) and exposing a ‘paradox of plenty’ (Karl, 1997). It is also at the root of many of the contemporary crises in the country.\footnote{Feelings of unfair allocation of federal resources linger within the Nigerian federal system to this day and are at the root of the Niger Delta crisis. The crisis has intensified so ferociously in recent times that it has had a very disruptive impact on oil exploration and production in the area. The Niger Delta contributes the oil which earns the country the majority of its revenue but the people of the area are unhappy that it remains grossly neglected and under resourced. Health facilities and other social services in many of the states in the area are either non-existent or dilapidated; a condition which is made worse by the incessant gas flaring from oil installations and the environmental degradation of the region which puts the health of the local people in jeopardy.}

By the early eighties, the global price of oil crashed and this brought about new economic realities for Nigeria. The country became unable to service its debts; it thus had to scale back public expenditure and introduce austerity measures. The severe hardships that followed soon provided an excuse for the military to force their way back into power. Austerity measures continued under the new military administration of General Buhari and stretched even further into public sector layoffs (Ekwe-Ekwe, 1985: 610) and intensive controls on imports to adjust severe trade deficits. These measures were however not enough to steady the economy; the military government resumed talks with the IMF but was unable to secure any facility because it staunchly refused to devalue the currency. The entire duration of the Buhari government was thus characterized by austerity measures without resort to the IMF’s prescription of structural adjustment policy. This position only changed after the country’s next leader, General Babangida, assumed power in 1985, succumbing to structural adjustment by 1986.

Before General Babangida adopted the programme in 1986 the previous military administration had been engaged in a long drawn negotiation with the IMF over the conditionalities attached to its loan facility. The Buhari administration wanted the loan but was wary of SAP. Ironically, the Babangida administration that succeeded Buhari turned down the loan but accepted SAP. This shows that structural adjustment came about because the administration and its external advisers had objective interests in bringing it about. Access to external credit was key to how the military government was going to sustain its promise of delivering economic growth and development and the
clear message that aid flows would be cut off from recalcitrant governments necessitated a demonstration of seriousness. The administration was thus not in a position to decline what was being pushed by development ‘experts’ as the best way to pursue growth at the time. What was even more important than the loan is the rescheduling of the country’s debts which was achieved three times over under Babangida’s administration in 1986, 1989 and 1991 (Sachs, 2003: 220). If the debts had not been rescheduled, the proportion of the country’s earnings going towards servicing them would have meant that very little of the earnings was available for financing government expenditure.

But rather than stabilize Third World economies as structural adjustment programmes claim, the experience in many countries was that the institutional framework for operationalizing the macro-economic adjustments stipulated by the IMF was weak. Severe upheavals were created in the economy, especially by the removal of subsidies and reduction of public expenditure. Williamson (1990: 11) highlighted education and health as often specially targeted in such exercises and both sectors witnessed sizable declines in Nigeria after structural adjustment. Structural adjustment is also particularly problematic in African economies because the unfortunate gap that is exposed as governments withdraw from the economy is hardly ever filled by investment from domestic private capital. Mkandawire and Soludo (1999) have argued that this is partly due to a traditional hostility on the part of African governments to domestic capital, even as they welcome foreign investment. The attitude of many African governments is one of hostility to expanding domestic capital. They view this as increasing the political relevance of an entrepreneurial class and, by implication, increasing the internal threats to the political class. The hostility meted out to domestic capital therefore generates a situation whereby huge amounts of investable funds held by citizens of many African countries are held redundantly in foreign banks.

This kind of tension between classes reveals one of the fundamental weaknesses of the Nigerian state; extreme rivalry among the dominant classes keeps them focused more on their group interests than the interests of the generality of the population. This is what has become most discernible as the character of the postcolonial state, a predicament traceable to colonialism. The nature of power in pre-colonial Africa is essentially different from its postcolonial form. The processes of reformulating power in Africa and

16 Cited in Rowden (2009, pp.59-60).
re-characterizing it can thus be said to have taken place during the transitional epoch represented by colonialism. Waite (1992), Vaughan (1991) and Feierman (1985) have shown how medical knowledge played a key role in shaping the distribution of power in pre-colonial Africa, and how the emergence of the colonial state meant that the diagnosis and management of illness and disease, as a source of power had to be wrested from the pre-colonial elite as part of the process of establishing the dominance of the former. Although Butler (1997) has argued that the colonial state did indeed attempt to prepare the colonies (in West Africa) for eventual economic and political advancement, the colonial state is still somehow implicated in compromising the post-colonial state as indeed the former produced the latter. This is especially so when we consider that important social transformations that took place in Europe as described by Foucault were not replicated in Africa.17 These transformations produced a phase in Europe when ‘repressive’ power gave way to ‘productive’ power and power became objectified in man, with a view to making its deployment more efficient. This kind of transformed view of power ran contrary to the interest of the colonial state. The colonial state by its nature was necessarily a repressive one. A major problem in the arena of health in Africa is therefore that the intervention of colonialism in the evolution of the state produced a new power structure and replaced the erstwhile dominant groups with a colonial state whose interests were invariably parochial, self-serving and was not consistent with the interests of its subjects. New practises defined by the new structures of power have therefore been very difficult to maintain since then.

What is also discernible in the relationship between the colonial state and the African population is that colonialism produced what may be termed the flip side of bio-power in Africa. Foucault’s notion of bio-power is important for understanding the diametrically opposed routes practices such as health management took in Africa and the West. Foucault argued that the health of populations in Europe became a compelling responsibility for the state from about the seventeenth century, when power started to lose some of its intrinsic value, and acquired a new utility in terms of how efficiently it could be deployed for the benefit of the state. ‘In order to ensure that their populations were productive, states had to work out ways of keeping people healthy, strong active, hard-working and safe’ (Danaher et.al, 2000: 64-65). The development of an administrative apparatus and of the medical and social sciences, with man as the object

17 See Megan Vaughan’s application of Michel Foucault to Africa in ‘Curing Their Ills’ (1991: 8-12)
of study, embodying as well as producing new *knowledges* to underscore the shift in the nature of power, became part of the process Foucault called *bio-power*.

As in Europe, colonial subjects were viewed as resources available to the state to deploy, but rather than view them as broadly useful in every sphere of daily life and aiming to keep them healthy in general, they were viewed as useful only to the extent that they fulfilled the agenda of the colonial state (Itayvyar, 1992). The process of ensuring the health of colonial subjects thereby became a selective one. This kind of selectivity distorts pre-existing social formations (Comaroff, 1985), public health knowledge and practice (Livingston, 2005: 16-19), modes of illness classification and perceptions of the extent of its implications. It also potentially leaves a legacy of managing the health of citizens as a power reinforcing activity rather than, as Foucault suggests, a safeguard of the state’s resource base.

In the end therefore, the persistence of the problem of disease and public health in Nigeria, though seemingly technical in nature, is strongly linked to how the state is historically constituted. Acemoglu and Robinson, for example, have argued that ‘institutional differences, meaning differences in the social, economic and political organisation of societies, are the major reason for such large and persistent differences in economic performance’ (Acemoglu and Robinson, 2003: 398). They favoured evidence that shows the historical linkages between disease environments in Africa and the inhibitions of institutional development. Evidence from history vindicates the logic that large numbers of emigrants from Europe settled in European colonies like Australia and New Zealand where the incidence of disease was so low as not to pose any immediate threat to life. Settling in such places produced a need to develop institutions of private property and to encourage economic and social development. Conversely, yellow fever and malaria in many areas in Africa ruled European settlement out of the question as these diseases produced unbearably high mortality rates for Europeans. In such places therefore, ‘they were more likely to opt for extractive institutions, designed to extract resources without investing in institutional development’ (Acemoglu and Robinson, 2003: 403). Socio-political developments that aggregate such developmental elements as property rights and civil liberties were considered less important and this is what has shaped the severe lack of viable modern institutions in Africa today. Rather than health therefore, Acemoglu and Robinson argue that institutional development is far more likely to engender a turnaround in Africa’s fortunes.
Scott has also analysed how modern states acquire the capacity, or otherwise, to be effective and efficient through historical emphases on simplicity and legibility. According to him, the pre-modern state was ill-equipped at dealing with the problems it was confronted by, because ‘it knew precious little about its subjects…as a result, its interventions were often crude and self-defeating’ (Scott, 1998: 2). This statement demonstrates the sense in which we can conceive of the state’s transition to modernity as the culmination of a process of ‘rationalizing and standardizing what was a social hieroglyph into a legible and administratively more convenient format’ (Scott, 1998: 3). Scott identified that this is what much of European statecraft was devoted to, and this permitted better tuned systems which tremendously boosted the capacity of European states to intervene efficiently in such areas as public health, political surveillance and relief for the poor. He however condemned the over simplification of modern life and planning from the centre, to the detriment of local knowledge, as huge developmental fiascos, of which the great leap forward in China, collectivization in Russia, and compulsory villagization in Tanzania, Mozambique, and Ethiopia were particularly problematic variants. In the case of northern Nigeria, Pierce has also identified the colonial failings in its modernist project of classification and categorization which he argued covered up but did not ‘destroy the chaotic particularities of local government practices… The history of state formation in northern Nigeria, then, is not one of a government’s coming to “see like a state” but rather of a transformation that enabled it to look like one’ (Pierce, 2006: 909)

The interest expressed in Scott is derived from his analysis of how the relationship between the state and its citizens and indeed the state’s perception of its own survival needs influenced the accentuation of surveillance. This capacity has become diffused and quite established in the modern European state. Health data collection techniques have also helped to improve health planning activities and outcomes. In the absence of such established systems of surveillance, African countries struggle to control their populations and to attend adequately to their welfare. More so, if the diffusion of historical surveillance practises as described by Scott as well as Bates (2001) has produced public health surveillance as a cornerstone of health management practise in the West, the question, in the case of Africa, becomes why a similar process did not take place in Africa and if it did, why a much weaker public health system was the outcome.
Overall, the usefulness of the foregoing historical analysis of the postcolonial state and how it was borne out of its colonial antecedent is that it shows how international development became located in the gaps in state responsibility created by the weaknesses envisaged during the decolonization process and subsequently demonstrated by the postcolonial state. Such an analysis generates questions such as why the capacity of the Nigerian state to manage public health in a way that effectively brings various diseases under control has not developed much in the post-colonial era, during which African states ostensibly control their own destinies. Could the colonial regimes of public health, based on its entrenched long term interests be so embedded in the African psyche that it is fundamentally unchangeable, or are the twinned problems of poverty and the kleptocracy of the African political leadership the factors that repress this capacity? Clearly, financial budgets are essential for dealing with problems of the magnitude of malaria in Nigeria, and the global involvement in malaria control has, especially since the late 1990s, achieved some progress in the management of the crisis of malaria as a disease but when looked at as an activity that purports to support or ease the development of affected countries, malaria control as we know it raises several questions. The nature and implication of malaria control today is the subject of an extensive discussion in chapter four; what follows below is a review of the disciplinary treatments accorded to the subject.

**Disease and Development: Malaria’s Place in the Rise of Medical Initiatives**

Research work on the malaria problem is, not surprisingly, dominated by biomedical scientists who, as progenitors of the mosquito theory, can lay claim to the best understanding of the technical ramifications of the disease. From Ronald Ross’ discovery of the mosquito parasite in the anopheles mosquito in 1897, there followed a series of works within biomedical science especially by those practitioners engaged in the young field of tropical medicine. They were largely focused on increasing the knowledge of the mosquito and how it spreads the malaria disease and they contributed overwhelmingly to the colonial efforts to control the impact malaria on the colonial mission. When, for instance, Stephens and Christophers published their *Practical Study of Malaria and Other Blood Parasites*, they declared their intent as proposing ‘to give the essentially practical methods, by which those not familiar with laboratory methods

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18 Ronald Ross’ discovery in 1897 replaced the prevailing miasma theory of causation with the mosquito theory. Before this time, the popular view was that malaria was caused by ‘bad air’, especially blowing across stagnant water
may, under their own microscopes, follow all the most recent work on Malaria, and eventually be in a position themselves to add new facts to our knowledge of this important disease’ (Stephens and Christophers, 1904: Preface to first edition).

After his discovery, Ross continued to serve as a source of inspiration for colonial administrators in their battle against the malaria disease and its challenge to the colonial project. Mathe-Shires (2001) has pointed out how his friendship with Macgregor, the then governor of Lagos, when Ross visited Nigeria as the head of the Liverpool School of Tropical Medicine Expedition to Lagos in 1900, contributed to the shaping of the governor’s more comprehensive malaria control policy with its strong emphasis on sanitation in and around Lagos (p.49).

Andrew Balfour (1923) also argued the disease could be greatly controlled if the hygiene and sanitation attitudes of the colonial natives could be enhanced and thus placed emphasis on personal hygiene, as did Sir Malcolm Watson (1937). Watson (1935) further detailed how Ross’ discovery influenced his own work in the decades since it was published. He showed how a proper understanding of the behaviour of the mosquito could influence the way public engineering works were planned and carried out. Despite their effectiveness, Ross’s proposed methods were also economically challenging for colonial governments given their priorities of supporting plantation agriculture and minimizing expenditure on public health.

The role of biomedical science in dealing with malaria became intensified by the Second World War antimalarial programs, especially in the United States where they were intensely focused on finding new sources of drug treatment for non-immune soldiers continuously moving through infectious zones. Following Pearl Harbour, Java fell into Japanese hands by March 1942 and the United States consequently lost access to most of the world’s supply of quinine (Slater, 2009). This development made the search for an alternative treatment to quinine intensely vital to the war effort. Fortuitously, a drug compound which had been discovered earlier in Germany in 1934 (initially called Resochin and Sontochin but later known as Chloroquine) entered the

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19 For more on quinine in second World War and how Java became its dominant supplier, see Dennis B. Worthen (1996).
US drug programme and after a series of tests it was eventually licensed for use in 1946.\(^\text{20}\)

Chloroquine lasted a long time as the leading antimalarial but by the 1970s the malaria parasite had become quite resistant to it. Biomedical scientists have remained in the forefront of the research into new medicines such as Mefloquine and artemisinin and also of new ways of managing the disease. Current malaria research such as in epidemiology (Moss et.al, 2012); chemotherapy and drug resistance (Hyde, 2005; Shah et.al, 2011; Hastings, 2011); microscopy and diagnostics (Riglar et.al., 2011) permeate many aspects of the disease; the wide range of research work into the disease has been and continues to be carried out essentially as a response to a Third World problem and this is the angle from which it becomes of interest to this dissertation, especially as it is also the case that this is the point at which development institutions become intertwined with the problem of malaria.

A global eradication programme embarked upon by the WHO in the mid-fifties to late-sixties successfully eradicated the disease in Europe and America but the failure to carry through the eradication programme globally turned malaria into a veritable Third World problem. This evoked a multi-disciplinary interest in the disease, and it became clear by the early nineties that drug therapy was not a sufficient response to the problem. Chloroquine resistance had become quite widespread and a reversal of all the advances against the disease loomed.

Anthropologists seeking to provide frameworks for understanding the disease beyond its technical confines explored socio-cultural explanations. Bledsoe and Goubaud (1985) highlighted how cultural beliefs associated with such elements as the colour of a pill influenced the choice of medicines and the interpretation of their efficacy, with significant impact on the spread of disease. McCombie (1996) also emphasised the importance of knowledge of clinical symptoms of malaria and treatment seeking behaviour, especially as many endemic areas lacked laboratory facilities and the management strategy was based on presumptive treatment of fevers.

\(^{20}\) In the numerous efforts to establish the relative advantage Chloroquine (still known at this time as Sontochin) offered over Atabrine (a previous synthetic antimalarial also produced in Germany), the drug had been taken for human tests in Tunisia: key data on the tests were on the ground at the time the Allied Forces arrived in Tunis in May 1943. The drug, along with test data were offered to the U.S Army and arrangements progressed towards continuing testing within the U.S drug programme – see Robert Coatney (1963).
The work of medical historians such as Snowden (2006); Packard (2007); Cueto (2008) and Webb (2009) have also brought very important ecological, socio-political and socio-historical perspectives to bear on how the disease is studied. Also the main thrust of a 1992 anthology by Feierman and Janzen was to pin health and healing in Africa to their social bases. Within the anthology, Marc Dawson (1992) explores, for example, the linkages between the epidemiology of smallpox virus strains in colonial Kenya and patterns of human activity; Meghan Vaughan (1992) scrutinizes the unequal distribution of hunger in the Malawian famine of 1949 and explores how that is linked to patterns of disease. Packard (1992) as well as Marks and Anderson (1992) also pursue a similar theme of linking social inequality to ill health.

Social, cultural, economic and political factors remained the concern throughout the anthology as evidenced in, for example, Curtin’s (1992) contribution on malaria, Abdalla (1992) on Islamic medicine in West Africa and Ranger (1992) on Anglican healing in colonial Tanzania. They indicate what the focus of scholarship on African disease was in the 80s and 90s i.e. to somewhat re-indigenize the way it was understood. More recent scholarship has tended to re-contextualize African medicine as firmly located within a global governance architecture and much of current work on disease in Africa describes or attempts to define Africa’s place within this global architecture. The trend in contemporary medical anthropology has been to engage with the global health apparatus at four levels, namely ‘ethnographic studies of health inequities in political and economic contexts; analysis of the impact on local worlds of the assemblages of science and technology that circulate globally; interrogation, analysis, and critique of international health programs and policies; and analysis of the health consequences of the reconfiguration of the social relations of international health development’(Janes and Corbett; 2009). Recent arguments have thus tended to focus either on pointing out how African disease conditions are generally neglected at the global level or on exposing the privileging of some diseases over others (Davies, 2010: 133-145). Julie Livingston (2012) has been one of the notable contributors to this recent trend in scholarship. She draws attention to the invisibility of African cancers arising from Western attitudes to them. As she puts it:

Across the globe, understandings of cancer as a ‘disease of development does not square with realities on the ground. This should not be surprising…we know that development trajectories based on specific Western European and North American
models do not fit actual economic, political, social and infrastructural histories from Changsha to Lahore to Bujumbura. Therefore models of epidemiological transition which take development as their temporal telos are ill-suited to project or capture the changing burden of disease (Livingston, 2012: 33-34).

Western attitudes have historically been strong determinants of how much focus is put on African diseases in the postcolonial era. This is true of practically every disease including malaria. What is descriptive of one disease may at some point or the other be applicable to another, in terms of how it is managed, as their relative visibility and invisibility alternate. In each case what is important, as Livingston suggests, is to ask ‘what kind of biological publics are envisioned in global public health, and what taxonomies of care and prevention ensue from this vision (Livingston, 2012: 31).

If Livingston’s denunciation of global health’s understanding of cancer is that it is unduly treated as a disease of socio-economic advancement and affluence, malaria is at the opposite end of that spectrum. It is specifically treated as a problem of poor countries, even as its study became, from the late 90s, increasingly incorporated into an emergent field of global health which distinguishes itself from international health by virtue of its transnationalism. Global health takes international health one notch further by articulating responses to health issues which have causes or consequences that “circumvent, undermine, or are oblivious to the territorial boundaries of states, and thus beyond the capacity of states to address effectively through state institutions alone” (Lee et al. 2002: 5; see also, Janes and Corbett, 2009). As malaria control becomes packaged into this enclave of global visibility therefore, what becomes incumbent is a scrutiny of the power structures that give purchase to its practice as well as the discourses that sustain its form. It is ever so important to understand how the mere construction of the malaria problem as a development problem facilitates the incursion of a plethora of global agents into its control, so that we may begin to understand how local contexts of public health practices are becoming transformed into hybrid power arenas and joined-up entities co-administered by local and global actors.

Of the set of disciplinary treatments that malaria control has been subjected, liberal economics has perhaps been the most responsible for constituting it into a problem of development. To borrow Livingston’s expression, economics can be said to have envisioned, for malaria, a ‘biological public’ stricken by abject poverty and want. The
chief concern for health economists was how the disease impacts on individual productivity (Goodman et. al. 2000; Meltzer et. al. 2003; Chima et. al. 2003) and stalls economic growth (Gallup and Sachs, 2001). To drive the point home, Bleakley (2003) argued that developments since the eradication of malaria in the American South indicate the negative economic burden of the disease previous to eradication. If the disease stunted human-capital accumulation in the American South it seemed very palpable that it was directly linked to underdevelopment in Africa. The disease is represented in economics as a serious burden that requires urgent global attention. Using bio-statistical models to construct severity, malaria became a problem too serious to be left to the devices of those countries affected by it. The more the problem could be represented as severe, the more important the role of international agencies became and the deeper it became enmeshed into a field of power that is best moderated by the mechanisms of international development. Jeffrey Hammer saw this kind of role as ‘ideal’ for economics. According to him, ‘Ideally, in devising and assessing policies to control disease, the rules and reasoning of economics should be combined with comprehensive epidemiological information to arrive at the best decisions. Simple economic concepts can be of great practical assistance to policymakers in disease control’ (Hammer, 1993: 1); he then proceeds to describe ‘the economic principles to be applied and the kind of information needed to make informed choices about the options for controlling malaria’ (Hammer, 1993: 1).

In the late 90s WHO health economists came up with a standard calculation of disease burden called DALY (Disability Adjusted Life Year) which ‘numerizes’ disease burden and expresses it as ‘years of life lost to premature death and years lived with a disability, adjusted for the severity of the disability. One DALY [equates to] one lost year of healthy life’ (WHO, 1999: 15). This makes it possible for policy makers to think of health expenditure in terms of purchasing units of health. Following WHO’s resort to DALY, it became the trend to calculate the cost-effectiveness of a malaria control programme in relation to how much DALY it prevents (Goodman and Mills, 1999; Akhavan et. al, 1999). Not only is cost-effectiveness calculated on a programme’s own merit; it is calculated as an opportunity cost relative to other diseases, allowing policy makers to allocate more resources to one disease over another as the price of purchasing one unit of health to treat each disease varies (Laxminarayan et. al., 2006).
‘Economicizing’ the problem in this way is what enmeshes it in an international field of power in which the operative logic is supposed to be devoid of political inflection. Intervention decisions taken on the strength of ‘sound’ scientific rationale are presented as the most expedient for endemic countries. They are thus unable to intervene politically to try and redesign assistance programmes to suit peculiar domestic situations.

This is the level at which this chapter has intervened. It has taken a look at how malaria control is encapsulated within international development and what this means for the way control programmes are approached. The rest of the dissertation will explore specific aspects of the involvement of international development in Nigeria's malaria control starting with a historical background, in chapter three, that is illuminated by colonial medical practice.

**Conclusion**

The chapter has argued two major points, the first of which is that the current approaches taken in the prevention of malaria in Nigeria have struggled to control the disease, not because planners are not conscious of the complexity of the problem, but because the capacity of the state to deal effectively with that complexity is impaired by a set of historical, socio-cultural and socio-political factors. Problems such as corruption, ethnic rivalry and other weaknesses of the state need to form part of how Nigeria is understood as a setting within which the problem of malaria occurs.

The second argument is that dealing with malaria in Nigeria has transcended the traditional boundaries of state remit and increasingly blurs the locus of responsibility. The severe lack of capacity by the Nigerian government in dealing with this problem has inevitably brought about an explosion of external actors which, within the field of disease control, has reconstituted the state into national and transnational arms of a joined up entity. The consequence of this is that the state is no longer able to define and design malaria control according to its long term interests and those of its citizens. Ultimately the shape that malaria control takes is highly influenced from outside.

The impairment of the state in Nigeria is also very visible in its inability to overcome the problems of integration engendered by its historical evolution; its inability to overcome problems arising out of the extreme factionalization of elite structures along
ethnic lines; its inability to overcome the debilitating socio-economic impact of corruption and patrimony. These are deep-rooted problems that fundamentally disconnect the state and its institutions, as political entities, from the general population affected by the adversity of disease.

Two things therefore become instructive here: one is that the key organisations that shape the practice of malaria control are exogenous to the settings in which they operate; the second is that they are fixated on the Weberian idea that a transition from patrimonial systems of operation to modern bureaucratic systems is a sine-qua-non for dealing effectively with malaria. But enforcing this kind of transition inexorably enforces systems of rule that global power is well invested in maintaining. The crucial question to consider is therefore not weather national systems of controlling malaria demonstrate capacity or not, but the systems of rule encoded in external interventions and the degree of subjugation they precipitate.

The dissertation also argues that the realities on the ground in Nigeria often show that controlling disease as part of Nigeria’s development agenda has as much to do with the intricacies of internal politics as with international intervention. Organising the nation-state into a productive entity is a task that is historically carried out by elite groups; it is therefore safe to ascribe the failure to harness Nigeria’s vast resources for the benefit of her population to the failings of the Nigerian elite. If this view is accepted, it provides the sense in which we can begin to understand that the overwhelming role of external actors in Nigeria’s malaria control is possible because, in a way, national politicians consider that it masks the locus of developmental accountability. National actors find that it conveniently relocates the responsibility for originating development away from the elite. All that elite groups have to do is subscribe to a constructed worldview or liberal notion of development. The impression is created that these tried-and-tested notions deliver clockwork outcomes if studiously implemented. The interest of Third World elite groups in acquiescing to a less considerable role lies in the fact that, apart from providing the opportunity for deflecting the culpability for failure, it provides an opportunity for aggrandisement. Doing so opens up channels of funding for all manner of projects that may or may not be crucial to the developmental needs of the country in question. Ample opportunity exists, and is often exploited, to embezzle some of the funding for private ends as well.
The tragedy for development however is that much as global institutions try to maintain a populist posture, their role is only possible with the partnership of national politicians who are willing, as demonstrated by structural adjustment, to go along because on one hand their interests are served and on the other hand they are able to appear serious about development. There is thus an emergent discourse of seriousness which bridges the interests of the Third World ruling classes and those of the global development establishment, the consequence of which is that it endangers the welfare of marginalised classes, as seriousness about development only abides by whatever the trend in global economic governance is. What all these mean for research into malaria control in Nigeria is that findings will have to be weighed against the intricacies of national politics. These intricacies are very complex and are very essential to how such findings are interpreted. This will be a better approach to understanding the intractability of the malaria problem than laying the blame squarely on the international development apparatus.
Chapter Three

Background to Malaria Control in Nigeria

Introduction

Colonial attitude to disease control in the colonies is succinctly captured in the quote below by John Farley and as the chapter will show, the malaria disease was very central to how this attitude was shaped and also how it manifested:

In 1898, nearly three centuries after the British had first settled among the malarial swamps of semitropical Virginia and had opened their first factory on the coast of pestiferous India, and over two hundred years after the Royal Africa Company had gained a monopoly in the West African slave trade, the British declared war on tropical diseases. In the year 1898, Colonial Secretary Joseph Chamberlain set in motion a chain of events that led to the founding of the London and Liverpool schools of tropical medicine, headquarters of a new army that set out to rid the Empire of disease (Farley, 1991: 13).

The British colonial attitude was akin to a declaration of war against disease in the colonies and the measures taken could be likened to the formation of an army but as John Farley went on to argue, these were hardly altruistic measures; colonial malaria control, as part of a broadly emerging discipline of tropical medicine, was part of how the empire maintained itself. ‘As stated consistently at that time, the basic goal of tropical medicine was to render the tropical world fit for white habitation and white investment…not surprisingly, their [i.e. the indigenous people] health needs became a priority only when their diseases were felt to threaten the health or profits of the white man, or when imperial policies demanded that the health needs of the indigenous populations be addressed’ (Farley, 1991: 4). Other sections of the literature (Cohen, 1983; Worboys, 1988) have reached similar conclusions in their explorations of both British and French colonial medicine. The purpose of this chapter is thus a kind of historical contextualization. It is intended to demonstrate the various ways in which malaria control efforts have existed in Nigeria for as long as there has been a Nigeria and for as long as there has been malaria control as a field. The chapter divides into
three parts, starting from around 1900: the colonial stage of controlled duality, during which the approaches designed to protect Europeans and native subjects against malaria were differentiated by the exigencies of the colonial mission; the early post-colonial stage of relative inertia during which independent Nigeria was more or less controlling malaria on its own, mainly through case management; and the current stage of unbridled partnerships in which there has been a resurgence of concerted global effort to attack the disease through the efforts of global public-private partnerships between Nigeria and various external actors, public and private. Each of these stages has its own distinct characteristics which are fundamental to understanding how the responses to the problem have been designed at each stage. They each also form part of a triangular picture that helps to set Nigeria’s malaria control in a historical frame that is fairly common to former African colonies but also peculiar in a number of ways.

The earliest successes recorded in malaria control among large populations were technical projects which combined the best ideas from the fields of medicine, entomology and engineering available at the turn of the 19th century (Watson, 1935: 55). For many years before that, quinine had been the available treatment against malaria. However, following the discovery of the malaria parasite in the anopheles mosquito by Ronald Ross in 1897 the thinking on how best to control the disease started to evolve beyond quinine; the fight against malaria acquired a new target essentially - the mosquito vector. The first large scale application of these ideas were implemented in Malaya following Sir Malcolm Watson’s engineering responses to the disease in the country, quite significant results were achieved (Watson, 1935).

Though Watson’s achievements using sub-soil drainage and other measures were soon re-enacted in Singapore, funding limited the extent to which these measures could be replicated across various endemic countries. The cost of campaigns thus brought in an element of political consideration in the way various jurisdictions decided on the best way to tackle the problem. A debate soon ensued regarding the extent to which engineering approaches could be taken as a *sine qua non* in the control of malaria. Watson’s contribution to the debate was expressed as thus:

“There is in my opinion, no antagonism and no competition between the various methods of preventing malaria. The wise sanitarian will use those which give him the maximum benefit for the minimum expenditure. In all campaigns anti-malarial
drugs have a place. In tropical regions where malaria is intense drugs must be used to cure rather than with the idea that they will prevent infection (Watson, 1935: 29).

Even today, the thinking as well as action taken with regard to the variety of options available, at different levels of cost, places malaria control at a socio-political conjuncture. Environmental management, including sanitation and major public works such as swamp drainage and urban housing have featured prominently in the history of malaria control. Although this led to successful eradication in some areas, the main response to the problem today is drug therapy.

In Nigeria, where like the rest of sub-Saharan Africa malaria is highly endemic today, substantial assistance is received from international development agencies for the procurement of these drugs in the fight against the disease. Substantial progress has been made through the many therapeutic and preventative programmes that have been launched in the last decade and half but environmental management approaches are still considered by many as not contributing enough to fighting the problem. This may be due largely to cost but the ecological situation in sub-Saharan Africa, especially its heavy rainfall pattern and very large forest areas turn environmental management into a less effective option. This leaves drug therapy and vector control measures such as indoor residual spraying with chemical insecticides as the main weapons against the disease.

The main control measures for fighting the disease today will be explored in chapter four along with what the approaches to implementation mean for development assistance. But first this chapter will set up a background to the contemporary understanding of malaria control.

**An Imperial Disease: Malaria Control and the Political Economy of the Colony**

Sir Andrew Balfour delivered the Hastings Popular Lecture on the 12th of March 1930, on ‘Health and Empire’. The lecture delved into several aspects of the British Empire’s encounter with diseases of various kinds across its colonies. His submission was that too many British lives had been lost to the imperial campaign and the time had come to accord the issue the utmost seriousness. Importantly, he classed many of the diseases common to the tropics at the time as ‘imperial diseases’ (malaria inclusive) and defined
them as ‘diseases transferable in a variety of ways from the sick person, or from the so-called healthy carrier, to the sound, existing as endemics, pandemics, or more especially as epidemics, and possessed of such crippling and lethal powers that, taking the British Commonwealth as a whole, they interfere with progress and development, hinder trade and commerce, and occasion monetary loss’ (Balfour, 1930: 81). His definition captures, in a rather succinct way, the unpleasant reality the disease represented to the colonial mission, and it also somewhat opens a window into understanding the colonial response to it.

Balfour’s speech conformed to the prevailing colonial conceptualization of malaria at the time: it was a problem because Europeans, unlike Africans, had no immunity to it. Dealing with malaria meant protecting European lives. The sense of urgency that it evoked was very strongly tied to concerns over the death toll among colonial administrators; an urgency also captured in the speech of the colonial Governor of Lagos, William Macgregor at the London School of Tropical Medicine in 1900: ‘there is excellent reason for believing that Her Majesty's Secretary of State for the Colonies took very seriously to heart the deplorable mortality among public officers and others in our more unhealthy tropical possessions. The calling into being of this school is but one of the many means devised or fostered by the Right Honourable Joseph Chamberlain for curtailing the death roll of our fellow citizens in those insalubrious, over-seas territories of the empire’ (Macgregor, 1900).

Because the colony was a very important source of raw material extraction for British industry, its preservation was essentially geared toward serving exactly that purpose. This meant that investment in the administration of the colony was based on an economy of dividends. The indigenous labour required in industries as well as for the production of commercial crops such as cocoa and groundnuts was therefore a much valued subset. As Balfour suggested in his lecture, ‘let it be clearly understood, however, that we must not attribute all the advance of recent years to discoveries like those of Theobald Smith on Texas fever, Bruce on undulant fever and trypanosomiasis, Manson on filariasis, Ross on malaria and so forth. Other factors were at work, such as the realization of the value of the tropics as a source of raw material for the Empire’ (Balfour, 1930: 79). Ityavyar has also identified port cities as generally being the earliest locations of hospital and health services, coinciding with the development of industrial activity in these areas. The earliest hospitals:
Were only for Europeans and later for the Africans they employed. Indigenous healers were still the major providers of health care services for the population…In 1912, when tin mining started in Jos, a hospital was founded. The same was true of Port Harcourt when work started on its mineral oil deposits. The case of Lagos was similar. Many of the hospitals in Lagos were commensurate with increased economic activities (Ityavyar 1992: 71-72).

The colonial approach to public health therefore targeted a highly selective public. What Ityavyar suggests above is that the need for healthcare was perceived in relation to the need to support colonial production. The colonial conceptualization of the malaria problem also meant that the areas that were perceived as most urgently needing to be rid of mosquitos were European settlements and the areas adjoining them, e.g. Ehin Igbeti:

Ehin Igbeti is chiefly of interest in that it is the district which supplies the anopheles which frequent the majority of the European houses in Lagos…This area, as it is the nearest to the European quarters, should be the first of the sources to be abolished… the filling up and increased drainage of this source of anopheles ought to be both a very practicable and advantageous proceeding (Stephens et al, 1900a: 18).

This report by the Royal Society goes further to declare that

So closely associated indeed are malaria and the native in Africa, and so wonderfully constant is the presence of anopheles where natives are collected in numbers, that we doubt whether any operations, now possible, directed against anopheles will do much to diminish the danger of malarial infection. In fact, in Africa the primary aim should not be the destruction of anopheles, but rather to remove susceptible Europeans from the midst of malaria. To stamp out native malaria is at present chimerical, and every effort should rather be turned to the protection of Europeans (Stephens et al, 1900a: 18).

The kind of effort the colonial government was expected to make was spelt out in the same report (published in 1900) which came up with a four-point plan by which the colonial government could ensure the protection of Europeans through segregation:
A site should be selected for European dwellings as far as possible from a native village, a mile would undoubtedly suffice; the camp of the native labourers should also be placed at the greatest possible distance (half a mile to a mile); the house servants and others should not sleep in the European compound, but a quarter to a half a mile away; one personal servant only should be allowed to remain in the camp at night (Stephens et al, 1900c).

Although the advice given to the government was to segregate the races, the purpose had not been to merely accentuate the dichotomy of races. Rather it followed from what was seen as a practical response to the discovery that the parasitic count and the spleen rates were higher in children than in infected African adults. It was thus realized that Africans acquired a natural immunity as they grew older. It was possible for an African adult to carry the parasite in his blood and remain asymptomatic. By implication also, African children were far more efficient conveyors of the disease than their parents. This provided medical experts with a new grade of knowledge that was to later legitimize some of the action that was taken in response to the malaria problem. Tropical medicine was evolving not just as a branch of medicine that studied diseases occurring in the tropics but also one that studied the ‘tropical man’ and how to explain the levels of immunity he was able to develop against some very deadly diseases: ‘whether the serum of such an immune person would have any curative properties, and what reactions in vitro, agglutinative or parasiticidal, it might possess, further observations [were] necessary to determine’ (Stephens et. al, 1900b: 10).

Although the expert advice proved fairly difficult to implement, urban racial segregation had taken root in Nigeria by 1907. In one of many acts that were to follow, the colonial government ‘condemned seven acres of urban land fronting the Lagos race course for conversion into an exclusive European settlement’ In the North of Nigeria, segregation was even more vigorously pursued; Frederick Lugard the colonial governor ‘extended segregation to all new district headquarters. Even the ‘rest houses’ built in many villages for the use of administrators on tour were to be built at least four hundred yards from the nearest ‘native’ dwelling, and Africans were forbidden to use them under any circumstance… [Lugard’s] Townships Ordinance of 1917 made it possible to impose a

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1 It was possible to palpate a distension of the spleen and take that as an index of infection – see James Webb, *Humanity’s Burden*, p.131
fine or imprisonment on Europeans who lived in a non-European zone’ (Curtin, 1985: 603-606).

The advice to set up a half mile cordon between Europeans and Africans was also based on the understanding that although the mosquito could fly for over half a mile it could not effectively carry the malaria parasite beyond that distance, a theory also confirmed by Watson’s work (1935: 10). Segregation therefore targeted two outcomes: getting Europeans as far away as possible from African children and also increasing the distance as far as possible between Europeans and parasite carrying mosquitos.

The resistance to segregation came from some unlikely quarters: Colonial governors in Nigeria and elsewhere in British West Africa (particularly the Gold Coast – modern day Ghana) did not welcome the policy and thought it was not a tenable solution in the long term. William McGregor who was Governor of Lagos till 1902 was himself a medical doctor and was of the view that European segregation as a policy would leave the source of malaria infection unattended (Curtin, 1985: 602-603). His preferred approach was quinine prophylaxis, sanitary education and diligence:

In the West African coast, it [malaria] must now be reckoned with at every step. Hospital management must be fundamentally affected by it. Wards will have to be painted of a colour that will facilitate the discovery of mosquitos; and probably some of them will have to be furnished for fever patients with doors and windows of gauze wire netting. Every bed, without distinction, will have to be provided with a fine muslin mosquito net. All water tanks must be supplied with wire net coverings to prevent the ingress of mosquitos. Wells and reservoirs and flower pots will have to be similarly protected. In hospital discipline it will be considered a serious offence to allow a fever patient to be bitten by a mosquito. All mosquito breeding places near a hospital or other dwelling will have to be made unfit for these insects, as far as this is practicable. Much attention will have to be given to the teaching of the new doctrine. All hospital nurses must obtain a mastery of the subject; and so, of course, must sanitary inspectors, otherwise they will be unfit for their posts. But the general public also must have the leading lines of malaria genesis put before them in a way they can understand. It should form a subject of tuition in all the public schools of a place like Lagos, and prizes should be given to the best scholars in the malaria class. The nervous individual that does not know
one genus of mosquito from another will, in future, lead an unenviable life in the tropics (Macgregor, 1900: 981).

He also appeared to be in favour of the stringent laws passed in Italy that ‘If a man working under contract dies of malarial fever without having been supplied with quinine in sufficient quantity by the contractor, the employer may be sued for damages, in addition to being prosecuted criminally’ (Macgregor, 1902: 1891). In Lagos ‘all officers and employees [were] supplied gratuitously with quinine; but besides this there [was] a special vote of several hundred pounds each year for the purchase of quinine to be distributed by the Lagos Ladies' League to the children of Lagos. It [was] also given free of charge at the Government dispensaries (Macgregor, 1902). The importance that Macgregor attached to sanitation education was also expressed in detail at the lecture he delivered at Glasgow University:

I should like to say that in the great struggle with malaria, I attach much importance to the education not only of the people that live in malarious countries, but also to those of us that remain at home in these islands. This idea was put in practice at Lagos in the first instance by a course of lectures, having special reference to malaria, by Dr Best, Resident Surgeon at Lagos Hospital. Then a more comprehensive and elaborate course was given by Dr Henry Strachan, C.M.G., Chief Medical Officer of the Colony. The teachers of the primary schools receiving money grants from the Government were invited to attend that course. They were examined at the end of it, and given, where they deserved it, first and second-class certificates that they are competent to teach sanitation in the primary schools…formerly the distribution of the Government grants was determined by the results obtained in reading, writing, and arithmetic. To these three is now added a fourth, sanitation. In putting this into practice I have had much assistance from the Chief Medical Officer. Lectures on malaria were also delivered at some of the country stations...Ministers preach on sanitation; and we have a most influential Board of Health (Macgregor, 1902).

Macgregor’s embrace of sanitation reveals segregation as the more desperate colonial response to malaria and it took the tenacity of Lugard to give some purchase. But even for Lugard, segregation was not the only policy sanitation continued to play an important role: a Destruction of Mosquitoes Ordinance had been introduced in 1910
before Lugard’s term as Governor-General of Nigeria, and it was superseded by the Public Health Ordinance, 1917, which provided powers and penalties aimed at preventing mosquito breeding. The plan was clearly to shape the hygiene and sanitation of the population through legislation; however, even though summons were issued in Lagos only to offenders who had previously received multiple cautions, the number of summons overwhelmed the capacity of the courts; about 2,000 applications for summons had to be cancelled. The idea of punitive control was dropped in favour of education and sanitary work by public authorities; control measures were expanded to include ditching, oiling, stocking wells with fish, and use of Paris green as larvicide. Initial resistance to segregation ensured that it began to wane as official policy after the departure from office in 1919, of Frederick Lugard who seemed more enthusiastic about segregation than all the other colonial governors before and after him. The policy had however succeeded by 1920 in ‘influencing town-planning schemes and the European health picture had vastly improved’ (Gale, 1980: 504). Coupled with the substantial reduction in European death rates due to other anti-mosquito measures, segregation was rendered increasingly redundant after 1920.

The colonial response to malaria, at least in the early 20th century was, in essence, a dualized one. At one level African subjects were being administered quinine doses and taught how to improve their sanitation and hygiene and at another level Europeans were being cordoned away from perceived sources of malaria infection, including Africans. Public engineering works like swamp drainages that attacked the mosquito vector more vigorously were planned with the safeguard of the health of European administrators as central. However, even though a discourse of racial supremacy had already gained currency at this time, this duality was not so much informed by race as it was informed by the political economy of the colonial mission, and malaria was directly linked to it. When the connection between the mosquito and malaria was established in 1897, the conundrum that it solved was not how the health of populations in endemic countries was going to be improved; it was how the malaria challenge to Empire was going to be circumvented. As Gale noted, Europeans had been present in West Africa since the 15th

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2 Being the commercial and administrative nerve-centre of the colonial operation, Lagos featured prominently as a centre of anti-malaria activity. Some of the correspondence that transpired between top colonial government officials in the twenties show preparations for dredging parts of Lagos as part of the anti-malaria campaign – see correspondence from the Director of Marine, Lagos, to the Chief Secretary to the Government, 8th December 1926, National Archives Ibadan, CSO 26 (17742) Vol.1
3 Report on Anti-Mosquito Campaign, Lagos by the Medical Officer of Health, Lagos and The Deputy Director of Public Works, December 1929, p.10, National Archives Ibadan, CSO 26/2 (115120).
century and mixed easily with the inhabitants of the coastal towns. ‘Not until after the
discovery, in 1897, that a mosquito was the vector for malaria was segregation ever
suggested as a general public health measure’ (Gale, 1980: 496).

Also, the West African coast had long earned a reputation as ‘the white man’s grave’
due largely to the high susceptibility of Europeans to malaria and the baffling mortality
rate among them. As Curtin pointed out, ‘by the 1820’s, the image of the White Man's
Grave came into its own, and the reputation of West Africa touched bottom. Three
governors of Sierra Leone died in three successive years between 1826 and 1828’
(Curtin, 1961: 103). The flurry of activities that followed Ross’s discovery in 1897
therefore underscored the importance of his contribution not just to the prevention of
malaria but also to the expansion of state power i.e. facilitating the entrenchment of
Empire. Before Ross, Malaria was already seen as posing a threat to the colonial
operation and this was a threat that remained formidable well into the 20th Century
(Curtin, 1964; Dummet, 1968; Mathe-Shires, 2001). In recognizing the advances to
malaria control in the early 20th century Balfour reiterated the way in which the
emergence of the mosquito theory helped to strengthen the imperial mission as thus:

The dreaded West Coast of Africa could no longer remain the white man's grave,
as it had with justice been called throughout the eighteenth and much of the
nineteenth century. No longer was it conceivable that the average tenure of office
for Government officials should be less than twelve months. No longer was there
any need for a judge to devise the ingenious expedient of making his home on a
small vessel moored off the coast, and going ashore only to carry out his official
duties. No longer could the gravestones in the cemeteries and the memorials in
churches be permitted to exhibit record after record of unfortunate persons who
had perished under the age of 40. Civilization altered the situation, and it is worth
noting that the British Empire as a civilizing and colonizing power has been a
good ally to health (Balfour, 1930: 79-80).

Malaria was thus viewed less as a threat to the colonial subject than as a threat to the
colonial state. The colonial subject and the colonial administrator were objectified in
different ways: while the subject was viewed quintessentially as an object of labour and
colonial production, the colonial administrator was, to all intents and purposes, viewed
as an object of power and the maintenance of the imperial state. This dichotomy
inevitably dualized the response to the malaria problem and produced what has been referred to as the ‘sanitation syndrome’ (Swanson, 1977; Stock, 1988:23). Environmental sanitation provided a ready cover for all manner of policy that mainly affected those regarded as posing a threat to European officials within the colonies. It also became a technique by which the colonial state not only regulated its subjects but also secured and protected those vested with the operation of its power.

Although the dual approach to malaria control met with some resistance, it lingered long enough to leave an indelible print as the defining medical practice of British colonialism in West Africa. For instance the major project in Lagos that contributed to the control of malaria during the war was a large scale drainage scheme as late as 1942 which the Under-Secretary of State for the Colonies, Thomas Cook declared to the House of Commons had been ‘initiated to protect Service personnel’. Gale (1980: 506) has shown how this approach was fundamentally different from French colonial policy. Also for other major powers like the Italians and Americans, malaria was not just an imperial disease; they each had serious malaria problems to grapple with at home during this period. This made them very involved in research work aimed at producing a solution. Accordingly, in 1944 the Rockefeller Foundation, working with the Allied Control Commission, was instrumental in the emergence of DDT as a potent chemical attack against the mosquito vector and its larvae (Webb, 2009:160). The unprecedented success of DDT heightened global optimism that the malaria problem could finally be conquered and this was also a period in which the international health architecture as we know it today was beginning to take root as a practice. The World Health Organisation had recently been formed in 1948; the run-up to decolonization was bringing sub-Saharan Africa into its own and political parties would come under increasing pressure to tackle issues of health and social welfare; the United Nations was embarking on its Development Decade; new technologies were also improving the prospects of eradicating some of the world’s deadliest diseases that had hitherto, as Balfour put it above, hindered trade and commerce, occasioning monetary loss.

By 1955 WHO came up with a plan that aimed at eradicating global malaria in the fifteen years to 1969. This plan was as fundamental to finally eradicating malaria from many parts of the world as it was essential to highlighting the difficulty of eradicating it in Africa. For reasons that were both administrative and technical the 6th report of the

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4 Hansard Commons Debates - HC Deb 11 July 1950 vol. 477 cc1316-24
WHO Expert Committee declared in 1956 that ‘the problem of finding an effective and economical method of eradicating malaria in tropical Africa had not yet been solved’ (RBM/WHO, 2000: 39). Ecological and other factors thus prevented the African continent from benefiting from the upsurge of optimism and hope for the eradication of malaria.

**Inertia and the Spirit of Dakar**

The idea that became known as ‘the spirit’ of Dakar’ was borne out of the 1997 project, headed by Harold Varmus, then Director of the US National Institutes of Health (NIH), designed for scientists from wealthy nations to work as equal partners with African scientists in the search for solutions to the intractable problem of malaria on the continent. The first meeting to discuss a way forward was held in Dakar, Senegal.

The indication that most African countries would struggle with controlling malaria on their own was most visible in the early post-colonial period. In Nigeria, between independence in 1960 and the establishment of the Roll Back Malaria programme in 1998 there were limited developments in malaria control. One way of accounting for this might be to say that global actors had reached a point of exhaustion with the whole enterprise of malaria control in Africa. But the period also demonstrated that the enormous attention the disease had previously received was highly connected to the impact it had on Europe and the U.S. Europe was bound to the malaria narrative as a result of its imperial mission in malaria endemic areas of the world and the U.S., apart from having cases of *vivax* malaria at home, was intricately engaged in malaria control as a result of casualties linked to the disease during military campaigns abroad (Beadle and Hoffman, 1993).

In the postcolonial period, Nigeria was faced with the reality of dealing with malaria as a specifically Nigerian problem. However in the early years of its independence in the sixties, the country faced multiple pressures of statehood and, as shall be discussed below, an intricate mix of expediencies relegated malaria control to the background.

By 1969, the global eradication programme had, to all intents and purposes, stamped out the disease from the West; colonial powers had mostly disengaged from Africa and a post-colonial form of engagement replaced the politics of the colony. Attitudes changed and interests waned. The main thrust of control activity revolved more around
the management of malaria cases with very little taking place by way of universal control projects either from the government in Nigeria or from global health institutions. Malaria was left up to hospitals, health centres and the private practitioners to deal with case by case. Africa was in essence left to rely on its own efforts to find practical ways of controlling the disease. The result was inertia; an outcome which seemed to vindicate those who had been making attempts to draw global attention to the need to be more committed to the African malaria problem. For example, when on the 11th of July 1950 Mr John Arbuthnot, the member of Parliament representing Dover, addressed the British House of Commons, his mission, according to him, was three-fold: ‘first, to give a summary of world progress with regard to malaria control; secondly, to give a factual statement of the position in Africa; and thirdly, to offer a few suggestions which [he] hope[d] the Government may see fit to employ, by which the present position in Africa can be materially improved’. He would have been expected to have a respectable understanding of the global malaria situation as he was also a member of the Industrial Advisory Committee of the Ross Institute, which had the duty of reviewing the progress made globally in combating tropical diseases. In his submission on Africa he lamented the state of malaria control on the continent: ‘one matter which stands out from a review being carried out at present is the great discrepancy between the progress which has been made in malaria control in Africa compared with the rest of the world, Africa unfortunately lagging badly behind the achievements elsewhere’. He was quite optimistic about the prospect for eradicating malaria on the continent and his call to the government was based on a view taken that an ability to effectively deal with the malaria problem would support perceptions of British might. He implored the government ‘to institute without further delay major schemes, one for East Africa and one for West Africa, much on the lines of the schemes tested elsewhere and found so successful.’ Given the expertise he believed was already available in Britain he saw no reason why such schemes could not be brought about.

Arbuthnot’s address broadly represented the popular sentiment on malaria control as it was unfolding at this time. His address also shows that such sentiments have a relatively long history (similar sentiments exist even today). Eradication programmes had been hugely successful in many places and many commentators imagined that there was very

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5 Hansard Commons Debates - HC Deb 11 July 1950 vol. 477 cc1316-24
6 Hansard Commons Debates - HC Deb 11 July 1950 vol. 477 cc1316-24
7 Hansard Commons Debates - HC Deb 11 July 1950 vol. 477 cc1316-24
little in the way of transferring those technologies and engineering feats to Africa. In his address to the conference on malaria held in Uganda in November 1950 John Hathorn Hall, the Governor of Uganda called this tendency ‘a dangerous assumption’ and expressed delight that the conference agenda contained ‘ample evidence that African malaria problems are to be examined with proper caution.’

The success rates seen elsewhere were possible because of many elements in the control efforts in those places that were not replicated in Africa, while the continent also presented many challenges to malaria control that were not replicated elsewhere. As Bruce-Chwatt (1954: 169) put it four years later, ‘the quantitative difference is so great that it imparts to African malaria several exceptional characteristics.’

In 1954 Leonard Bruce-Chwatt while working as Director of the Malaria Service in the Ministry of Health in Nigeria also published a catalogue of problems that stood in the way of achieving eradication in Africa: medical administration was still in a chaotic state and medical records were not adequate enough to support such an ambitious project; knowledge of the parasite-host relationship in African malaria was still inadequate, creating a danger of jeopardizing naturally acquired immunity in many communities if eradication were to be pursued; the most virulent vector specie found in Africa (A.gambiae) had in smaller scale control projects demonstrated such adaptability that it had been possible to suppress but practically impossible to eliminate; cultural limitations regarding such practises as the seclusion of women also meant that vector eradication measures had to be deployed with the utmost caution if the cooperation of local people was not to be lost; the financial cost of attempting eradication over Africa’s very vast rural landscape and very dense vegetation was also very daunting. In the early 1950s, it represented in the best case 50% and in the worst case 120% of the total expenditure on health per head per annum on the continent.

Coupled with the uncertainties surrounding the efficacy of the available measures in Africa the likely cost of carrying them out only helped to increase scepticism.

What the WHO Expert Committee recommended was ‘increased emphasis and assistance to pilot projects in Africa, including combinations of residual spraying and chemotherapy’ (RBM/WHO, 2000: 39). What this meant in essence was that although

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8 Sir John Hathorn Hall – Opening address to the malaria conference in Equitorial Africa, Kampala, Uganda, 27 November – 9 December 1950
10 See Bruce-Chwatt (1954) “Problems of malaria control in Tropical Africa ”
eradication was not going to be the main focus in Africa the machinery of the WHO and some of its resources would continue to maintain on-going and new programmes of technical assistance and support in order to keep malaria in check on the continent. The support given to African countries augmented their own pre-eradication programmes. These programmes as advised by WHO, comprised essentially of development of rural health services to serve as a platform upon which a future eradication plan could be based. WHO also strongly encouraged developing countries, especially from 1978 (after the Alma Ata conference) to focus health delivery efforts on primary health care, primary health care being especially important because malaria is more endemic in rural areas than urban.

As the World Health Organisation more or less disengaged from malaria control activities in Most of Africa, the expectation might have been that countries like Nigeria would seize the initiative and generate strong internal measures to deal with the problem but a set of circumstances exerted some impact on the country’s ability to do so. The first shock was the Civil War of 1967-70. The specific figures relating to the extent by which the Civil War in Nigeria increased malaria prevalence are not available but Collier (2003) has shown a direct correlation between refugee movements during civil wars and the rise in malaria cases. The effect of civil wars on malaria prevalence is particularly significant when compared to other emergencies such as drought and famine because ‘civil wars force people to walk through unfamiliar rural areas and forests to avoid areas of military operations, but people displaced by famines and droughts do not have to avoid paved roads, so they are less likely to be exposed to the mosquito’ (Collier, 2003: 39).

Ogba (1989) pointed to Nigeria’s 1967 civil war and other forms of violence in Nigeria’s early post-colonial period such as the Tiv riots in 1960 and 1964 or the violent student and religious riots that pervaded the 1970s and 1980s as sources of social stress which induced the state to re-appraise its priorities. Social responsibilities such as health maintenance were de-emphasised in Nigeria’s First Republic in favour of a perceived need to strengthen military and police forces. Comparing defence expenditure to health expenditure Ogba further showed how the former was increasing exponentially at the same time as the latter was declining drastically. As shown in table 2 below, the need to control internal violence and strife doubled Nigeria’s defence spending from 3.2% in 1960 to 6.4% in 1965, increasing it further throughout the decade until it reached a peak
of 42.6% in 1970. In comparison health expenditure was falling during the same period, declining steadily from 6.2% in 1960 to 1.1% by 1970 (Ogba, 1989: 83). Conflict and violence especially of the religious form has continued in Nigeria even to this day and the military response it evokes from the state has consistently exerted pressure on health and other social spending.

Table 2 - Percentage Expenditure on Defence and Health in Nigeria (1960-1970)

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<td>Defence</td>
<td>3.2%</td>
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As a direct result of the Arab-Israeli conflict revenue accruing to the Federal Government in Nigeria was vastly increased from 1973 onwards. This erroneously increased the expectation that African countries like Nigeria had finally gotten into a position where they could fund their own development (Freund, 2007). But the oil boom only revealed the rentier character of the state and economy. In relative terms, only a handful of labour was required to produce the oil that was being exported annually from the country (Freund, 2007: 93). So while oil workers have always been relatively very well remunerated and often have a comparatively very good standard of living, the state did not find it expedient to seize the opportunity of the oil boom to improve the welfare of the general population in the same way. Military and security expenditure along with an explosion in importation made possible by oil wealth continued to dominate government spending well into the late 1970s, to the detriment of health.

If the prioritization of defence and security as well as a profligate taste for imports shifted attention away from health expenditure during the oil boom, by the early 1980s a reality check had set in: unsustainable oil prices crashed and the Nigerian economy was hit with recession which ushered in austerity measures. Health and other social expenditure fell even further. As recession hit harder, private medical practice proliferated across the country. This was rather convenient for the government as it served to plug some of the gaps in healthcare delivery. But part of the problem was that the spread of these private practices showed a rural/urban dynamic in which there was a
preponderance of practices located in urban centres as the poverty ridden rural areas did not offer much in terms of profitability. For instance, 80% of the total number of registered facilities and beds were located in the six most commercial of the 21 states in the country as at 1991, namely Lagos, Oyo, Imo, Anambra, the old Bendel and Kaduna (Ogunbekun et. al., 1999: 174). This dynamic clearly put poor rural dwellers at a disadvantage but what was even more difficult was the gradual abolition of free medical services in public health institutions (Ogunbekun et. al., 1999: 175).

Given this scenario, the implementation of primary healthcare arising out of the International Conference on Primary Health Care (PHC) held in Alma-Ata, USSR, in 1978 was ill-fated. The conference was mainly for the purpose of addressing the problem of health inequalities identified as common to health systems in most member states (WHO, 1988). The conference emphasised primary health care as the way forward for dealing with health inequalities everywhere and produced a rallying call to encapsulate the spirit of the conference - ‘health for all by the year 2000’, the crucial principle (according to the Director-General) was ‘that primary health care shall be widely adopted as the cornerstone to health development’. ¹¹ To make primary healthcare effective, anti-malarial activities in endemic countries were supposed to be integrated into the PHC system but in Nigeria, especially in the North of the country, the programme was not as effective as may have been hoped.

As Bruce-Chwatt noted, ‘malaria control within the framework of primary health care demands full commitment by the government concerned, constant support of the community, and a close cooperation with all other sectors of the health system’ (Bruce-Chwatt, 1987: 76). The federal system of government in Nigeria which places healthcare on a concurrent list of responsibilities has however been partly responsible for why PHC had only a limited success. Local government authorities bear the constitutional responsibility of providing primary health care and maintaining health facilities within their local areas. The problem with this decentralized approach is that it creates disparities in the delivery of services; it creates classes of states with hugely different capacities to provide healthcare and causes very wide gaps in the health of citizens. For instance the role of the private sector in the provision of health is significantly higher in southern states such as Lagos while government remains the

predominant provider in the North (World Bank, 2010). Even though the implication of this disparity is reflected in the level of inefficiency and decay in facilities, healthcare facilities generally suffer from the attendant problem of low investment and therefore have a low equipment base and lack many of the necessary pharmaceutical stock required for treatment.\textsuperscript{12} Primary healthcare therefore proved burdensome as a result of the weak resource base of government at the local level. It was sustained in the ‘80s due largely to donor funding from many international bodies. But the programme started to falter as the country became overtaken by political crises from 1993. A sanctions regime followed the annulment of the June 12 1993 democratic elections by the military government of Ibrahim Babangida, and also the intensification of the Niger Delta crisis due to the arrest, around the same period, and the subsequent execution in 1995, of the leading figure in the resistance of the Ogoni people of the delta region against the Nigerian state over oil rights. Britain withdrew new aid to the country and withdrew its military training team in protest (Dowden, 1993). EU, UK, as well as US envoys to Nigeria were recalled and the Commonwealth countries suspended Nigeria’s membership (Adetula et al, 2010).\textsuperscript{13}

Some states in the country took the approach of trying to improve health at the local level by introducing sanitary inspectors to improve the sanitary behaviour of citizens. Many Lagosians remember these ubiquitous uniformed sanitary inspectors very well. Their work largely involved going round homes and fumigating gutters and other water holders to kill mosquito larvae. They advised residents on standards of hygiene and sanitation. The generation of Lagosians who were in school from the sixties to the eighties in fact remember this with a high degree of nostalgia; it is discussed more as a golden era of healthcare. One participant expressed it as thus:

I gave you information from my own history; that when we were growing up, school children were not only de-wormed twice annually free of charge to their parents but also Paludrine, the ‘Sunday-Sunday’ medicine, was given prophylactically to children against malaria. It was cheap and affordable. There were jingles on radio; there were no televisions then. When television came the

\textsuperscript{12} The myriad of problems faced by primary health care in Nigeria is catalogued by the World Bank report on improving primary health care delivery in Nigeria. also Magnus Ojeifo (2008) ‘Problems of Effective Primary Healthcare Delivery in Owan East and Owan West Local Government Areas of Edo State, Nigeria’ *Journal of Social Sciences*, 16(1) 69-77.

jingles migrated to television also. When I was in boarding school it was mandatory; routine, every Sunday evening after supper. They passed it round to all of us and we took. The gutters were clean and fumigated regularly. And I’m talking about the same Nigeria that we have today. Control was good then. Environmental conditions have deteriorated to the point where they are now conducive to the breeding of mosquitoes.¹⁴

In spite of this fond memory of sanitary inspectors, their role was only partially successful. Their authority was compromised by bribery and corruption; ordinary individuals by and large began to take them less seriously as they acquired a reputation for looking the other way as large companies flouted waste management and industrial waste regulations (Werlin, 2005). This contributed in large measure to the environmental chaos that is often cited as a huge factor in the breeding of mosquitoes.

By the mid-90s the severe effect of vector resistance to chloroquine in Africa, which manifested as an alarming increase in mortality rates, intensified the resolve amongst biomedical scientists to do something about the situation. Subsequently there was in 1997 a meeting of the research community in Dakar, Senegal which brought together scientists from Africa, the United States and Europe to confront the problem. Known as the Multilateral Initiative on Malaria (MIM), the high level involvement of a lot high figures in bio-medical research, including Dr Harold Varmus, holder of the Nobel Prize and Director of the National Institute of Health, USA, helped to cast a much needed spotlight on the meeting. Varmus spent about two weeks in Africa for the sake of the meeting and this also set the tone that malaria was important and the people who were working in malaria deserved support.

The major objective of the Dakar meeting was to ‘put malaria on the scientific, media and political agenda and in particular to identify it as a priority for research’ (Bruno et al, 1997). Accordingly the meeting came up with a set of priorities for research not just in one area but a multiplicity of areas including vaccines, drugs, nets, case management and so on. Following in the spirit of the Dakar meeting, a meeting of donors was held in Amsterdam in the same year to consider mechanisms for funding the priorities identified in Dakar and the combination of these events led WHO to take the initiative in setting up Roll Back Malaria (RBM) in 1998, which has since become a separate entity on its own.

¹⁴ Interview 8, medical researcher, Lagos University Teaching Hospital, Lagos, Nigeria, 14/09/2011
with strong links to WHO. In order to secure political commitment for the plans and objectives of RBM, a summit of political leaders was held in Abuja in April 2000. This meeting was with senior officials of the leading multilateral agencies spearheading the initiatives and it successfully committed African leaders to the priorities filtering through from the Paris Declaration in 2005 and the Accra Agenda for Action, 2008.

In essence the shape that the operational architecture of malaria control would take was forged by the Dakar initiative. The areas of concern that were reified as priority in the spirit of Dakar are the current major thematic areas of the global effort to control malaria. What comes into focus at this stage is that the power to prioritize is fundamental to the way development is organised and executed. On the surface, the process of priority setting in organisations presents itself as a simplification model for tackling complex resource problems (Singer et al, 2000; Mitton, 2002). It is however important to also note that in the light of multiple options for dealing with a problem of national significance, the emergence of one option as priority cannot be divorced from vital socio-economic and political considerations (Reichenbach, 2002; Grannemann 1991). The priority option can for instance be used to create or stimulate internal markets and improve sectorial production; the available capacity to meet the needs imposed by the prioritized option is also taken into consideration along with the political implication of excessive external dependence. This provides the sense in which prioritization can be seen as instrumental; the ability to control what is prioritized confers tremendous influence over outcomes by eroding the scope for discretion at lower levels as set priorities percolate downward. It also grants the power to regulate the pace at which those outcomes are achieved.

In the context of malaria control in Africa, research needs to be directed towards determining whether prioritization simply manages wastage, inefficiency and programme duplication or if indeed it regulates something much more arcane, such as access to markets for Western manufactured disease control products. For instance at the Dakar meeting, African delegates were hesitant to support the rolling out of artemisinin as first line treatment in malaria, preferring instead to adopt it as a second line of treatment in the case of treatment failures with chloroquine and Sulfadoxine Pyrimethamine (SP). Their concern was the cost and sustainability of artemisinin and they also felt that chloroquine and SP were still working considerably well. It took some persuasion to establish that chloroquine was already largely failing on the continent and
also that a child might die before getting access to artemisinin as a second line of treatment. Incidentally the delegates from South-East Asia, where most of the plant ingredient for artemisinin combination therapy is grown, were even more tenacious in persuading the African delegates. The hesitation was eventually dropped in favour of artemisinin.

Coming on the back of the long years of inertia and its consequence (i.e. chloroquine failure and an increase in malaria deaths), the spirit of Dakar represented the unfolding of a package of liberalization for malaria control in Africa. Consultations at the level of the Dakar meeting were necessary to trap and douse the embers of political contestation that could have scuttled the initiative. The thinking of the MIM group was expressed in a correspondence published in the journal *Nature* in April 1997: ‘in the spirit of the Dakar meeting we recognise that control of malaria in Africa will require a long-term collaboration between scientists in the North and South and the involvement of many more countries than the initial group which took part in the Dakar meeting. It will require commitments from the industrialized countries to funding and from African leaders to support scientists and health and research infrastructure in their countries’ (Bruno et al, 1997).

Indeed, the form that malaria control has taken since the Dakar initiative has been one that has opened it up to multiple transnational actors who operate under an umbrella spirit of partnership. The next section will explore the nature of this notion of partnership and its implication for malaria control in Nigeria.

**Partnerships of the Wolfensohn Kind: Open Season in Malaria Control**

The pace of events moved rapidly for malaria control following the Multilateral Initiative on Malaria (MIM) 1997 meeting in Dakar. It awoke from its long hiatus and evolved into more targeted active partner programmes promoted by the Roll Back Malaria initiative from 1998; an initiative which brought together several multilateral and bilateral organisations as well as international NGOs and private companies in partnership with malaria endemic countries. This revitalization coincided with a period when development assistance was beginning to assume the shape it would take in a post-Cold War era, and the World Bank was a spearhead for this change.
By 1995 anti-World Bank sentiments around the world had intensified. The Bank’s public image was not at its best. A number of movements sprang up to challenge its relevance and to demand change. The ’50 years is not enough’ movement in particular argued very strongly that the Bank ‘was doing more harm than good for development and should, consequently, close its doors’ (Rice, 2005:76); protests by the anti-globalization movement also intensified in the 1990s with the World Bank as its target (Rice, 2005:76).

Appointed World Bank president in 1995, the way Jim Wolfensohn responded to these challenges was to institute a number of initiatives that aimed at changing the operative approach of the Bank to development assistance. The Bank also became more open and collaborative in the way it worked with other institutions, public and private, in enhancing the scope and the delivery of development assistance. Some of the most often discussed initiatives are the Comprehensive Development Framework (CDF), The Global Development Network and the Development Market Place.

The core element that unified Wolfensohn’s initiatives was the premium placed on knowledge as the main driver of an emerging new economy of development. The Bank at this time ‘attempted to organize its knowledge activities systematically [while] Wolfensohn pushed to make sure the Bank improved its own understanding of the role of knowledge in development’ (Leautier, 2005:98). A Knowledge for Development Program was designed as the basis of a new way of interacting with developing countries and to help them in strengthening their own systems and improve competitiveness. What the programme pointed to, more than anything else, was that the nature of development engagement was changing as far as the World Bank was concerned. Developing countries were required to evolve in the same direction and ‘participate effectively in the knowledge-driven supply chains and markets that now dominate the global economy’ (Leautier, 2005:98-99).

In his address to the Board of Governors at the Annual Meetings of the World Bank and the International Monetary Fund in October 1996, Wolfensohn’s call to other development institutions was for ‘a specific form of partnership that will take on a special importance as we enter the new millennium: a partnership for creating and sharing knowledge and making it a major driver of development…our unique reservoir of development experience across sectors and countries, position us to play a leading
role in this new global knowledge partnership’ (World Bank, 2005: 52). Subsequently in 1999 the World Bank president had an opportunity to elaborate on what he thought the nature of development partnerships should be:

We need to build coalitions for change: coalitions with the private sector, which will bring investment, create jobs, promote the transfer of technology and skills, and foster social responsibility; coalitions with civil society and communities, to mobilize the kind of grassroots support we have seen behind the debt-relief campaign and extend it to health, to education for all, to participation, and to poverty reduction; coalitions with governments, to assist them in taking charge of their own development agendas with the participation of their citizens. Coalitions with each other, to put an end to the turf battles, the waste and the duplication; coalitions with religious communities, with trade unions, and with foundations, to benefit our common work; coalitions of commitment to the seven United Nations pledges on sustainable development, gender, education, infant and child mortality, maternal mortality, reproductive health, and the environment. I pledge to you our intention to work with all our partners to help build those coalitions for change so that, when we meet next year in Prague, we will have begun to put in place that new development architecture.  

Wolfensohn’s call for change and for building coalitions with the private sector were clear and specific. It indicated a shift in global thinking: development aid was no longer going to be a one-way disbursement; private sector approaches were being considered for redesigning aid as investment. Malaria Control was one of the earliest areas of development assistance where Wolfensohn made good his promise to work with other agencies across the development community to ‘put in place that new development architecture’. The World Bank was chiefly involved as one of the four leading international organisations that set up the Roll Back Malaria Programme with a strong and very broad partner network. As the programme entered its action phase in 2001 he declared to participants at its fourth Global Partnership meeting:

Here the partnership that we have to build is not an uncommon partnership. It’s a partnership first and foremost with governments. Governments must give this work the priority that it needs and deserves. It needs to be more than a health

priority. It needs to be a priority that is embedded in government policy at all levels and perceived as such…but governments alone can’t do it. It has to be done together with nongovernmental organisations, with civil society in its broadest forms…we need to engage academia, and we need to engage the drug companies and the vaccine companies, and we need to give a focus to this war in which we’re engaged.\textsuperscript{16}

To be sure, the above statement, pointed as it is, is not interpreted as Wolfensohn’s attempt to place developing countries at the mercy of private companies. He argued very strongly, in his keynote speech at the Fifth German World Bank Forum in Berlin, that private companies had a huge stake in contributing meaningfully to development assistance (World Bank, 2005: 261-264). Private sector investment in developing countries was expanding rapidly and they needed to pay attention to development needs in order to ensure stability in these countries and guarantee the continuity of markets. Also the harshest challenges to the relevance of the World Bank and similar institutions were from civil society and they were growing. Wolfensohn was convinced that if the nature of development assistance was not fine-tuned these types of challenges would spill over to the private sector. He cited the examples of McDonald’s, Kentucky Fried Chicken and some oil companies that were already coming under a lot of strain in their public relations. He thus called for a new way of delivering international development assistance that would bring private companies in close working partnerships with civil society as a force for increasing the dividends of development.

The Wolfensohn type of partnership therefore represents a well-considered response to a foreseeable stream of contestation; a quick-thinking rejigging of the relationship between developing countries and their developed benefactors, aimed at reforming the very conceptualization of this relationship. By reconstructing the development architecture to include multifarious new actors, the implication for traditional bi-lateral donors has been that it has been possible to maintain and even increase activity in international development without putting too much pressure on public funds. Creating a route for the entrance of many private companies has however meant that international development has had to grapple with how best to balance the infusion of the profit motive into an area of global relationships that has traditionally been legitimated along

\textsuperscript{16} Address at the 4\textsuperscript{th} Global Partnership Meeting to Roll Back Malaria, Washington, D.C, April 18, 2001. See World Bank (2005) pp.287-290
humanitarian lines. A new legitimacy has had to be constructed, and it is that today’s global markets are fast-paced and knowledge driven; the solutions to many of the world’s problems exist not in Western political mechanisms but in the knowledge driven markets that sustain them; transferring these knowledges and technologies to the African situation points to a global commitment to helping Africa find lasting solutions to its problems.

Many of the current initiatives in malaria control today are thus managed by private concerns that operate as ‘partners’ in the effort to control malaria. For instance to create A2S2 (Assured Artemisinin Supply System), WHO and the Medicines for Malaria Venture (MMV) organised a conference in Guilin China in November 2008\textsuperscript{17} and the outcome, A2S2, was a funded initiative by UNITAID to be managed by i+solutions, Netherlands; FSC Development Services Ltd, UK; Artepal project, France; and Triodos Sustainable Trade Fund, Netherlands. Roll Back Malaria and WHO continued to provide guidance.

The infusion of the profit motive into development assistance is not in itself problematic but its structuring reveals a problematic objectification of Africa. The malaria problem is simply analysed as requiring therapeutic and technical responses and those responses are seen as sufficient assistance to malaria endemic countries; at those points in the process where private firms are enabled to reap large profits, the pendulum swings away from the continent. An era of development assistance is thus emerging in which the profitability of these development assistance programmes will constitute an incentive to maintain them and hence maintain the problems that they purport to address.

In Nigeria the National Malaria Control Programme (NMCP) has quite a broad based partnership network which is generally described as vibrant and quite successful. Its essence was explained to me by one of the WHO representatives in Nigeria:

\begin{quote}
I will just give you an example to show that we have a very strong partnership within the country. In 2007 the way nets were distributed in this country was to tag net distribution to immunization programmes. We had these special immunization days we called IPD but the partners came together and said we’ve done this IPD for more than a year and we are still [in the range of] 4-5% ownership in terms of
\end{quote}

\textsuperscript{17} See A2S2 website http://www.a2s2.org/index.php?id=48 (accessed 22/10/2012)
net. So we had this meeting in 2007. First of all, Nigeria had a policy change to universal coverage, so the partners saw that as an opportunity and we came together to support Nigeria in that area. We had donation of nets; out of the 63 million the partners donated 54 million. They didn’t only do that, they developed a comprehensive plan for net distribution. We brought in technical assistance in the various areas like in logistics and demand creation. The DFID/SUNMAP was the secretariat for all partners as far as that project was concerned and the success we have recorded today was as a result of that partnership, that initial meeting and deliberations that we had to actually move this forward.

Nigeria’s malaria control programme has been supported a lot by the partnership, by coming together. Coming together also helps us in the area of harmonization; like I just told you about the nets now, there was no duplication, there was no wastages because we all sat together and harmonized the plan that the government had for the country and we were able to say “I will take this state; you will take that state.” So invariably you will hear people talking about World Bank states; Global Fund states; they are Nigerian states not our states. What they are saying in essence is where our presence is and things like that.

We have also done that basically in putting in place logistics management systems for the country; they’ve not finished but they’ve gone a long way from where we started, in building that system. Before now, distributing things was so haphazard, you couldn’t even follow; you couldn’t have consumption data from facilities and all these things. We are almost there; we are not there perfectly like we would have loved but it was a joint thing between USAID/JSI (John Snow International) championing it; the rest of us that were not providing the technical skills were providing the fund to be able to do it and things like that…so I think the partnership has been very helpful to Nigeria; I hope Nigeria also can sustain it; sustain it in the sense of giving the partners also the encouragement. Partners can’t take over what the government of Nigeria should be doing; the government itself should provide the leadership that is needed for this partnership to work but I will say it has worked. I’ve been on HIV, I worked on HIV projects before but HIV too is solid now as far as partnership is concerned. At the beginning partners were just

18 IPD is an acronym for Immunization Plus Days
going this way and that way but I think everybody is coming together now and it is very strong.  

Extolling the virtues of external partnerships in this way does two things at least: it suggests the vast improvements that are possible if the channels are kept open for external actors to continue to play significant roles in Nigeria’s development activities and it also rationalizes this kind of full cooperation as effective policy on the part of Nigeria. There is however a tendency for the country to be so enamoured by the apparently advanced approaches delivered by foreign partners that it loses the ability to project the problem unto a national consciousness. With such a projection, the urgent task of dealing with the problem manifests in a re-examination of many aspects of socio-economic life. But this is not happening in the current situation. Efforts have become overly focused on how to coordinate multiple partner activity and maintain visibility in the extensive maze of projects taking place on the ground. This tendency was alluded to in the recent testament by the Coordinator of Nigeria’s malaria control programme. In explaining why malaria control in Nigeria should be regarded as successful, she expressed that the partnership network in Nigeria ‘is now robust and quite effective. The NMCP ensures good coordination of all partners’ activities and we have good plans and a clear framework for action, planning and programming together. This is probably the most important key to our success’ (WHO, 2012b:23). What this means in essence is that the recent successes that have been achieved in Nigeria’s malaria control have been possible because the country is getting better at coordinating what partners do in the country. Partner presence has not in itself improved the way internal country systems work.

In its implementation, the partnership approach is coordinated at a level of power that is able to assure continuity. It is harmonized and coordinated at three levels: the first and the most strategic level is at the level of the ATM committee – Aids, TB and Malaria committee that is chaired by the Minister of Health. At that level all the partners that are active in Aids, Tuberculosis and malaria (at the level of country directors) convene for quarterly meetings. In Nigeria these started out as monthly meetings but have become quarterly as things have settled a bit more into place. The ATM committee discusses all the strategic coordination issues around these three diseases including use of health system strengthening. The second most important level in malaria is the TWG malaria

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19 Interview 3, WHO official, UN House, Abuja, Nigeria, 19/08/2011
(Technical Working Group malaria). Here the technical officers of the partnership come together and nominate a chairman who directs the affairs of the TWG malaria. TWG malaria is fed by some working groups or sub-committees i.e. the intervention area sub-committees that exist for case management; Integrated Vector Management (IVM); Monitoring and Evaluation (M&E); Procurement and Supply Management (PSM); Programme Management; Advocacy, Communication and Social Mobilization (ACSM). Partnership communication flows bi-directionally from and to these sub-committees as many of the malaria partners are entrenched in them and attend their meetings. These structures of power are also replicated at state level.

Civil servants involved in different areas of implementation also express that the partnership approach is helpful for similar reasons. One participant said it’s helping because different organisations bring different things to the table: ‘instead of duplicating the programme you see other people taking it individually, so it’s really helping.’ The fact that there exists this environment that accommodates a multiplicity of agents is what is in itself considered helpful. The belief is that if this multiplicity is sustained over time malaria will certainly be conquered at some point. The qualitative assessment of those efforts and how impactful they are over the long term is really not considered.

Many partners are highly selective with regard to where they locate their operations within the country. Because of their abiding focus on commercialization and demand creation, as well as a strong need to stimulate private sector participation, they tend to prefer more highly populated commercial centres like Lagos, thereby creating a problem in terms of the evenness of partner distribution. This was explained to me as ‘part of the communique from a meeting where we tried to look at how to make the health interventions work better because there were some complaints. At the point when we tried to do mapping of partners in the country we could see the lop-sidedness of it: you had all the partners [falling over] themselves to intervene and then you had several states with virtually no partners there at all and it shouldn’t be [the case].’

The various ministries in the country are working together more than they used to and this seems to be improving the situation but only gradually. SUNMAP’s original six state presence for instance ended up being a compromise between the need for

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20 Interview 15, Federal Ministry of Health official, Abuja, Nigeria, 18/10/2011
commercialization and the need for even spread. One of the programme’s Directors explained this to me as follows:

Yes it cuts across, and the justification for selection of the states relates to areas where there are two considerations: one, existing areas of gap at the point at which we were looking at resource availability for malaria control. At the point at which the programme was initiated, these were states where they had very low partner presence so there was suggestion that we moved there but beyond that, in three of the states namely Lagos, Anambra and Kano there were other considerations as relates to commercial sector activities in those states because part of the programme strategy was looking at ways of boosting or strengthening a commercial sector or private sector involvement in malaria control.21

Highlighting the debate around the way partners choose their location within the country emphasizes the complexity of Nigeria as a setting and hence the enormity of the work of controlling disease of any kind. It further reinforces the idea that Nigeria cannot undertake the task alone. Commenting on the impact this partnership approach is making to malaria control, another participant from the Ministry of health told me she’s had cause in the past to complain about the selectivity of partners who seem to have an unhindered ability to pick and choose what they do:

It depends on how you look at it: I’ve been at a forum where I’ve had to argue that some of the problems we have in the health sector are caused by partner opportunism. Partners come with a defined mandate to support a specific activity. For instance when a partner comes to support a malaria programme to the exclusion of the others, what we try to do is to create a vertical line of looking at that, because unfortunately the department that looks at malaria control is different from the one that looks at mother and child; when you want to make impact in malaria control you have to look at mother and child because that’s where you are going to have your impact. And if sometimes in child health for instance I want to do a programme and I [include] the same partner he will tell me he does not have mandate to do child health but he can support malaria control. So that took a long time again for understanding to come. If you support training for child health for instance, you are still supporting implementation of malaria control but you know,

21 Interview 1, Support to Nigeria’s Malaria Control Programme (SUNMAP) Official, Abuja, Nigeria, 15/08/2011
when you talk of integration, it takes a long time to come because the understanding is different.\textsuperscript{22}

This kind of selectivity is of course not a very appealing prospect for government officials who want to get as much financial support for their programmes as possible. Some of them have devised an ingenious way of getting around the problem: ‘in my department I get funding for dealing with children and also for dealing with reproductive issues; malaria is just a component. Perhaps we interface on things; if you need to do an activity for instance and you don’t have enough funds you can approach the Roll Back Malaria programme for support, financial support, and try to link what you are doing with malaria. We’ve done that a couple of times especially for child health, case management training, community intervention and general programme management.’\textsuperscript{23}

In this sense partner organisations have become something of an extended arm of the health system. Even government ministries think of them as having sufficient resource that can always be accessed if they are able to come up with good enough proposals. This increases the power quotient of such bodies; an outcome which is intensified by the fact that on the specific programmes they choose to fund, they appear to be spending much more money than the government. Another element of frustration for public officials is that partner selectivity interferes with the comprehensiveness of their work, as this participant explained:

For the child health programme manager it’s a problem; I don’t want to save a child from malaria and lose the child to pneumonia. I think you know the way it is: partners move where it is very easy to document results and to quickly say how many nets you’ve distributed; how many ACTs have gone to this site [or that site]; it’s easier to measure and then you want to quickly document results and say LLIN, blah; blah; blah.\textsuperscript{24}

The rigidity of partners was also expressed as a problem. With the partner approach there is almost no room left for manoeuvre between field expectations and actual field situations. Partners are often very inflexible to variance. Upon arrival into the country, partners declare their intended focus and will often not go beyond that mandate under

\textsuperscript{22} Interview 15, Federal Ministry of Health official, Abuja, Nigeria, 18/10/2011
\textsuperscript{23} Interview 15, Federal Ministry of Health official, Abuja, Nigeria, 18/10/2011
\textsuperscript{24} Interview 15, Federal Ministry of Health official, Abuja, Nigeria, 18/10/2011. LLINs are Long Lasting Insecticidal Nets; ACTs are Artemisinin Combination Therapies
any circumstance. They are understandably constrained by the fact that their mandate is a strictly documented one which they receive after registration with the national planning commission. It spells out their areas of operation as well as the focus of their intervention. But the real problem, as my participant explained to me, is that the agencies that have the mandate to admit partners and NGOs into the country are far removed from the health ministry. The health ministry has tried to remedy this by putting up a memo to demand health representation in the National Planning Commission so that when partners apply for registration, their proposals can be thoroughly scrutinised and some guidance on which interventions they can be made to accept, or suggestions on adequate and effective placement can be offered by relevant officials in the health ministry. In the usual tendency for each government department to closely guard its own brief, the memo of the health ministry was rebuffed as likely to produce a duplication of efforts.

Although some health ministry officials feel that government should step in to streamline agencies and weed out inflexible ones or the ones whose priorities do not match the current focus of government, the reality is that these partners have become vital to the government in a wider context; collectively, they have become woven into the macro-economic tapestry. They create jobs and they are able to absorb the best brains. This means there’s less restlessness in terms of graduate unemployment; they provide further training and also inject some investment into the economy. All these help to obscure part of the weaknesses of the state, so its position has become one of ‘the more the merrier’. There’s also a sense in which creating a stringently regulated intervention environment does not augur well for the state: it could make the government appear to development agencies as unserious.

**Conclusion**

The protean nature of development assistance is very well demonstrated in the dynamic history of malaria control in Nigeria. Pre-colonial communities in the country had various methods of managing the disease. The advent of colonialism exposed European administrators to virulent strains of the disease without the natural immunity that adult populations in the country had developed over years of living with malaria.

The threat to the colonial mission that this very high susceptibility of Europeans posed brought about the earliest forms of organised anti-mosquito work by 1900. This threat
also meant that substantial focus was maintained on the malaria problem by colonial medical officers motivated, more than anything else, by the need to remove the hurdle to the colonial incursion into the hinterlands in overseas territories.

Decolonization substantially reduced this motivation at the same time as the United Nations multilateral system was fashioning the shape of its engagement with the Third World. The outcome of the process was significantly influenced by the ideological tension between Capitalist Western countries and the Communist East. Development assistance programmes became influenced by the need to channel funds towards propping up Third World governments that were more amenable to the West and thereby check the spread of Communism.

Consequently, insufficient global attention was paid to such concerns as malaria control. It suffered serious setbacks and the gains of the past were reversed by growing parasitic resistance to chloroquine, a drug which had for many years offered cheap and effective treatment against malaria. The 1990s ushered in the end of the Cold War and the philosophy of development engagement was re-articulated. Since that time, there has been a quadrupling of funding for malaria control, with US$ 4.5 billion of external assistance committed globally between 2003 and 2009 alone.25

The global economy also became re-modelled as a knowledge economy that the Third World needed to become an effective part of in order to survive into the future. The expectations of the Third World from international development were altered: recipient countries were being urged to ‘formulate a national strategy to narrow knowledge gaps and promote domestic R&D to make it more responsive to the markets’ (World Bank, 1999: 144-5).

Malaria control has had to be reformed to suit the new dispensation in development engagement. The major global organ coordinating malaria control efforts today is a partnership (the Roll Back Malaria Partnership) that brings together several organisations that cut across public and private spheres to ensure that lasting solutions are found to the problem of malaria. Although the extensive involvement of private companies has meant an infusion of the profit motive into development assistance, this is hardly politically contested as Nigeria and most other recipient countries have been.

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conditioned to this approach as an ideal way of dealing with the problem if agreed targets such as the Millennium Development goals are to be met.

The commitment that African leaders have given to support the partnership model does not have a ‘get out clause’. There is no point at which they are empowered to reverse the trend if they think it is not working for them. If anything, the extent of private sector involvement is set to increase. This is substantially borne out in the recent rhetoric on development filtering out of the United States especially. The United States has in the last decade promoted a Global Development Alliance (GDA) which ‘is a market-based business model for partnerships between the public and private sectors to address jointly defined business and development objectives.’ Rajiv Shah, the Administrator of USAID said of its tenth anniversary, ‘this week, we’re celebrating ten years since the creation of the Global Development Alliance. We’ve formed over 1,000 partnerships with over 3,000 private sector players-companies like Microsoft, General Mills and Coca Cola.’ What this comment indicates is the increasing relevance of the private sector in the future structure of development assistance, a trend which the US is not alone in demonstrating; as shown above, a report in The Guardian of Friday 3 June 2011 by Claire Provost and Liz Ford shows the UK reformed the Commonwealth Development Corporation’s business plan mainly to boost private sector participation in future UK international development activity.

The mass of private companies Shah alluded to may also explain the shift in nomenclature from donors to partners. ‘Donors’ became something of an unwelcome terminology among private firms and might have limited their willingness to invest capital into the development agenda. In a sense, the spread of partnerships of this nature appears to be a precursor to the full-scale privatization of development. The burden of development assistance has hitherto been more or less borne by governments. While some large private companies and Foundations engage directly with developing countries, many others have contributed by channelling funds through the UN multi-lateral system. This system suited the Cold War years well as aid at this time had more geo-political than developmental ramifications. The post-Cold War development architecture is one in which Western governments are seeking to pull further back and let the private sector engage fully and in a much more direct way. This much is revealed

27 “Embracing Enlightened Capitalism,” remarks by Dr Rajiv Shah, Administrator, USAID at the USAID Public-Private Partnership Forum, Washington, DC October 20, 2011
in a recent pronouncement by the former US Secretary of State, Hillary Clinton: speaking recently at the Clinton Global Initiative, she declared “you cannot have development in today’s world without partnering with the private sector”\(^\text{28}\) Also the pace of integrating the private sector into international development continues to grow with USAID at the forefront. Partnering with Devex, an online development community, the agency recently set up a platform with the single-minded purpose of bringing business and development professionals together. On the occasion of its launch, Raj Kumar, president of Devex expressed that “the private sector is moving into development so quickly that few institutions have had a chance to adapt.”\(^\text{29}\) This clearly underscores the fact that the overriding consideration in the transition that is taking place is how quickly the private sector can become a dominant player in international development initiatives.

In order that this transition is exposed to as little political contestation as possible, the entire philosophy of development assistance is being re-articulated. Rajiv Shah further stated in his speech that ‘as President Obama’s first-ever Policy Directive on Development made clear—and Secretary Clinton’s Quadrennial Review of Diplomacy and Development operationalizes—foreign assistance has to evolve once more. Amidst the seismic changes in today’s world, aid shouldn’t serve as a substitute for private capital. It shouldn’t just improve health statistics. It should prioritize broad-based, sustainable economic growth that can boost incomes, create jobs, and reduce poverty, including right here at home. President Obama launched an effort called Partnerships for Growth emphasizing that American engagement—if deployed creatively—could help catalyse private-sector investment in countries best positioned for future growth.’\(^\text{30}\)

The implications of this change in US policy, especially with the emphasis placed on ‘creative deployment’ are predictable: with the involvement of private capital, what the US calls ‘partnerships for growth’ will not simply mean partnerships for the growth of recipient economies; international development partnerships will become a particular type of enterprise and they will be justified on the basis of a logic that returns profit.

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\(^{29}\) Pete Troilo, “USAID and Devex create new platform linking business and development professionals”

\(^{30}\) “Embracing Enlightened Capitalism,” remarks by Dr Rajiv Shah,
For malaria control, the likelihood is that this shift toward increased private participation in international development interventions will continue unabated. If anything, malaria control represents the best candidate for this kind of shift. The markets for the bio-medical products approved for use are predominantly in endemic countries, a good proportion of which are in Africa. There is also a universal need on the continent for these products, as they are required across all the demographic segments either for treatment or as prophylaxis. What the government in countries like Nigeria can do is begin to work out how best they can be positioned to benefit economically from this emerging trend.
Chapter Four

Malaria Control and the Emerging Discourse of Seriousness

Introduction

The obituary of J.W.W. Stephens, published in the *Obituary Notices of Fellows of the Royal Society* in 1947 focused on his outstanding contribution to the development of tropical medicine, especially blackwater fever and malaria. As a member of the Malaria Commission of the Royal Society and Colonial Office, Stephens travelled extensively through Africa researching these diseases. In often inclement conditions the Commission made temporary camps for themselves in bush clearings made around railway construction sites, eking out rations by shooting pigeons and game. Amazingly (for that period), as declared in the obituary, ‘neither worker in the whole of a year spent under such conditions contracted malaria, a result undoubtedly due to the extreme care employed in the use of the mosquito net and other protective measures’ (Christophers, 1947: 527)

Although quinine was already in use during this period, by resorting to net use Stephens and the Commission adopted a measure that was generally considered a very sensible protection against malaria. Relative to the death rate among Europeans the protection the nets offered for a whole year was quite significant. Nets are still very widely used against the mosquito today but technologies have evolved several times over since the early 20th Century. The battle against malaria is fought today from a number of fronts. The main antimalarial measure is currently the widely distributed artemisinin combination therapies (ACTs). This chapter will in effect do two things: one is to take a look at three case studies of anti-malarial measures in Nigeria vis-à-vis the use of mosquito nets which have always been around but have undergone technological improvement over time; the current large scale distribution programme for ACTs and the case being made for rapid diagnostic tools as the future of malaria control. The second thing that the chapter does is to look critically at the way these programmes are being operated and the roles played by national and international actors. The chapter
concludes that what emerges from this kind of scrutiny is a discourse of seriousness in which national actors are driven to particular actions and forms of responses on the basis of a compulsion to demonstrate seriousness to global actors. The way this compulsion is generated and strengthened as well as its implications for development assistance will also be examined.

The interest in discourse follows the tendency in a large body of work (collectively referred to as post-development theories) to move beyond contextualizing development according to how it is currently practised.\(^1\) They question the strong linkage of development to the Western idea of modernity and argue that development thinking and practice represent an organised way of keeping small countries firmly attached to the modernity project. Discourse is thus crucial to the arguments in this chapter as it explores the dynamic between international development and the state in Nigeria in the area of malaria control and attempts to understand the events that occur as the interests of the two converge at what one may call the crossroads of development. The discourse of seriousness also represents an important paradigm in the sense that post-development theory does not provide an analytic framework for understanding how the discourse of development is actually operationalized. This is the gap in the literature that this chapter proposes to fill.

The extent to which Western approaches can be foisted on poor countries without attracting criticisms from various advocates of self-determination is limited. The linking of official development assistance to structural adjustment programmes in the 80’s was broadly criticised as eroding national sovereignty (Loxley, 1990) and imposing a neoliberal burden (Rowden, 2009). Conditionalities shifted in the 90’s to the promotion of democratization but has also been criticised as achieving limited results (Browne, 2006). What is therefore emerging from development relationships today is a reluctance to be seen as assigning conditionalities to development assistance. There’s a move away from conditionalities towards a regime which demands that developing countries demonstrate a serious-mindedness in their capacity to effectively utilize disbursed funds. The end of the Cold War has diminished the need to use aid disbursements for ideological conditioning; the current emphasis is on ‘system strengthening’ which urges national systems to demonstrate serious result-oriented reforms in their operational

\(^1\) Some of these have been cited in chp1. They include Ferguson, 1990; Escobar, 1984, 1995; Hobart, 1993; Gardner and Lewis, 1996; Fairhead, 2000; Mills, 1999.
mechanisms. As I have shown in chapter three, emerging trends in especially US aid policy is infusing the profit motive into how international aid will be structured in the future. Conditionalities will hardly be required in this scenario: recipient countries will predictably be disciplined by a culture that compels them to attract interventions by an ability to demonstrate how it will yield profit or how it will create markets.

The attempt by national systems to conform to global expectations of seriousness has meant that they are not in a strong position for contesting whatever is promoted by global actors as better approaches. This remains so even when those globally sponsored programmes do not promise much in terms of a long-term potential to turn things around. The effect of this enforced acquiescence is explored in the following case studies.

**The Political Economy of Long-lasting Nets**

Of all the measures deployed against malaria and its vector, the female *Anopheles* mosquito, the use of mosquito nets probably has the longest history. Sir Patrick Hehir was able to trace a mention of them to one of the earliest known works of history in Western literature: the Histories of Herodotus, according to which marsh Egyptians had a peculiar contrivance ‘to protect themselves from the musquitoes (*sic*), which abound very much. The towers are of great service to those who inhabit the upper parts of the marshes; for the musquitoes are prevented by the winds from flying high; but those who live round the marshes have contrived another expedient instead of the towers. Every man has a net with which in the day he takes fish, and at night uses in the following manner: in whatever bed he sleeps, he throws the net around it, and then getting in, sleeps under it; if he should wrap himself up in his clothes or in linen the musquitoes would bite through them, but they never attempt to bite through the net." (II, p.94 cited in Hehir, 1921: 529).

Herodotus wrote in the 5th Century BC and it is unclear from this passage if the marsh Egyptians made a connection between mosquito bites and any form of disease; they might thus have used nets to shield themselves from the discomfort and irritation of the unrelenting mosquito bites. The connection to malaria came much later in 1897 when Ronald Ross, a Surgeon-Major in the Indian Medical Service, published his discovery of the malaria parasite in the *Anopheles* mosquito. This was an advancement of the
work started by Alphonse Laveran who in 1880 discovered the parasite in malaria patients.\textsuperscript{2}

With the definitive linkage between the mosquito and malaria, control measures evolved rapidly: swamps and other breeding grounds were drained and chemical agents such as arsenic and kerosene were used to target the mosquito larvae and adult mosquitoes (Young, 1966). But ‘unless vigorously pursued, these methods were only moderately successful. The costs of control were high and recurred annually’ (Young, 1966: 6). Nets thus continued to be used by many individuals to protect against the disease. This was especially so in African countries as the continent was excluded from WHO’s global eradication programme in the mid-fifties.

In the absence of major international control programmes, some participants recalled that household measures such as the use of insecticide sprays became increasingly popular in the 60s and 70s and are still in use today to augment publicly run control measure. To increase protection, households would spray insecticides to kill the mosquitoes that were already lodged indoors and then cover-up with nets (where available) when going to bed. For reasons associated with cost, many families could ill-afford the insecticides and would spray them in small measures to make each can last longer. This started to reduce the effectiveness of some of the available brands in the market and if a newer, more effective brand was launched it cost even more. Net manufacturers however found a way of pre-treating nets with insecticide from the factory and this brought about the era of the insecticide treated nets (ITNs). Uptake was however low in Nigeria before the advent of the Roll Back Malaria Partnership in 1998/2000.

Roll Back Malaria has been mainly responsible for the renewed interest in ITNs by determinedly advancing a Global Malaria Action Plan (GMAP) that aimed to distribute 730 million nets globally, about 350 million of them in Africa by 2010. The spotlight is also maintained by the Millennium Development Goals under target 6(c) where WHO urges, among other measures, the reversal of the incidence of malaria through prevention with long-lasting insecticidal nets.\textsuperscript{3} Accordingly many malaria control

\textsuperscript{2} His paper was accepted on the 11\textsuperscript{th} of March 1881 – see Bruce-Chwatt (1981) “Alphonse Laveran’s discovery”.

assistance projects such as the World Bank’s Booster Project and DFID’s SUNMAP have incorporated net distribution into their plans.

Nigeria’s National Malaria Control Strategic Plan 2009-2013 was tailored after the GMAP and it similarly emphasised prevention as key, especially against vectors. The main strategy under the Integrated Vector Management (IVM) approach within the control programme is the use of insecticide treated nets. Indoor Residual Spraying (IRS) and Larviciding (or source reduction) also feature in the IVM approach but perhaps due to cost related issues their deployment is limited relative to insecticidal nets. Pregnant women and under-5s are particularly targeted with nets as the most vulnerable groups. A pilot project was carried out in Nsukka in 1992 the success of which encouraged the roll out of insecticide treated nets in other states through the ITN Massive Promotion and Awareness Campaign (IMPAC). This was a strategy designed to ensure that the nets get to the vulnerable groups already identified; the nets were used to incentivise pregnant women and attract them to health centres. The opportunity provided by such visits was then seized to persuade them to access other health interventions such as immunization and other ante-natal services.

Following the success of IMPAC, insecticidal net programmes were rolled out in a number of states and net ownership increased (NMCP, 2005). There were however some setbacks in the uptake of nets in the community: many users complained that it is too warm under the nets and therefore very uncomfortable. The officer in charge in one of the primary healthcare facilities in a local government area told me that the nets are not supposed to pose this problem and that the people who complain of the heat probably sleep in poorly ventilated rooms. This brings to the fore one of the problems with the technical approaches taken to deal with malaria: the problem of poverty defines the socio-economic context in which the programmes are implemented and no matter how sound the technical solutions may appear to be, they can and are often countered by the reality of poverty. In this case, because the reality that many poor people find themselves in is that their ventilation problem will be complicated by the nets, many simply don’t use them. If the rooms are not properly ventilated, somehow there is the sense that it is the fault of the occupant who possibly doesn’t appreciate the benefit of cross ventilation. This sort of problem is not easily tied to poverty and the state does not seem to see a role for itself in organising housing and enforcing building codes in a way that avoids this problems. In Lagos for instance, it is easier for the proverbial Carmel to
go through the eye of a needle than for someone who is not ‘well connected’ to get planning permission. What a majority of people do is to build their homes anyway and worry about planning permission later. It is not uncommon for fully built homes to have their application for planning permission still pending approval several decades after completion. Some users also complained of getting skin rashes from contact with the chemical treatment to the nets and again this accounted partly for why they would not use them.  

In a 2006 study carried out in Kwara state in Nigeria, Musa et al found a number of other reasons given by respondents for not using the insecticide nets (see table below). As shown in the study, 27% of current users declared they had difficulties with retreatment chemicals for the nets. This was a widespread problem with the initial grade of ITNs that were launched into the market; they had to be re-treated every six months to retain their efficacy. Even though retreatment kits were available in the market many users who could not afford retreatment simply abandoned the nets at the expiration of six months. Government sometimes embarked on retreatment campaigns (incurring logistical costs) with limited coverage and individuals who could afford to, procured retreatment on their own. A technological advancement helped to ease the problem of retreatment as it became possible to impregnate nets with at least three years guaranteed efficacy; as such the nomenclature changed to Long-Lasting Insecticidal Nets (LLINs).

The change in name from mosquito nets to bednets (as innocuous as that may seem) had in 1993 prompted one Derek Charlwood in Tanzania to write to the Journal Parasitology Today to express how confusing he found the change. ‘When I was growing up [he wrote], a net that stopped someone from being bitten by a mosquito was called a 'mosquito net'. I believe that that is still the name that a layman would use. It seems as though entomologists working with these nets for a time didn't know what to call them. Now in my dotage, I find them called 'bednets' most of the time. Why aren't they called mosquito nets anymore? Is this a case of scientific obfuscation’?  

When in 2007 WHO issued a position statement advising a shift to long lasting nets perceptions of obfuscation were stirred, as one of the programme managers involved in

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5 Derek Charlwood (1993) “Mosquito nets by any other name”, Parasitology Today, Vol.9, no.4
the net distribution told me; he also added that he only mentioned this ‘as a Nigerian, not as a programme manager’.  

**Table 3 – Reasons for Low ITN Uptake**

<table>
<thead>
<tr>
<th>Difficulties Experienced by Current Users of ITN</th>
<th>Frequency (%)</th>
</tr>
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<tbody>
<tr>
<td>Scarcity of new ITN</td>
<td>17(19%)</td>
</tr>
<tr>
<td>Lack of chemicals to re-treat ITN</td>
<td>24(27%)</td>
</tr>
<tr>
<td>Experienced excessive heat under ITN cover</td>
<td>38(43%)</td>
</tr>
<tr>
<td>Available ITNs are poor quality</td>
<td>12(14%)</td>
</tr>
<tr>
<td>ITN harbours dust</td>
<td>19(22%)</td>
</tr>
<tr>
<td>Most ITNs are fragile and tear easily</td>
<td>9(10%)</td>
</tr>
<tr>
<td>Expired ITNs are on sale</td>
<td>7(8%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reasons for stopping ITN use among ever used</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feel uncomfortable under ITN cover</td>
<td>9(25%)</td>
</tr>
<tr>
<td>Problem of re-treatment of expired ITN</td>
<td>11(30%)</td>
</tr>
<tr>
<td>No replacement for torn or worn out ITN</td>
<td>6(17%)</td>
</tr>
<tr>
<td>Feel hot under ITN</td>
<td>5(14%)</td>
</tr>
<tr>
<td>No specific reason</td>
<td>5(14%)</td>
</tr>
<tr>
<td>Total</td>
<td>36(100.0%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reasons for not using ITN (multiple response N=331)</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ITN is too expensive</td>
<td>26(8%)</td>
</tr>
<tr>
<td>Not aware of ITNs</td>
<td>136(41%)</td>
</tr>
<tr>
<td>ITN not available for purchase</td>
<td>67(20%)</td>
</tr>
<tr>
<td>Believed ITN is ineffective</td>
<td>20(6%)</td>
</tr>
<tr>
<td>Don’t know where to purchase or get ITN</td>
<td>56(17%)</td>
</tr>
<tr>
<td>Thinks it is not comfortable to use</td>
<td>47(14%)</td>
</tr>
<tr>
<td>No specific reason</td>
<td>23(7%)</td>
</tr>
</tbody>
</table>

*Source: Musa et al (2009)*

The popular sentiment is that WHO’s position statement was only a response to the vastly increased local ability to convert ordinary nets to insecticide treated nets so that not just ITNs were being retreated but many enterprising individuals had deciphered the technology and were offering services based on making ITNs of any net.

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6 Interview 7, National Malaria Control Programme State Support Team, distribution point, Bariga, Lagos, 10/09/2011
The WHO statement was clear; it read in part,

WHO/GMP calls upon national malaria control programmes and their partners involved in insecticide-treated net interventions to purchase only long-lasting insecticidal nets (LLINs). LLINs are designed to maintain their biological efficacy against vector mosquitoes for at least three years in the field under recommended conditions of use, obviating the need for regular insecticide treatment (WHO, 2007: 1).

The clear direction that only LLINs should be purchased provided a basis for questioning the real objective of the change; the only difference between the old ITNs and the LLINs was the duration of efficacy. While the former lasted 6 months the latter remained efficacious for 3 years. In other words, within that six month window, ITNs worked as effectively as LLINs. If universal coverage was truly considered crucial it should have been possible to advice the continued deployment of ITNs in areas where LLINs were considered unaffordable or where implementation was delayed for logistical and other reasons. This was a particularly compelling logic considering that the 63 million nets intended for distribution was, quite apart from not being sufficient for universal coverage, already a logistical challenge. The pilot phase of the distribution campaign was started in Kano in 2009. With Kano’s 44 local governments and being the largest state in Nigeria it made sense to the programme managers to start there so that crucial lessons could be learned. The first lesson learned was how logistically daunting the distribution was going to be. The decision was taken to split the campaign in Kano into two with the first phase running in May and the second in August of that year. By September 2011 when I was monitoring the campaign in Lagos, close to a quarter of states in Nigeria were yet to be covered. It thus appeared that the nets distributed in Kano two years earlier were going to hit their life span before the entire country would be covered; I asked one of the programme managers what the plan was, regarding Kano. His answer conveyed doubts about replacement:

In the strategic plan, we have a plan for what is called replacement of the nets but of course you know that has a lot of challenge. Even this current one that we are distributing through the universal campaign is driven majorly by the donors – Global Fund. Can you be able to get another 63 million nets or half of that to replace? Though the replacement is phase by phase we expect that we should start
replacing the nets in Kano and Anambra next year May. But of course that is the challenge we have; the plan is there but how are we going to source the nets?7

Such doubts demonstrate the level of dependency on external support required to keep control programmes running. There is often very little internal capacity to support such programmes and external initiatives tend to gloss over internal complexities. There is thus always an underlying worry that programmes will collapse if external involvement is withdrawn.

Another problem with net distribution, which arises out of poverty, is the one in which one household could be made up of upwards of 10 people and this problem seemed not to have been envisaged by planners. There were therefore some peculiar notions of the term ‘household’. According to the 2006 population census there is an average of five persons per household, so the decision was taken to give two nets to every household with a 5% buffer. This had considerable implications in the North which is predominantly Muslim and predominantly polygamous. The approach was to designate each wife as one household with a limit set at four wives. This created logistical nightmares around which wives would be recognised and which ones would be disregarded, not to mention the question of how the disregarded wife (usually the most junior ones) would protect herself and her children from mosquito bites. Also in Lagos state residents were not regarded as households if they were not married; as the distributors knocked on each door the first question they asked was the marital status of the residents and the unmarried ones did not get the net cards which were required to claim the nets.

The distribution logistics were not the only problem; the nets came with instructions for use that many users were completely disregarding: in order to avoid irritation to the skin it is advised that the net must be aired for at least 24 hours before first use. It must also not be aired in intense sunlight; a shaded area should be found for airing purposes. It must not be washed with harsh detergents which degrade the insecticide.8 Compliance has long been a problem for poor rural people who are often unable to read instructions and may forget them after they have been passed on from demonstration centres. The experience with net use is no exception but again, compliance is made more difficult by

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7 Interview 7, National Malaria Control Programme State Support Team, distribution point, Bariga, Lagos, 10/09/2011
8 Popular brands that users are usually cautioned against are Omo and Surf
poverty. Harsh detergents for instance are considered more affordable and cost efficient by many people because they lather more and last longer; it is thus the most likely type of soap the nets will be washed with in spite of the instruction. Some urban settings such as Lagos are high density areas where space is simply an issue that users are unable to overcome. This means nets are simply being aired only in the spaces available for that purpose, which may or may not be shaded.

Apart from improper use of the nets the non-use of redeemed nets is also a problem. Reports of diversions of net use of different kinds abound; I put it to the official I spoke to, that I had been informed of many users selling on their nets in Nigeria and there had also been reports of nets being converted into fishing purposes in some communities in Tanzania and wondered if such reports had been received in Nigeria. His response was:

I’ve never seen it but we have reports of it. I have never seen them fishing with LLINs but we have had reports of it. We have had reports of people using it for wedding dresses. We even had reports of people using it for burial. When I say burial I mean they cover the dead body with it so that flies will not come and disturb it. So we’ve had all those reports, some of them through our stakeholders, partners etc. but I for one has never seen any of those things done; but yes of course we have reports of those things.

These reports are largely unsubstantiated but they point to a growing feeling of scepticism about the mosquito nets. One of the medical doctors I spoke to in a very well established private hospital in Lagos was quite vocal against the net policy. He maintained that if there was sufficient political will the emphasis should really be on preventing malaria through proper environmental management especially with regard to drains, swamps, open sewers and other breeding grounds. He expressed cautiousness about regarding net distribution as a preventive measure. According to him:

The current approach is lackadaisical. The current approach now is the use of mosquito treated nets: It’s a form of prevention but it’s like fetching water in a basket; you disburse nets, you give everybody nets to prevent malaria but the moment you remove that net in the morning the mosquitoes are still there trooping

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10 Interview 7, National Malaria Control Programme State Support Team, distribution point, Bariga, Lagos, 10/09/2011
into your house. Even in the afternoon now they suck blood… the mosquito nets will go a long way but I think environmental sanitation and proper drainage system of the environment will play the highest role. The treated mosquito nets can only act as an adjunct to a clean environment. Until we can achieve very good drainage system in our environment and reduce pollution they’ll just keep spending billions and billions of naira on mosquito nets and it won’t be effective. So there’s need to have good political will that will take care of the environment then we can add the treated mosquito nets as an adjunct to prevent malaria.\textsuperscript{11}

It is interesting that this participant points out that mosquito nets ‘will go a long way’. This is an opinion that is broadly held by many discerning individuals but they are always quick to point out that concentrating resources on net distribution as a priority approach is a wrong measure. As this participant put it, ‘it is like fetching water in a basket’; the effect of nets drains out in almost the same instant it is felt. These sentiments were echoed by a well-respected malariologist in Lagos who is a professor of parasitology. According to her:

Until health is depoliticized in this country we will not make much progress, even with malaria control. Somebody was telling me the other day that Lagos state wants to give out free insecticide treated bed nets. Why not use that money to clean up the environment and make it less conducive to mosquitos. Somebody will take the contract to buy the net; some people get rich on useless programmes. I have never been a fan of mosquito treated nets. I have never been a fan, from the day it was introduced I have said this one is useless so it is not one of the things I advocate for malaria control. Do the obvious, which is cleaning the environment; education; prophylaxis; treatment.\textsuperscript{12}

This response went further than the previous one in suggesting the reason net distribution is prioritized in spite of the limited long-term impact derivable from it. She points to commercial interests as the reason the programme is given so much weight to the detriment of measures she considers more effective in the long-term. This is a contentious point in the way the effect of net distribution is assessed. The programme is a well-intentioned one and there are studies that show that it is yielding results: statistics such as net ownership; net use; percentage of children as well as pregnant women

\textsuperscript{11} Interview 13, medical doctor at a private hospital in Lagos, Nigeria, 12/10/2011
\textsuperscript{12} Interview 8, medical researcher, Lagos University Teaching Hospital, Lagos, Nigeria, 14/09/2011
sleeping under the nets; malaria deaths in areas of net saturation, are frequently taken
and the positive trend in each of these categories form part of the rhetoric of progress in
the fight against the disease. These are all however in the short term. When poverty is
factored into the long term scenario a different picture emerges; insecticide nets become
viewed as a drop in the ocean, a measure that should be no more than an adjunct of
more fundamental action in the area of environmental planning, urban and rural
drainage management, public health surveillance and the overall alleviation of poverty.
Even though many people agree that nets offer protection against mosquitoes when
properly used, the general perception is that they cannot be relied upon to control
malaria in the long run and the intensification of the programme is based more on
creating a market for imported nets than any other consideration. The reluctance to
accept development assistance of this nature at face value, as being purely humanitarian
is not peculiar to net distribution; artemisinin combination therapies have become the
major measure deployed in the fight against the malaria disease today but, as the next
section shows, there are already shadows cast in some quarters over its long-term
motives.

**The Political Economy of Prequalification**

The principal therapeutic weapon against the malaria parasite today is artemisinin based
combination therapies (ACTs). Artemisinin has quite a long history in China, where it is
known as *Qinghaosu* and has been used in the treatment of fevers for hundreds of years.
In 1967, as a counter-measure to malaria casualties in its war in the North Vietnam
jungle, the Chinese government assembled over 500 researchers from across the
medical sciences to find a replacement for Chloroquine in an anti-malaria project known
as Project 523 (Butler et al., 2010: 174; Li, 2007). By 1971 Chinese researchers had
isolated artemisinin from the plant *artemisia annua* (Klayman, 1985: 1049) and by 1974
its efficacy against chloroquine-resistant *P.falciparum* (the culprit parasite in malaria)
had been confirmed in large-scale clinical trials (Butler et al., 2010: 174). Perhaps
because of the closed nature of the Chinese system especially in the Cold War era it
took a while before artemisinin as an antimalarial made it to the global pharmaceutical
mainstream.

Before artemisinin, chloroquine (CQ) was the drug of choice in the treatment of malaria
for many decades. It was discovered in 1934 by Hans Andersag at the Elberfeld
laboratories of the Bayer I.G. Farbenindustrie. It was eventually adopted as the drug of choice for the treatment of malaria in the U.S in 1946 after over a decade-long hiatus (Coatney, 1963). Various tests carried out between 1934 and 1946 had indicated the superior efficacy CQ would deliver over the drugs that were available at the time and indeed it revolutionized the treatment of malaria. It was cheap and easy to administer and also led to highly reduced morbidity and mortality in many countries of high incidence across the Americas, Africa and Asia (Wellems, 2002). CQ remained efficacious for many decades but by and large, due partly to its over-enthusiastic usage in programmes such as salt medication and direct mass drug administration (MDA), the malaria parasite developed resistance to it (Payne, 1988). As drug resistance spread from its first suspected area around the Cambodia-Thailand border across Africa and South America the pharmaceutical industry responded to the challenge with new drugs, Mefloquine and also Sulfadoxine-Pyrimethamine (SP) but they in turn succumbed to parasitic resistance of their own.

Against the background of increasing parasitic resistance to existing malaria drugs the World Health Organisation (WHO) held an informal consultation in Geneva from 10-12 June 1998 to consider WHO policy on the comparative efficacies of available medications (especially Artemisinin) and offer recommendations. Evidence pointing to the higher efficacy of artemisinin in the treatment of malaria was upheld and the danger of mono-therapy identified (WHO, 1998). Another round of consultation in 2000 formally recommended the use of artemisinin in combination with other anti-malarial drugs such as Lumefantrine and Amodiaquine (WHO, 2001a).

Artemisinin combinations are typically available as Artemether/Lumefantrine, Artesunate+Amodiaquine, Artesunate+Mefloquine and Artesunate+SP although other combinations may also be available. Each country generally makes its own decisions, based on country specific health experiences, as to which combinations to issue in its treatment guidelines. The Federal Ministry of Health in Nigeria recommended Artemether/Lumefantrine and Artesunate+Amodiaquine (Federal Ministry of Health, 2005).13

13 National treatment guidelines are predicted to change as newer more effective alternatives become available or the clinical response patterns begin to vary for current options – see Clinton Foundation, 2009
The major advantage that ACTs promised was that they were found to be highly efficacious, leading to very high cure rates even in areas of high parasitic resistance to the co-formulated (or co-blistered) drug. An example is Artesunate+Mefloquine which produced a cure rate greater than 95% around the Thai-Myanmar border even though the area previously had a seasonal recurrence record of a Mefloquine-resistant *p. falciparum* (the parasite implicated in the most lethal form of malaria). Because it is a combination of drugs, it is also effective in countering the spread of drug resistance (International Artemisinin Study Group, 2004).

The adoption of the WHO recommendation of ACTs in Nigeria as in many other endemic countries came after studies had shown parasitic resistance to chloroquine and other alternative therapies at home. In 2002 the Federal Ministry of Health in Nigeria took the decision, with the technical support of the World Health Organization, to conduct malaria drug therapeutic efficacy tests (DTETs) for CQ and SP in each of the six geopolitical zones in the country. According to the test consultants, the purpose was to “provide sound scientific data on the efficacy of the two drugs and evidence from the tests should then form the basis on which the present treatment policy could be reviewed and, if necessary, amended (NMCP, 2002:6).” After a careful consideration of the adequacy of the clinical response to both therapies and their respective treatment failure profiles, as compared to ACTs (table 4), the tests concluded that “response to chloroquine and Fansidar (a brand of Sulfadoxine-Pyrimethamine) has reached unacceptable level practically everywhere in this country and the time has come for us to develop strategies for a change to other drugs (NMCP, 2002:5).” By 2005 ACTs were adopted in Nigeria as first-line treatment of uncomplicated malaria (Federal Ministry of Health, 2005). The advantages they offered over alternative therapies were reiterated in the 2009-2010 drug therapeutic efficacy test reports where ACT fever clearance rates of 90% were recorded in Children 24 hours after the commencement of treatment (a fact the report described as ‘intriguing’) and parasitic clearance rates were up to 95% in children 48 hours after treatment commenced (NMCP, 2010).

The major challenge that ACTs would face in the drugs market was that of cost. Relative to pre-existing drug therapies such as chloroquine and SP, ACTs were seen as very expensive in many parts of Nigeria especially rural areas (table 5) and this is partly related to the high production cost: artemisinin has not yet been chemically synthesised so that it could be readily produced in a laboratory for any volume of the drug to be
manufactured. Manufacturers still have to rely on the raw ingredient which is the plant *artemisia annua*; production therefore depends on the planting cycle every year and the limits imposed by farm yields. The immediate consequence of its cost was that ACT struggled for market share.

**Table 4 – Therapeutic Efficacy of Anti-malarial Drugs in Nigeria** (Adequate Clinical and Parasitological Response ACPR)

<table>
<thead>
<tr>
<th>Zones</th>
<th>Chloroquine*</th>
<th>Sulphadoxine/Pyrimethamine*</th>
<th>Artemether/Lumefantrine**</th>
<th>Artesunate/Amodiaquine**</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 SE</td>
<td>3.7%</td>
<td>14.9%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>2 SS</td>
<td>9.1%</td>
<td>8.5%</td>
<td>87%</td>
<td>82.5%</td>
</tr>
<tr>
<td>3 NC</td>
<td>53.2%</td>
<td>82.7%</td>
<td>100%</td>
<td>96%</td>
</tr>
<tr>
<td>4 NW</td>
<td>77.3%</td>
<td>94.2%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>5 SW</td>
<td>40.9%</td>
<td>75.6%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>6 NE</td>
<td>50.8%</td>
<td>64.8%</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

* 2002 Drug Efficacy Study

Market share was further limited by an oversight which meant that the health seeking behaviour of Nigerians was not taken into account in WHO’s drug policy orientation: public sector treatment policy shifts had been expected to update antimalarial drug prescriptions across the country. But for a combination of reasons ranging from perceptions of ease of access to public health delivery and socio-economic status, the majority of Nigerians seek treatment for malaria privately (Onwujekwe, 2008). In particularly the case of the rural poor, this treatment seeking behaviour is not simply exhibit as a preference but is shaped by the fact that private patent medicine vendors (PPMVs) are far more readily available than public hospital facilities, which many rural dwellers have to travel long distances to get to (Onwujekwe, 2008: 8).

This treatment seeking pattern meant that the private sector continued to be dominant in the ACT supply chain and the relative cost of ACT continued to be the most important factor in the choice of treatment for malaria as many patients preferred to purchase chloroquine or SP for treatment.

As table 5 shows, they were more than 10 times cheaper than ACT. More importantly, they were believed to still be efficacious. This belief was rife even among health professionals, a fact which the author of the DTET report alluded to when he stated that “the irony of these findings is that in all but one centre, Maiduguri, the health personnel
responsible for treating malaria seemed to be pleased with the performance of both drugs [i.e. CQ and SP]. While the clinical impressions of the health stall are useful to know, I do not think impressions should replace scientific facts and the facts here are clear” (NMCP, 2002:27).

Table 5 – Relative Anti-malarial Prices

<table>
<thead>
<tr>
<th>Price of Antimalarials</th>
<th>Lower North</th>
<th>South East</th>
<th>Upper North</th>
<th>South West</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distribution of free drugs:</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Proportion of first-line ACTs distributed free of cost (by volumes of adult treatments)</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Median Price of a full course of an adult treatment</td>
<td>Median</td>
<td>Median</td>
<td>Median</td>
<td>Median</td>
<td>Median</td>
</tr>
<tr>
<td>First-line treatment (AL)</td>
<td>$6.89</td>
<td>$7.65</td>
<td>$5.78</td>
<td>$5.74</td>
<td>$6.12</td>
</tr>
<tr>
<td>WHO approved ACT</td>
<td>$7.65</td>
<td>$8.89</td>
<td>$7.35</td>
<td>$7.65</td>
<td>$7.65</td>
</tr>
<tr>
<td>Nationally registered ACT</td>
<td>$5.97</td>
<td>$6.12</td>
<td>$4.59</td>
<td>$4.95</td>
<td>$5.74</td>
</tr>
<tr>
<td>Non-WHO/nationally registered ACT</td>
<td>$4.78</td>
<td>$5.74</td>
<td>$5.16</td>
<td>$4.59</td>
<td>$4.97</td>
</tr>
<tr>
<td>Non-artemisinin therapy</td>
<td>$0.61</td>
<td>$0.61</td>
<td>$0.38</td>
<td>$0.54</td>
<td>$0.54</td>
</tr>
<tr>
<td>Oral artemisinin monotherapy</td>
<td>$3.12</td>
<td>$3.57</td>
<td>$3.12</td>
<td>$2.68</td>
<td>$3.12</td>
</tr>
<tr>
<td>Sulfadoxine-Pyrimethamine (SP), the ‘most popular’ antimalarial treatment in Nigeria</td>
<td>$0.61</td>
<td>$0.61</td>
<td>$0.46</td>
<td>$0.54</td>
<td>$0.54</td>
</tr>
<tr>
<td>Median Price of a full course of an adult treatment of ACT relative to SP</td>
<td>Ratio</td>
<td>Ratio</td>
<td>Ratio</td>
<td>Ratio</td>
<td>Ratio</td>
</tr>
<tr>
<td>First-line treatment (AL)</td>
<td>11.3</td>
<td>12.5</td>
<td>12.6</td>
<td>10.6</td>
<td>11.3</td>
</tr>
<tr>
<td>WHO approved ACT</td>
<td>12.5</td>
<td>14.6</td>
<td>16.0</td>
<td>14.2</td>
<td>14.2</td>
</tr>
<tr>
<td>Nationally registered ACT</td>
<td>9.8</td>
<td>10.0</td>
<td>10.0</td>
<td>9.2</td>
<td>10.6</td>
</tr>
<tr>
<td>Non-WHO/nationally registered ACT</td>
<td>7.8</td>
<td>9.4</td>
<td>11.2</td>
<td>8.5</td>
<td>9.2</td>
</tr>
</tbody>
</table>


Even a decade on, this kind of perception of efficacy has not waned very much: many health professionals continue to hold this impression, with some of them actually reporting that they (and many of their patients) respond better to CQ than ACT. One respondent whose job involves conducting plant research for the discovery of medicines told me:
Even at my level, I don’t allow my children to take ACT because ACT is not good for me. I get so scared that maybe my children might also be like that; so I don’t allow them to take it. I just give them herbs and I don’t have any problems.\textsuperscript{14}

The reason given for avoiding ACT is that it gives her a breathing difficulty and causes palpitations. The result is the same with artemisinin mono-therapies whereas the only reaction she has to chloroquine is remedied when it is taken with anti-histamines such as Piriton (to prevent itching). I pressed her for how all this is connected to the children and the response was:

I do give them if I am desperate; if I didn’t know [that it was coming on]. Now I don’t even allow them to be knocked down before I do. But maybe when they catch me unawares and they are already down, I give them. I also don’t like the effect on them; it makes them feel weak and drained. But me, after the first one, I don’t try it any more. I prefer to take chloroquine.\textsuperscript{15}

This is not an isolated case: another respondent who is a senior manager in a drug company that actually markets ACTs told me:

My wife was actually down with malaria last week, we tried her on ACT and it wasn’t working for some time but with the chloroquine, shocking to me, she actually responded to treatment. Maybe after all these ACT talk we may have to revisit other antimalarials still.\textsuperscript{16}

When I shared the opinion of a respected malariologist in Nigeria, that CQ may still be 60\% efficacious in the population, yet another respondent who is a qualified medical doctor said:

In fact, I’ve never tasted any anti-malarial except chloroquine and I get malaria often. I treat malaria at least 2 times a year and I use chloroquine tablets. So for

\textsuperscript{14} Interview 20, pharmaceutical researcher at the National Institute for Pharmaceutical Research and Development (NIPRD), Abuja, Nigeria, 31/10/2011
\textsuperscript{15} Interview 20, 31/10/2011
\textsuperscript{16} Interview 23, joint interview with two executives of a pharmaceutical company in Lagos, Nigeria, 9/11/2011
me it is still 100%: for me and ditto for my wife too, she uses chloroquine and no other antimalarial.\textsuperscript{17}

These comments show that health personnel are aware of chloroquine resistance but the general impression they have is that resistance in Nigeria had not reached a level that justifies a total disregard of the drug especially if it is generally more affordable for the poor, for whom ACT is clearly unaffordable. A comparison of ACT prices and income levels in the country lends credence to this logic. The national minimum wage as it stood in 2008 was $68.45 (8,625 naira) per month.\textsuperscript{18} Even though the private sector as well as each state of the federation is able to fix its own minimum wage level above the national floor, the variation is often not a lot, and galloping patterns of inflation erode the earnings of people at the lower end of the income scale. As such the recent legislation signed into law in March 2011 to increase the minimum wage to 18,000 naira has not made much of a difference to Nigerians in terms of real income.\textsuperscript{19}

Global Fund’s response to the ACT market was to set up the Affordable Medicine Facility for Malaria (AMFm).\textsuperscript{20} The funding mechanism between the government of Nigeria and Global fund under the AMFm scheme was signed in November 2010. With a declared aim of eliminating ineffective drugs from the market, AMFm planned to subsidize ACTs imported into the country up to 95% of the cost. For this purpose it registered a list of 55 first-line buyers who were entitled to benefit from the subsidy when they approached manufacturers. The way the subsidy worked in practise was that when an order was placed with a manufacturer for any amount of drugs, the manufacturer contacted Global Fund to confirm the status of the buyer as a first-line buyer in the country the order originated from. If the status was confirmed the buyer paid 5% of the order amount and the remaining 95% was covered by Global Fund. Since Global Fund was paying the bulk of the amount, the drugs were shipped to the buyer at a highly reduced rate and the subsidy could then be passed on to the end user after consideration for clearing and forwarding costs.

\textsuperscript{17} Interview 11, medical official, Badagry local government, Nigeria, 06/10/2011
\textsuperscript{18} U.S State Department records, March 11 2008
\textsuperscript{20} The Global Fund to fight Aids, Tuberculosis and Malaria – An International financing mechanism set up in 2002 to generate additional financing for the global control of HIV/AIDS, Tuberculosis and Malaria.
Through this subsidy scheme Global Fund hoped to match or better the price of alternative therapies and gain substantial market share for ACTs. To help things along, the National Malaria Control Programme’s Behaviour Change Communication (BCC) mechanism was strengthened to, inter alia, work all the way down to community levels in changing health behaviours; including recognising and ensuring correct treatment options are embraced.\(^\text{21}\) It was hoped awareness would be created and hence demand for subsidized ACT (which is distinguishable by a distinct leaf logo printed on all of them irrespective of manufacturer – see fig.2). Mokuolu et.al (2007) had shown earlier, what can happen to drug consumption with official or institutional backing. In their study published in the *American Journal of Tropical Medicine and Hygiene*, artemisinin-based therapies were shown to precipitate a higher upsurge in consumption and, in some cases, out-sell alternative therapies contrary to the general situation in the market. This was explained as due mainly to the change in treatment policy and the stepping up of awareness efforts at the University of Ilorin Teaching Hospital, a shift that came about in readiness for the change in malaria treatment policy across Nigeria.

Through the feedback it has received from programme managers in the field, the Global Fund conceptualized the challenges of behaviour change as being culturally located. Because Nigeria is made up of a multiplicity of ethnicities, local communities in separate regions need to be dynamically targeted in the way awareness campaigns are designed. However the regional launch of BCC campaigns has been limited by funding inadequacies. This situation is not helped by the fact that local leaders in some of the communities become provincial in the way they direct the affairs of the community. In conversations with some officials for instance; I learned that there are slight linguistic differences between the Hausa language spoken in Bornu state and how the same language is spoken in Kano state. Kano is generally regarded as the cradle of Hausa culture and language and even today, Kano’s place in the cultural and linguistic history of Northern Nigeria is still being guarded by the Kano cultural elite. In Kano, the Hausa language, as it is spoken in Bornu, is viewed as low class. Because Bornu wasn’t conquered in the Jihad, it is believed they are not nearly as good Muslims as people of the Caliphate are. If BCC material produced in Kano’s blend of Hausa is circulated in Bornu it goes unchallenged, but Kano wouldn’t have it the other way round: Bornu Hausa is resisted in Kano. The consequence of this is that the cost of pre-launch tests is

\(^{21}\) This mechanism is now integrated into an all-embracing framework called Advocacy, Communication and Social Mobilization (ACSM)
increased because of the rigorous efforts that have to be made to ensure messages do not offend various communities.

Three important developments also took place to facilitate the entrenchment of ACTs in the market: the first relates to the recommendation of a mission review visit to Nigeria from October 20-24, 2003 to assess progress of Roll Back Malaria programs the country. The mission identified gaps in the use of and limited awareness of Pre-packed Drugs (PPD) and lack of promotional activities for them (RBM/NMCP, 2004). Certain essential actions were suggested as a response, to include mass media campaigns, the training of Private Patent Medicine Vendors’ (PPMVs), use of Community Based Organizations (CBOs), mobilisation and advocacy for the use of PPD. Consequently, following the National Antimalarial Treatment Policy in 2005, “the Federal Ministry of Health met with pharmaceutical companies to advocate for mass production and marketing of ACTs in pre-packaged, age-specific and colour coded blister packs” (RBM/NMCP, 2008: 34). The 2008 report reiterated that “home management of malaria, supported by public information and Pre-Packaged Drugs (PPDs) can help to reduce malaria morbidity and mortality in children: the PPDs ensure that patients take the full treatment course at the right time (RBM/NMCP, 2008: 32).” It also declared that “the ideal direction in BCC strategy implementation is to build on the existing communication channels (mass media, intermediate groups and interpersonal levels) to promote the ACT medicines as well as developing new materials and tools in line with the current National Antimalarial Treatment policy” (RBM/NMCP, 2008: 34). The second measure was the recommendation of artemisinin mono-therapies (AMTs) for deregistration. Because AMTs could potentially lead to the malaria parasite developing resistance to ACTs the National Malaria Control Programme collaborated with the National Agency for Food and Drug Administration and Control (NAFDAC) to ensure they are were deregistered (RBM/NMCP, 2008: 34). Consequently as the five year Certificates of Registration issued by NAFDAC to current AMTs expire they will not be renewed (Palafox et.al. 2009: 15). This move may also have been necessitated by the fact that the association of artemisinin with both AMTs and ACTs may encourage consumers to demand the cheaper AMTs more. It would also have been seen as the only option to controlling AMT consumption as the manufacturers would not have been willing to voluntarily give up its production and yet be so heavily disadvantaged in the ACT market as a result of the AMFm subsidy.
The third measure taken was a deregulation of ACTs from prescription only medicines to over-the-counter drugs, recognising the role of Private Patent Medicine Vendors (PPMVs) as a significant source of medicines for malaria treatment in the community (RBM/NMCP, 2008: 33). In any case, the categorization of some medicines as ‘prescription only’ hardly limits access to them in any significant way: private patent medicine vendors have always been able to illegally sell such medicines to patients over the counter with very little or no consequence. The official re-classification remained necessary because of the massive market push planned for subsidized ACTs.

Global Fund’s assessment of the progress made by the AMFm programme has been based on its four-fold objectives at inception namely to increase availability of ACTs in the public and private sectors; to reduce the price of ACTs; to increase ACT market share and to increase the use of the drugs including among vulnerable groups like the under-fives and pregnant women. In a recent report commissioned by the Fund substantial progress was reported on all of these counts (Schaferhof and Yamey, 2011).

The AMFm facility is however a subsidy scheme at the end of the day and has had some unwelcome effects on the antimalarial market. The major impact is that while it undoubtedly increased ACT supply in the market as a response to increased demand, the price intervention has rendered unsubsidized ACTs less profitable and has thereby reduced demand for the raw artemisia plant; this in turn has reduced global capacity to meet ACT demand as the production process is very heavily dependent on the artemisia planting cycle. A separate programme (A2S2 – Assured Artemisinin Supply System) which aims to support the global production of artemisia has had to be created to address supply shortages.

Reports also suggest that batches of the subsidized drugs are going missing and re-emerging at market price either within the country or across the border in neighbouring countries, a situation accentuated by the fact that the Republic of Benin and Cameroon which share Nigeria’s western and eastern borders respectively were not included in the pilot phase of the AMFm programme.22 A Global Fund internal document leaked to the

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22 The Pilot phase ended on 31 December 2012. Global Fund has decided to integrate AMFm into its ‘core processes’. This means that ‘eligible countries will be able to allocate funding from their core Global Fund grants and determine how the money should be spent. Following an assessment by technical partners, the AMFm model may be further modified to include malaria rapid diagnostic tests (RDTs)’ – See Global Fund News Release, “Board Approves Integration of AMFm into Core Global Fund Grant Processes”, 15 November 2012, (accessed10/05/2013)
Associated Press (AP) in January 2011 identified Nigeria as one of the countries in which drugs worth $2.5million were stolen between 2009 and 2011. The AP report also showed that in about 70% of cases, the drugs were stolen at government–operated warehouses by security personnel, warehouse managers and doctors. The operators of the programme in Nigeria insist that no stones are left unturned in investigating such reports; because these batches are normally numbered, the culprits can be traced and black-listed. But such simplistic views under-estimate the ingenuity of black-markets and their ability to disguise batches through re-packaging and other forms of gimmickry. They also avoid confronting the basic premise that subsidies can be counter-productive if not carefully deployed within an economy. More often than not, subsidies are made internally by governments to support a particular sector of the economy with a view to preventing its collapse and in that sense, are usually temporary tools. If deployed indiscriminately they can cause sectorial distortions and stifle growth. It is not often the case that products imported into the country will be subsidized at home especially when such subsidies give them an edge over locally available competitive brands.

The black-market situation was not helped by the fact that orders placed for subsidized ACTs were hardly ever fully met, creating severe shortages that kept prices high in spite of the subsidy. One respondent told me that this makes it very difficult to assess the impact of the AMFm programme:

As you know Nigeria is a country of about 150million people; 60% of our out-patient visit in any hospital is due to malaria and 30% of our infant mortality is due to malaria. Out of about 80million doses of ACTs that were ordered only about 20million are now in-country. So we can’t judge; the yardstick is not there to judge and assess the programme yet.

Based on a rough estimate of Nigeria’s population at 150million he suggested that 50% of the Nigerian population needs antimalarials and hence ACTs. It will therefore take 75 to 80million doses as have been ordered so far to meet a single treatment course for

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http://www.theglobalfund.org/en/mediacenter/newsreleases/2012-11-
15_Board_Approves_Integration_of_AMFm_into_Core_Global_Fund_Grant_Processes/


24 Interview 23, joint interview with two executives of a pharmaceutical company in Lagos, Nigeria, 9/11/2011
each patient but of course malaria recurrence rates are also rather high: most people come down with malaria a few times in a year. This is especially true of under-fives due to low immune levels. The ideal supply of ACT to Nigeria should thus be far in excess of 80 million but only a quarter of even that conservative order has been met so far. Another respondent who represents a company on the first-line buyer list for ACTs told me that even the orders that were received have come in trickles, making it even more difficult to have a meaningful impact on average ACT prices:

Based on the number of doses Nigeria has ordered, if all those doses had come in at the same time and we had been able to circulate, there would have been proper saturation and then the price would have come down. But what we are having now is the fact that it comes in bits: when Cipla’s batch comes, Sanofi’s batch is yet to come; by the time Ipca’s batch is coming, others have dried out. So it’s coming in bits; it is still not meeting the demand and what has happened is that we have a situation where wholesalers and retailers are making a lot of money: they are buying the product for 50-60 naira and are selling it for 150-200 naira.25

The price intervention represented by the AMFm programme raises questions about the contradictory logic of the subsidy. It is bewildering that subsidies have suddenly become such a good idea considering that it wasn’t that long ago that the World Bank’s Berg report was emphasising ‘getting prices right’ (World Bank 1981 cited in Gladwin 1991); the removal of subsidies as well as trade liberalization formed part of the preconditions for structural adjustment loans to African countries. In spite of the widespread upheavals that structural adjustment engendered across Africa this approach was continually reiterated as the most efficient way of allocating resources and encouraging growth. The combined outcome of subsidy removal and trade liberalization was that on one hand production costs, and hence prices, shot up astronomically and on the other hand the prices of foreign products became more competitive and hence flooded domestic markets, further dampening the economic outlook for many African countries. The sentiment among some health professionals in Nigeria is therefore that the AMFm subsidy was only aimed at once again opening access to the Nigerian market for foreign manufactured products and this is why it is a globally supported intervention. It may be argued that humanitarian considerations make the subsidy appropriate because the malaria situation is so drastic it requires desperate responses. That may be so, but

25 Interview 23, 9/11/2011
humanitarian considerations were not applied to the prospect of severe food crises when agricultural subsidies were targeted as part of structural adjustment policies. In the end, they express that what the ACT distribution campaign and the way it is carried on will achieve, more than anything else, is to create a sustained demand for ACT imports even when the subsidy is eventually removed.

Perhaps the strongest defence of the intervention is the need to ensure the highest quality of drugs is delivered to the market; indeed subsidized ACTs are distinctly referred to as ‘quality assured ACTs’. There’s good reason to be concerned about quality: one of the most urgent factors frustrating the efforts of health authorities in Nigeria is the nefarious activities of counterfeit drug networks who import adulterated drugs into the market for sale to unsuspecting members of the public with untold consequences, including drug resistance and treatment failure. This problem became even more pronounced after the distribution of pharmaceuticals was denationalized in 1968 which eased the licensing regime and resulted in the issuance of drug importation licenses to non-professional companies. A direct consequence of this was an atmosphere of unmitigated flouting of drug regulations (Akunyili, 2006) which has persisted till the present time, although the efforts of the country’s National Agency for Food and Drug administration and Control (NAFDAC) has yielded some commendable improvements in the last decade (Garuba et al, 2009). Criminal acts have often involved the active connivance of state officials who, for their own financial benefit, either participate in the operation to import fake drugs into the country or fail to investigate known culprits. Cases have been cited by Akunyili (2006) of fake drug consignments passing through customs ‘checks’ with falsified shipping manifests only to be intercepted by NAFDAC officials afterwards. Corrupt practices are so wide spread in Nigeria that members of NAFDAC have in the past also been found to engage in corrupt practises that compromise the agency’s work (Akunyili, 2006)

In their study of the Nigerian pharmaceutical industry, Garuba et al (2009) found the industry to be most wanton in the area of registration. The processes and procedures for registration within the industry were still showing gaps that made it very prone to corrupt practises. Time frames for processing applications were not standardised and as such not publicly available and there was very little or no publicly available detail regarding the composition or membership criteria of the committee in charge of assessing applications. Its terms of reference were not even publicly clarified. With the
already pervasive nature and scale of corruption in the country, it is inevitable that such loopholes and gaps as exist in drug administration will be exploited as has been widely reported. However in spite of this backdrop, the official drug administration regime is continuously made to appear strengthened and this is being used to demonstrate that Nigeria is serious. This is one of the ways the rules of formation around seriousness are playing out.

To ensure good quality and uphold standards, WHO pre-qualified six companies namely Guilin (China); Ipca, Ajanta and Cipla (India); Novartis (France) and Sanofi-Aventis (Switzerland) to supply quality assured ACT drugs to Nigeria’s AMFm programme. As one participant involved with the programme put it, ‘WHO will stick its neck out for these companies because it’s given its seal of approval to these labs or to these manufacturers; they can assure you that these drugs actually contain whatever they claim to contain’. Against the background of Nigeria’s poor drug management record this move was not difficult for WHO to rationalize, but it did not go down well with many discerning Nigerians. One newspaper report likened it to ‘what Zambian Economist Dambisa Moyo might refer to as “Dead Aid”: a donor supported programme comes in and destroys the promising local industry, making it inevitable that the country in question will always be aid-dependent’. Another report captured the general mood in this way:

How could the Federal Government have acquiesced to an initiative whereby Nigerian stakeholders are being asked to register with TGF [The Global Fund] merely as first line buyers on strict conditions? Even indigenous pharmaceutical firms whose ACTs have been effective over the years will only become sales agents of the six foreign manufacturing firms because, as TGF claimed, they are not WHO pre-qualified. Besides, what will be the fate of these local pharmaceutical firms already constrained by poor infrastructure, inadequate power supply and myriad other socio-economic challenges, when the Nigerian market is flooded soon with highly subsidised anti-malarials from overseas at a time when they have not been provided the enabling environment and favourable legal framework by the government to boost their competitiveness?

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This critical attitude to the scheme was foreseen by Global Fund: in the report of a survey done in 2009 by ACTwatch among government officials and private suppliers of malaria treatment, opposition from local manufacturers of anti-malarials was highlighted as one of the factors that could stand in the way of the private sector penetration of ACTs. The likely reasons for this mood were also suggested as the loss of market share arising from an inability to access funds under the ACT subsidy and the shift in consumption pattern away from mono-therapies and older therapies such as SP and CQ. The way Global Fund responded to the spectre of such a formidable group threatening to scuttle the subsidy programme was to ask them to enlist as first-line buyers of ACTs imported into the country under the programme. By creating a role for them in the supply chain it was hoped that they would see a stake in the success of the programme and hence comply with WHO’s plans of discouraging the continued local production of CQ as well as AMTs. They also had the prospect of becoming pre-qualified to look forward to: a number of manufacturing sites were visited by the WHO pre-qualification team to assess their manufacturing fitness under WHO’s standards; none of them has been pre-qualified so far.

Companies like May and Baker (Nigeria) that have the capacity to, and have been producing ACTs have struggled with pre-qualification.28 As one respondent told me, ‘the prequalification process is quite stringent; WHO looks at not just good manufacturing practises, they look at plants and equipment, factory outlay and even processes and working procedures’. This is an enormous measure of power: WHO is able to indirectly regulate manufacturing practise in the country, enforce standards and decide what production lines are discontinued or maintained. Drugs are produced in Nigeria to BP standards (British Pharmacopeia), an internationally recognised standard that reputable pharmaceutical companies in the country are known to adhere to. It might have been possible to pre-qualify Nigerian ACTs for the Nigerian market only so that by being able to access the Global Fund subsidy Nigerian manufacturers retain their competitiveness. It would certainly have been cheaper as freight and other associated costs would have been avoided. Instead what Global Fund did was to create severe market distortions in Nigeria’s pharmaceuticals industry which brought about a difference of 700-1000 naira between locally manufactured ACTs and the subsidised ones from Europe and Asia. The only reason the death knell has not been sounded for local ACT manufacturers is that AMFm has been grossly unable to meet the demand for

28 May and Baker Nigeria (Plc.) manufactures the MalAct brand of Artesunate-Amodiaquine.
ACTs in Nigeria; the resultant shortage has meant a general willingness to continue to buy the local brands at higher prices.

As international development assistance is increasingly privatized, regulating access to profits will become more and more visible as an arena of power. In the case of malaria control as it currently operates, this task falls within the domain of the international organisations like WHO which provide the multi-lateral mechanisms that make such operations of power workable. It is also part of the enforcement of place that the opportunities which exist in the ACT market are allocated by a seemingly predetermined grading: major foreign companies operate as producers and reap the economies that flow from that, while local companies operate as distributors and be thankful they are still able to reap appreciable margins. What the WHO action represents is not just an indictment of the pharmacovigilance regime in Nigeria; it also enforces penalties for perceivable weaknesses. These penalties take the form of loss of valuable tax revenues that would have accrued to the country through the sale of millions of doses of ACTs. As will be discussed below, market considerations are also perceived to be at the root of a third measure against malaria, the rapid diagnostic tool, which is currently being pushed as the most effective way of fighting the disease in the future due to the bio-complexity of both the vector and the parasite.

**The Political Economy of Rapid Diagnostic Tests**

A troubling aspect of the action against malaria in Nigeria is that most, if not all, febrile conditions are treated as malaria in the first instance. If symptoms persist after a first course of treatment health personnel would then consider exploring other possible diagnoses. This distorts available statistics on the disease and also affects the way control programmes are planned, not to mention the potentially adverse outcome of misdiagnosis and mistreatment. The tool that is currently seen as the most effective way of getting around this problem is Rapid Diagnostic Test (RDT). Developing the tests is technology intensive and depends heavily on specific funding for research and development (R&D). Yet R&D funding has historically been negligible as a proportion of total malaria control funding. Even at that, a huge chunk of R&D funding goes to drug development.

The sustained action against malaria in the last decade has however brought about an appreciable increase in R&D funding and as the table below shows funding for malaria
diagnostics has improved tremendously since 2004, standing at $11.9$ million as at 2009. In spite of this, a recent report by the Programme for Appropriate Technology in Health (PATH) has identified that a funding gap still exists which needs to be plugged; diagnostic funding needs to quadruple to around $50$ million per year if the benefits of diagnostics and their full potential in fighting malaria is to be reaped (PATH, 2011: 3). This is an understandable projection considering the renewed focus that the GMAP has placed on diagnostics going forward: among other interventions, the plan estimates that 1.5 billion diagnostic tests will be carried out in order to reach universal coverage with its Scaling-up for Impact (SUFI) strategy.

**Table 6 – Funding for Malaria Diagnostics (US$\text{m})$, 2004-2009**

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*Source: PATH (2011)*

Not all health personnel are convinced RDTs offer significant benefits in the tropics. The PATH report indeed acknowledges ‘one of the major challenges in the development and use of diagnostics has been some confusion in the malaria community regarding the utility and need for these tools’ (p.65). One of the programme managers I spoke to at the National Malaria Control Programme in Nigeria expressed his opposition to the tools. According to him, it is common knowledge that although RDTs are useful for mass screening in epidemic malaria situations they are not the gold standard for the diagnosis of malaria; microscopy is much more regarded for that purpose. ‘Let me give this instance: [he said] RDT cannot detect any parasite load less than 100 parasites per micro-litre’. Considering that Nigeria is in an endemic zone of malaria prevalence, most people carry the parasite and remain asymptomatic: RDTs won’t detect that. Pregnant women are a particular risk group as asymptomatic malaria can have severe consequences, including placental malaria which leads to serious consequences for the new-born child (PATH, 2011: 61).

Another shortcoming he pointed out is that the tool is expensive and unaffordable for ordinary Nigerians who may continue to self-diagnose all fevers as malaria. They may either insist on skipping diagnostic tests or self-medicate. Juxtaposed with the already prevailing perception identified by the PATH report that ‘health care workers do not
follow the results of RDTs’ (PATH, 2011: 63) it becomes very imperative that if it is ever rolled out on a universal scale, a way has to be found to make it affordable.

The test kits available in Nigeria are also still unable to detect other species of the malaria parasite apart from *P. falciparum*. Although this accounts for about 98% of malaria infections in the country, other forms, especially *P. vivax*, are still present in 2% of cases which unfortunately are mostly children. Diagnostic tests that could possibly detect such cases have not been stabilized for tropical environments. Such environments provide the strict standards against which the diagnostic tools are measured. The most virulent types of malaria tend to be quite prevalent in tropical environments and as such the diagnostic tools have to demonstrate sensitivity to different species as well as mixed infections. Field conditions in such environments are also of high temperatures; as such the tools need show an ease and stability of performance in such conditions (Murray et al, 2003).

The research community is currently hard at work to discover ways around the identified problems associated with RDTs; new technologies such as the Loop-mediated isothermal amplification (LAMP) of DNA for malaria are currently being tested for the detection of low parasite densities. Ways are also being sought around the instability of RDTs at temperatures greater than 30°C. Some of these trials are also currently going on in Nigeria and form part of the concerted partner efforts at controlling malaria.

In 2004 WHO placed a call for the pre-qualification of sites in Africa in the area of malaria case management using diagnosis. The plan was to set up specimen collection sites where materials will be collected for the quality assurance of RDTs. Before this time two centres had been established in Asia running for about 5 years but the *P. falciparum* strain of the malaria parasite is most prevalent in Sub-Saharan Africa so WHO felt it was reasonable to have this collection sites in Africa as well. There was a call for countries to express their interests in building up in-country malaria specimen banks where they can have quality assurance materials for the rapid diagnostic tests. Four sites were selected initially and later expanded to six. The original four sites were in Nigeria; Democratic Republic of Congo; Kenya and Tanzania; Senegal and Ethiopia were added later. It is expected that the culmination of this project will be the development of a global specimen bank that will be located in the Centre for Disease Control and Prevention (CDC) in the United States where a pool of different countries
parasites can be collected in a place so they can be used as quality control materials to test for the performance or the accuracy of the rapid diagnostic tests.

One of the malariologists I spoke to (who is very involved with the WHO collaboration centre) considered this to be a very exciting development which offers a very promising turn-around in the fight against malaria. He had a strong basis for this optimism: the CDC sample bank will contain a representative sample from major countries including Asia. The representative samples will be used for WHO’s product evaluation. Many rural areas in Nigeria are without electricity and this will make the malaria rapid diagnostic tests very useful in such areas; tests can be carried out very quickly and produce results in 15 minutes. Even in urban areas only about 15-20% of health facilities have laboratories so neither diagnostics nor microscopies are currently in use in a majority of facilities. This is why fevers are treated as malaria as a rule of thumb leading to a large case pile of over-treatment; a widespread embrace of diagnostics can potentially turn things around.

This approach however raises some fundamental questions about the role of WHO. By mediating the assemblage of a quality assurance platform on behalf of private sector led technologies it is effectively acting as an agent for the private companies at the forefront of these technologies. The market for anti-malaria technologies is patently in malaria endemic countries and this makes such countries crucial to the life cycle of new technologies. It is also important that they are able to independently negotiate issues around access to the technologies and what stake in the ownership of those technologies they are able to acquire through their contribution to their stability. Thus far, ‘successful RDT implementation has been curtailed by poor product performance, inadequate methods to determine the quality of products and a lack of emphasis and capacity to deal with these issues’ (Bell et al, 2006: 682).

As was explained to me, all manufacturers of RDTs have in the past four years been sending their products to the CDC annually through WHO; WHO evaluates the products and comes out with a report that rates them. As the world moves towards a phase in malaria control whereby confirmation through diagnostics will be issued as a standard policy guideline, it is becoming increasingly incumbent on manufacturers that a reliable quality assurance platform is available for them to base product descriptions on, especially as orders are expected to spike in response to guidelines. The bottom-line
is that they will need to be able to test their products using samples from practically everywhere in order to be able to market them as ‘accurate under field conditions’.

The nature of partnership in today’s development encounters makes it possible that WHO’s multi-lateral system is deployed as an umbrella under which other networks operate to gain access to such vital markets for a burgeoning technology. Endemic countries such as Nigeria feel compromised by their disease status and will often not contest these methods; especially as the interaction is explained as one in which countries with zero cases of malaria are putting together concerted action to deal with a notoriously debilitating disease in the recipient countries. Such rationalizations are often not qualified by the fact that there are huge profits to be made at the end of the day. In Nigeria WHO has brought together a network of partners which include the College of Medicine, University of Lagos; Hospital for Tropical Disease in the UK; the Centre for Disease Control in Atlanta Georgia and the Australian Army Malaria Institute (AMI). Australia is particularly crucial to the process because it possesses the data harvesting skills necessary to upgrade the samples to what is technically known as ‘Highly Characterized Samples’ which improve the robustness and reliability of results.

It is not the first time WHO and Australia are mentioned together in this kind of arrangement: in 2007 Indonesia announced that the country would stop sharing virus samples with WHO collaborating centres on the discovery that an Australian company had been granted access to Indonesian virus samples for the development of an Avian Flu (H5N1) vaccine. The country argued that it was unfair that Indonesia would have to pay high prices for vaccines developed using its own sample stock. It took high-level meetings in Jakarta between WHO flu experts and the country’s health minister, Siti Fadillah Supari, to resolve the impasse. Indonesia resumed virus sharing on securing a promise that WHO would ensure the country has access to flu vaccines at an affordable cost.29

If the outcome of the Jakarta meetings is what Indonesia had hoped for, it goes without saying that the action it took was well timed: the Avian Flu epidemic had every potential to spread everywhere in the world and cause a monumental global health crisis. Indonesia therefore easily secured the concessions it wanted because the cooperation of every country was indispensable if the problem was going to be speedily

brought under control. However, not many poor countries can take the Jakarta option. In the case of malaria endemic countries in Africa, apart from feeling compromised by their disease status, the need to appear serious about dealing with the continent’s health malaise is engrained into a discourse that works well not just for the West but also for the continent’s political elite; this often makes the outcome of development’s engagement with these countries highly predictable. The next section will further explore this discourse of seriousness.

**Did You Get the ‘Memoire’? Development Encounters and the Emerging Discourse of Seriousness**

The ‘aide memoire’ is a very important guidance document for the World Bank’s engagement in the field. It nevertheless also illustrates the weakness of the claim often made by international organisations and their field agents, that they consciously steer clear of the national policy arena. The reality is that there is hardly a need for them to attend cabinet meetings; most, if not all, of the policy frameworks for controlling malaria in endemic countries are preceded by counterpart global frameworks. So for a national monitoring and evaluation (M&E) framework, for example, there’s a Global M&E framework; national malaria action plans have the Global Malaria Action Plan to draw inspiration from. The first test of how serious a country is in its efforts to control malaria is how aligned to the global plan the national plan is. Because these international organisations are major sources of funding, the national plans often do not deviate from what is expected of them; many of them are simply national versions of the global plan. They will not promote measures that are not promoted globally nor will they demote measures that are not demoted globally. The ban on the use of the larvicidal chemical Dichlorodiphenyl Trichloroethane (DDT) is a good example: when Uganda announced in 2005 that it was going to use DDT to control malaria the EU announced that if the move was implemented all agricultural exports from the country would be banned.

When applied to water bodies in which mosquitoes breed DDT forms a thin film that prevents the passage of air. It starves the mosquito larvae of oxygen and they consequently die.\(^\text{30}\) It is the chemical largely credited with the eradication of malaria in North America and elsewhere in the 60’s and 70’s; it was however overused and caused

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substantial ecological and biological concerns. Its use in malaria control was subsequently banned by WHO. It is hard to tell what Uganda was thinking as it made the announcement but in the eyes of the development community it was clearly demonstrating a lack of seriousness and this needed to be nipped in the bud. Nigeria tended to be more serious and avoided the use of DDT until the ban was partially lifted for a limited use in indoor residual spraying.

International organisations realize that if there is going to be any deviation from agreed plans it will occur during implementation. The coordination and monitoring machinery is therefore very strong on the ground. As a representative at DFID’s SUNMAP programme put it ‘our situation as a programme is quite unique because as it relates to our function and mandate we are almost embedded within the DNA of the malaria control programme itself’. He continued as follows:

If the malaria control programme fails we fail as a project and the partnership countries also look up to SUNMAP to encourage that consensus building and often, as a project, we may find a situation where we are caught between the devil and the deep blue sea because for every project we have fairly well defined project mandate and outcomes but we also need to be able to say okay, if it is to the benefit of the national programme and to the partnership we need to step back from our core mandate, essentially doing similar work to what WHO does on a global scale. Ideally we would expect more of that coming from the WHO but we say okay, within the situation, how do we ensure that we are at least able to move the agenda forward. And so, because we have taken that step back often it has endeared us to the national programme at the point at which they need support. But we recognise also that earlier on it may not be perceived to be something that the stakeholders will appreciate because, largely speaking, you are in their face all the time asking questions, difficult questions. And so, it’s a love-hate relationship but ultimately they recognise that if they want something done and done well, this is where they need to go. And as part of the coordination structure for the programme there’s a technical sub-committee structure around specific knowledge areas. Knowledge areas for instance such as M&E have a technical sub-committee providing technical support for the programme and is led by a partner but the

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31 Interview 1, Support to Nigeria’s Malaria Control Programme (SUNMAP) Official, Abuja, Nigeria, 15/08/2011
secretariat for all the technical sub-committees are the programme itself to ensure
that whatever discussions and recommendations are fed back to the national
programme in its decision making, at least they get some advice that is
appropriate. And so, for instance like I mentioned, based on the core competence
of the various partners they’ve been allocated roles providing technical advice in
specific areas. SUNMAP for instance chairs two and is a co-chair of another sub-
committee…We have JSI (USAID) chairing the PSM\textsuperscript{32} sub-committee; we have
WHO chairing the Advocacy, Communication and Social mobilization sub-
committee and we have Case Management chaired by the Society for Family
Health (SFH)…And then for each one, the Branch Heads of the NMCP are at our
service secretariat so that at the point at which the discussions are on-going they
express their views, the partners also with core competence in those areas also
express their views and then there’s a meeting of minds which are fed as
recommendations to the National programme, around how we address knotty
issues.\textsuperscript{33}

The above statement shows how emphasis is placed on technical interventions, which
suggests the way the problem of disease is understood by most international
organisations operating within the country. For the international organisation, two
things are vital: to be seen to be doing something logical in response to the problem and
secondly, for the adopted measures to be able to report results. But for the country,
malaria control can mean more than this. The challenge of dealing with malaria can
stimulate inventiveness; it can provide a way of knowing which spills into other
national endeavours. External actors are however so overwhelmingly involved with
current approaches that there is very little room left for developing internal capacities
for disease control. When I posed a similar question to a WHO representative regarding
how they coordinate their work with the Ministry of Health in the country as well as
monitor for efficiency, the response was as follows:

For the malaria programme we have our operational plan that is drawn up at the
beginning of every year. This operational plan is supposed to be a guide to which
we work: it’s like our bible, and then following the operational plan, we have a

\textsuperscript{32} Procurement and Supplies Management.
\textsuperscript{33} Interview 1, Support to Nigeria’s Malaria Control Programme (SUNMAP) Official, Abuja, Nigeria,
15/08/2011
mid-term review of the plan. First of all we have a strategic plan: the national strategic plan has given us the strategies on malaria control. Based on these strategies we develop an operational plan for every year – the annual plan. In the middle of every year we do a mid-term review of the plan: it’s like a road map. You want to identify, you know, evaluate your targets against your performance at every given time. So you do a mid-term review to know what achievements you’ve gotten up at mid-term, what is left to be done, bottlenecks, gaps, what can be possibly done and then at the end of the year, we do end of the year review. Outside of that, we also have what we call the malaria programme review. The malaria programme review is much bigger; there are different phases, a field proposal, desk review, thematic desk review, data collection and all that. It’s also evaluating the programme as a whole: what has the programme done in terms of case management; in terms of provision of guidelines; in terms of community involvement; in terms of integration with other disease programmes; so you are evaluating the programme as a whole, which is different from the annual plan because the annual plan is drawing up a plan of action for the programme for that particular year. But the MPR, the malaria programme review, aims at the entire programme. So if we are going to do a malaria programme review now we are looking at what the malaria programme was at baseline, what it was at mid-term and what it is now and then we are looking at the entire system… And then we do an impact evaluation; it is much longer [and] it is an outcome indicator… And then the different aspects within the programme is also monitored individually like the procurement and supply management, case management, integrated vector management, M&E, every programme; we all have our different frameworks, like M&E framework, PSM framework, M&E plan, so every programme is appraised again at the end of the year based on targets and achievements so at the end of the year we just draw up a road map to see where we are; where we are headed to.  

The over-bearing presence of key international organisations which these responses allude to is not so hard to detect. I was at the headquarters of the National Malaria Control Programme practically every day during my time in Abuja between August and November 2011, and I observed some of them coming and going so seamlessly it was clear to me they were truly ‘part of the DNA’ of the programme. On one occasion the

34 Interview 3, WHO official, UN House, Abuja, Nigeria, 19/08/2011
Programme Assistant to the Roll Back Malaria Focal Person for West Africa (who is based in Dakar, Senegal) came into the Abuja Headquarters; he melded so well into the fabric and the character of the office that if I wasn’t already aware of him I could have mistaken him for someone who reported to that office every day. He appeared very well-known and apparently quite popular with many of the staff; many of them said hello to him as they passed what seemed, to all intents and purposes, like his regular desk. Roll Back Malaria, the global coordinator of malaria control does not have an office in Nigeria anyway. It coordinates malaria control in Nigeria from its regional office in Dakar, Senegal; its office in Nigeria is the NMCP office. The WHO is also quite well integrated with the NMCP. As the WHO representative responsible for malaria in Nigeria also told me:

We are part and parcel of the national programme. I walk [freely] into the national programme; in fact I spend, call it, 80% of my time there. Most times I come in here [WHO] only in the mornings to check my mails and that’s it, and then I’m off to the national programme, supporting the different thematic areas, from the vector control; case management; monitoring and evaluation [and] programme management.35

DFID’s SUNMAP goes one step further in the way they integrate with the malaria control bureaucracy; they are headquartered in the same building as the NMCP and as an NMCP official put it, ‘it’s just like an extension of Malaria [i.e. NMCP].’ 36

The everyday presence of ‘international partners’ does not always have to be as intensive. What is even more important is how the programmatic tenets are articulated and enforced. Once these tenets are agreed, what international organisations expect is that recipient countries demonstrate seriousness by sticking to them. One participant at the World Bank put it succinctly when he expressed that:

From the Bank Head we have what we call supervisory missions which entails people like me; we have three of us working on the malaria project. We actually visit the states where these projects are taking place and at the national level we contribute to being part of the coordinating mechanisms. We are represented in all

35 Interview 3, WHO official, UN House, Abuja, Nigeria, 19/08/2011
36 Interview 2, National Malaria Control Programme (NMCP) Official, Abuja, Nigeria, 18/08/2011
the six coordinating committees that they have at the national level and we have dialogue with government based on our consultations and based on what our findings are where we do our supervisory missions. At every supervisory mission we generate what we call an ‘Aide Memoire’ which is like a consensus of what we agree with government on the project, what we are going to do and what we are asking them to do; what they have not done and we are asking them to do. At the state level, even at national level, we have what we call the project implementation unit which is like the eyes and the hands and the legs of the project for us at the federal and the state level. They report their activities back to us on a quarterly basis. Let me just step back a little bit to say that at the beginning of the year we have what we call a work plan that is developed and we all agree together on it and sign off on it. We also have a procurement plan which we agree and sign off on and also a training plan. It is on these bases that the states report to us on a quarterly basis and that is what we go to monitor also when we go in the field. We monitor the implementation of their plans; what are the bottlenecks and how can we help at the higher policy level to make sure that the project is implemented?"37

The long quotes above have been necessary because of how much they detail the day-to-day engagement of international organisations with country counterparts. The representatives of these bodies that I spoke to seemed slightly more animated as they narrated these operations to me. They seemed to be energised by the conviction, and probably rightly so, that plan implementation rather than the capacity for strategic planning is where everything falls apart for Nigeria. Their operations, especially with the strategic and resolute way in which they are carried out, therefore represent positive change for the country: a better model that offers the potential to strengthen country systems. What are often not transparent in these narratives is how the conceptualization of the problem is systematically controlled and how this type of control is in itself a problem for Nigeria. These so-called serious minded ways of approaching the problem of malaria as with other iterations of seriousness in development assistance are part of a well-constructed discourse of seriousness that is built upon three main formations, namely the strategic deployment of language; the idealization of modernity; and control of the reporting process.

As is demonstrated in malaria control, the language of development assistance is spoken to strategic effect. Chambers’ work on participatory development suggests that language and rhetoric support the practice of development. They produce many labels and schools of thought which ‘hide underlying changes in philosophy and practice’ (Chambers, 1994: 1). Rather than genuinely empowering local actors, international development tends to be quite invested in masking unequal power relations with various terminologies that suggest a serious process of empowerment. Chambers identifies ‘participation’ as one of such terminologies. It dominated development lexicon in the 1990s and was used to refer to development projects in which local people were organised into self-help groups under skeletal external supervision. According to Chambers, this was often rationalized as involving local people in development practice and allowing them to take ownership of projects, whereas it was in fact a ‘co-opting practice, to mobilize local labour and reduce costs’ (Chambers, 1994: 2).

Other examples of this kind of linguistic practice exist in international development today, one of which is seen in the pronounced tendency to express communication in acronyms. In malaria control, acronyms are so many that virtually every piece of literature opens with a very long list of acronyms used in the document. Some of the acronyms like Artemisinin-based Combination Therapy (ACT) are somewhat self-evident but others like Scaling up for Impact (SUFI); The Roll Back Malaria Essential Actions Progress Investments Gaps (REAPING) or ITN Massive Promotion and Awareness Campaign (IMPAC) come across as another opportunity seized to construct an acronym and quite frankly reveal an institutional desperation to do so. The relevance of this to an analysis of the emergent discourses in development encounters is that aggregations of these acronyms tend to operate as an applied form of language use: they focus attention and thinking along particular lines. The global/national dynamic is such that the commissioning of development programmes is communicated downward and the reporting of operations is communicated upward. Each channel transcends national boundaries, and as such there is a perceived need for communication to be standardized. This creates an important role for acronyms and also has a considerable bearing on the way problems are analysed and responses evaluated.

The fact that an acronym exists for an expression like ‘scaling-up for impact’ for instance guarantees that it is used with a regularity that has strategic implications. Almost any other way of conveying the same meaning will stand in binary opposition to
SUFI. Consequently any scale-up exercise will be confined within the context of what is understood as ‘impactful’ in development terms. It is therefore vital that the epistemological ramifications of such widespread use of acronyms are understood. It is also vital that the way existing structures of power influence the definition of such notions as ‘Impact’ is understood in order to fully capture the knowledges that they distribute. Another example of language use is the categorization of leaf logo ACTs as ‘quality assured medicines’. This disqualifies rival brands as lacking in quality even though there may be not one jot of difference in their comparative efficacies. In this case the category of quality assured medicines becomes the standard and any government policy that negates this standard will clearly be viewed as compromising the health of its citizens. This does not mean that the government is not at liberty to register rival brands for sale. As a matter of fact there are probably more rival brands in Nigeria than there are ‘leaf logo’ brands. What it means is that the government will not consider it sensible to refuse to register foreign manufactured ‘leaf logo’ ACTs based on the logic, for instance, that they impact negatively on the local anti-malarial market.

What even further strengthens this discourse of seriousness is the positioning of the malaria problem as a global problem that is being addressed through a global network of partners. The universality of the problem is further emphasised by the fact that the majority of development partners addressing the problem have their roots in non-malarial countries. The question for many endemic countries therefore is what membership of this network means and the minimum modes of practise that are necessary to maintain membership within it. In much the same way as rap artists feel they have to dress, speak and even dance a certain way in order to be ‘authenticated’ as engaging fully with the subculture of rap music, countries that see a benefit in maintaining the ‘right’ relationship with the network of development partners feel the need to demonstrate an imposed seriousness about dealing with the malaria problem by embracing standardized approaches and more importantly, practically disavowing non-standardized ones. The implication of this is two-fold: Firstly, the dominant partner in this relationship is empowered to construct communication in such a way as to take the coherence of that communication for granted. The ‘junior’ partner is driven by a need to validate his membership of the epistemic community, to which he imagines both parties belong, by demonstrating that they are unified by an understanding of the pragmatics involved in the language of this enterprise. To this extent they explicitly endeavour to align practise with prevailing expressions such as ‘system strengthening’, ‘disease
centred approach’ etc. Secondly, because there are two cadres of power within the network i.e. the national and the global, rationality is no longer locally defined: any local notion of rationality aligns itself with the global one. To the extent therefore that seriousness connotes making rational judgements and taking rational action, the privilege of regulating what is seen as serious is externalized.

In terms of the idealization of modernity, this works in malaria control the same way it works with practically every other form of encounter with global networks: the global way is the modern way and hence the better way. There is as much effort from these global networks to imbue modern approaches on Third world countries as there is on the part of the leadership in the latter to imbibe them. In the end, the countries that are perceived as more serious are the ones that adopt ‘modernity’ to a higher degree. Consequently, what development assistance entails is helping countries to become more ‘modern’. This idealization has its own ramifications of power: in the race towards modernity there is the need for some kind of organisation and the need to achieve a balance that maintains such elements as ‘fairness’, ‘equality’ and human rights. In the spirit of this balance bodies such as the World Health Organisation have become global custodians of best practices; they generate, regulate and enforce global norms on various countries and the ways they seek to develop. Again, the extent of seriousness is aligned to the degree to which these norms are embraced. One of the participants I spoke to is a senior marketing manager in a local pharmaceutical company and as we discussed the relevance of the WHO inspection to their product portfolio he said ‘you see, for us in the manufacturing industry what we take into cognizance again is the marketing aspect. It doesn’t make any marketing sense, if WHO is saying this line is no longer the line of choice; it is like if you are doing this, you are doing a disservice; so you want to at least stop that very line and see how you can pursue what is obtainable and is ideal’.

The discourse of seriousness is thus backed by the idea of cooperation which creates the impression that all hands are on deck to deal with the problem. The guidance and direction of the dominant partners in the enterprise of development therefore acquires a forceful idealism which is able to coax out acquiescence from recipient environments with minimal or no challenges at all. The kinds of rationalizations that take place within

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38 Interview 23, joint interview with two executives of a pharmaceutical company in Lagos, Nigeria, 9/11/2011
development practice mean that once a situation is globally defined as a problem, it becomes expedient for it to be seen nationally as a problem. This is even more so today as development assistance is increasingly fractionalized. A new programme is set up to address practically each and every identified problem and funds are generated and disbursed through that programme for that problem; examples abound in malaria control: Assured Artemisinin Supply System (A2S2); Voluntary Pooled Procurement (VPP); Affordable Medicine Facility for Malaria (AMFm); ACTwatch; CHAI Procurement Consortium; DFID/SUNMAP (Support to Nigeria’s Malaria Programme) etc. If there is no shared national/global perception of the problems projected through these programmes and also the way they are articulated, accessing the funds available through them will simply be impossible. As it happens, national authorities in Nigeria rationalize development needs as funding needs; if money is being disbursed through a programme, it is seen as always beneficial to the country to be part of the programme. What usually happens with these global programmes is that the public sector is usually first in line to adopt whatever plans a new programme is putting forward, leaving the private sector behind. This public/private dynamic has implications for national coverage especially with the health seeking behaviour of Nigerians assumed to be about 40% public and 60% private. The Global Fund’s response to this dynamic was to appoint a Principal Recipient – Society for Family Health (SFH) - to specifically target the private sector. By responding dutifully to this discourse local politicians are also seen to be operating in a development space which the backing of powerful global bodies helps to legitimize. Progress within this space can be claimed as victories by both internal and external actors: a unity that is facilitated only through the standardization of seriousness.

Part of the consequences of idealizing modernity in this way is that the development agenda for poor countries becomes highly protean. Each time there is a new technology a new regime of regulation accompanies it. Usually this new regime disregards the old technology and as such thwarts the agency of the people in the recipient country who might have started to adapt the technology in ways that produce multiple benefits to them. There is always a good reason given for abandoning the old approach for the new e.g. artemisinin mono-therapies might lead to drug resistance so we ban mono-therapies. But in practise the behaviour of these multi-lateral organisations begins to look more like governance. If these bodies are invested with so much authority within what are traditional spheres of state power, the question that it provokes is whose
interests they will ultimately be serving and how much relevance is assigned to public opinion in the recipient countries.

An even more systematized way of reinforcing this discourse of seriousness is the global control of the reporting process. Progress is defined and reported on by global institutions; poor countries are expected to take action and embark on programmes that would lead to what can be defined globally as progress. As Paul Driessen identified in a 2005 newspaper article, international organisations like USAID, WHO and UNICEF ‘proclaim insecticide-treated bed nets a success for reducing malaria rates by 20% - but say DDT was a failure because it did not completely eradicate the disease’.  

**Fig.2 - Advertisement for Leaf Logo ACT - Source: SFH Annual Report, 2009-2010**

39 Paul Driessen “Let’s Change Anti-pesticide Policy”, *Thisday*, 29 July 2005
40 The main caption in the advertisement says ‘The ACT with this logo is the authentic malaria medicine at a low cost’. The sub-caption says ‘The ACT with the green leaf logo on its packet is the authentic ACT that works very well for malaria. What makes it better is that it is cheap. This is because the government and Global Fund have subsidized it so that everyone can have access to it. NAFDAC has also approved it’.
This kind of power comes from the ability to control what is reported to the world and how it is reported. Poor countries are grouped under the regimented aegis of international bodies; as the World Bank and the IMF supervise matters of economic structuring, WHO supervises matters of global health governance. This regimentation ensures that the media through which progress or failure is reported are strategically controlled. The way performance is evaluated and reported in such media as World Malaria Report, WHO Annual Report etc. becomes standardized. Among poor countries a race to the top of these reports is created. The thinking is that if these international bodies have such a multiplicity of countries to look after, the way international development resources are allocated may be such that more of it goes to the countries that are seen to be aligning themselves with the guidelines and direction of these bodies and also producing what they will consider to be commendable results. Global plans and targets such as the Millennium Development Goals (MDGs) and the Global Malaria Action Plan (GMAP) are not just strategic objectives for articulating approaches to solving health problems; they also operate as beacons of seriousness. And they are often invoked as a rallying call to seriousness whenever there is a need to focus attention on specific elements of the plan. For instance the Programme for Appropriate Technology in Health (PATH) in its desire to direct the focus of malaria control expenditure to research and development declared (in a report titled ‘Staying the Course’) ‘one of the key messages from the GMAP was that the best way to achieve these goals and to dramatically reduce future costs of malaria was to dedicate a short-term time window to increased investment in new tools now… however, the onset of the global financial crisis and shifting government interests have the potential to undermine donor commitment and investments, threatening the significant progress already made toward the GMAP goals’ (PATH, 2011: 8). Stressing the need to continue to make progress towards the GMAP goals in this way tends to focus attention on that specific objective as the ideal and unassailable mission.

Similarly, the Global Fund has a rating scale \((A: \text{Meets or exceeds expectations}; \ B1: \text{Moderate}; \ B2: \text{Inadequate but potential demonstrated}; \ C: \text{Unacceptable})\)\(^{41}\) that is quite effective in incentivizing countries to demonstrate more seriousness. It is called Performance Based Funding and it means that those countries that are taking the right measures and achieving what is seen as the right results get more funding; this is

demonstrated in fig.3 below, with an explanation in Global Fund’s own words taken from its website. It was clear that my respondent was totally absorbed into a mind-set of ascending up this scale as he discussed the country’s malaria control efforts with me. He gleefully declared to me in our interview that ‘with that phase two and with the changes that came about we were able to move to, I think, B1, and B1 says ‘you have demonstrated capacity; however there are still areas for improvement. That is the direct translation of that B1. That is a signal, a blue signal that you can comfortably go for another round and you’ll get it. So we went in for round eight which is the grant that is currently working now. And when we went in for round eight we got round eight approved’.

Beyond the rating scale, a process of pitching for funding is introduced. The standards of scrutiny are not just to ensure that funds are efficiently disbursed; they constitute part of the internal rules governing the discourse of seriousness. Those rules have certainly had a profound effect on the official I spoke to. When the decision was taken to get a third principal recipient to drive the adoption of diagnostics as a malaria control intervention, Access Bank which if one of the major banks in Nigeria initially expressed interest and subsequently pulled out. His interpretation of the withdrawal of interest is that the bank might have found it overwhelming. As he put it, ‘it is so technical and it is time consuming; you have to really put your foot down and say I’m going to work on this result or nothing’.

In its own pitch with Global Fund, the National Malaria Control Programme had occasion to put its foot down and demonstrate some seriousness: Global Fund initially had concerns about bureaucracy which almost ruled them out, but as my respondent explained ‘we told them point blank that NMCP had implemented HSDP2 (Health System Development Project 2) for World Bank and with that system development project for World bank the fiduciary is such that bureaucracy was cut down: instead of passing through eight tables we reduced it to just two or three in HSDP. And we told them for the bureaucracy we are going to use the experience learned in HSDP to correct and that is what is happening now’.

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42 Interview 16, National Malaria Control Programme (NMCP) official, Abuja, Nigeria, 25/10/2011
43 Interview 16, 25/10/2011
44 Interview 16, 25/10/2011
“Performance-based funding ensures that funding follows performance.”

Funding decisions based on performance (at Grant Renewal)

The above figure shows the percentage of funds earmarked in the original proposal for Grant Renewal that has actually been committed to grants following the performance assessment conducted towards the end of the second year of implementation (Grant Renewal process). The graph demonstrates that the well-performing grants in the Global Fund’s rating scale (A and B1 rated) have received a much higher percentage of their original amount, compared to B2 and C rated grants (poorer-performing grants). The above figure shows the percentage of funds earmarked in the original proposal for Phase 2 that has actually been committed to grants following the performance assessment conducted towards the end of the second year of implementation (Phase 2 review process). The graph demonstrates that the best-performing grants in the Global Fund’s rating scale (A and B1 rated) have received nearly their entire Phase 2 amounts, while B2 and C rated grants (poorer-performing grants), have received less.

Where bureaucracy is a potential obstacle to the objectives of international development a policy of eliminating bureaucracy will not be dictated or set as conditionality. Conditionality operated as part of a discredited approach to development assistance where countries were either asked to democratisre or restructure their economies in order to qualify for assistance. The approach today is to create a pan-optic environment in which the independent action of countries and their seemingly self-regulating decisions all produce carefully orchestrated outcomes.

From the foregoing, the argument has been made that a discourse of seriousness exists in relationships of international development and that this discourse is instrumentalized

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45 The Global Fund, “Performance Based Funding”
in the way external organisations engage with recipient countries in contexts of development transactions. The question remains however whether the conceptual apparatus of discourse is a useful organising principle for this kind of instrumentalization. Many scholars (Wetherell, Taylor and Yates, 2001; Gee, 2005; Brown and Yule, 1983) define discourse most succinctly in relation to language use, whereby language and the way it is constructed is loaded with its own enforceable meanings, it is also generally noted that the term could be extended to cover a range of semiotic expressions which, in aggregation, encompass other forms of signification. Discourse therefore is not always exclusively related to textual and verbal expressions (Adlam et al. 1977 cited in Macdonnell, 1986: 3). Imposing UN buildings; ‘red carpet’ receptions for visiting UN dignitaries; events such as ‘World Malaria Day’; programme paraphernalia, including very imposing all-terrain vehicles running around in very poor local settings all combine with other symbolisms to impose a compelling sense of rationality and facilitates a deeper entrenchment of the operative discourses in current relationships of international development. Such discourses then become all the more effective as tools for communicating specific agendas because the international organisation is positioned as equipped with a more pragmatic rationality, a level of rationality which the semiotic aggregation tends to show as producing ‘better results’

Perhaps what most aptly organises the elements of the relationships elaborated in this chapter into a discourse of seriousness are those internal rules of engagement such as performance based funding whereby national control programmes are goaded into particular actions in order to be endowed within a grading system that is linked to funding. This is a meaning of discourse more readily discoverable in Foucault’s conceptualization of it. For Foucault in The Archaeology of Knowledge, and perhaps Said in Orientalism (1978), discourse goes beyond the persuasive use of language to influence. It harbours its own internal rules that govern the way speech and writing is constructed to produce effect or knowledge. Foucault however recognises the looser use of the term when he said ‘instead of gradually reducing the rather fluctuating meaning of the word ‘discourse’, I believe I have in fact added to its meanings: treating it sometimes as the general domain of all statements, sometimes as an individualizable group of statements and sometimes as a regulated practice that accounts for a number of statements (Foucault, 1972: 90). The last part of this statement stresses the meaning of discourse that Foucault is more concerned about: the idea that the rules governing
the particularized construction of statements are equally (if not more) important as the statements they produce and an understanding of those rules or what he calls discursive formations allows an extension of the simpler meanings that are garnered otherwise. Following Foucault Said refers to similar rules as ‘strategic formation’, which he describes as ‘a way of analysing the relationship between texts and the way in which groups of texts, types of texts, even textual genres, acquire mass, density, and referential power among themselves and thereafter in the culture at large…everyone who writes about the Orient must locate himself vis-à-vis the Orient; translated into his text, this location includes the kind of narrative voice he adopts, the type of structure he builds, the kind of narrative themes, motifs that circulate in his text - all of which add up to deliberate ways of addressing the reader’ (Said, 1978: 20). It is thus possible to surmise that the best way to study the effect of development assistance is through a careful scrutiny of how the specific relationships between the beneficiaries and benefactors are constructed.

**Conclusion**

In spite of the severe toll malaria has taken on human lives in Nigeria, the context in which malaria control operates in the country is not one in which the country looks inwards in generating strategies for combating the disease. It looks out-wards to international organisations and ‘development partners’ to not only generate strategies for tackling the problem but also strategies for funding and implementing programmes aimed at dealing with it.

The fundamental weakness of this mind-set is that it does not seem to acknowledge that it is impossible to separate the idea of international development from the idea of international economic competition. Development assistance can be noble in its nature but can hardly overlook the strategic interest of those rendering it. Where the problems being dealt with require deep-probing fundamental measures as well as peripheral measures, international development will always settle for the latter precisely because it is sufficient for it to define a role for itself in the affairs of the countries being assisted. It ignores fundamental issues that engender economic disadvantage and poverty and deals with problems almost always from a technical standpoint. Where infrastructural defects are identified, poor countries are advised to seek loans from the World Bank or
IMF to deal separately with such problems which plunges them further into economic crises.

In order to maintain its own relevance, international development seeks to control the perception of development problems as well as the way the solution is imagined. There have been a number of ways in the past through which this control has been achieved but more recently what is emerging is a discourse of seriousness through which the seemingly independent actions of Third World countries are guided towards specific outcomes. Without directly dictating policy international development is able to achieve these outcomes through three main strategies namely the strategic deployment of language, the idealization of modernity and the control of the reporting process. Development actors do not merely come to ask how they can help with what is being done locally; they come with an agenda to do things a pre-defined way. Evidence on the ground also shows that the effort made locally is to keep in tandem with global frameworks.

Acquiescing to global frameworks in this way shows that, at least in some respects, there’s a unity in the interests of the post-colonial elite and the international development community. However, in the end, the post-colonial state will do well to review its role in enhancing the productivity of its population and hence the vital linkages of that role to public health. In order to fulfil this role it needs to seek to break out of the structural impositions of its political history and reclaim the policy space that is currently clearly dominated by external or globalized policy responses to national health problems. This is even more urgent because much as global responses are driven by what Didier Fassin (2012) calls humanitarian reason, ideological persuasions and long term national interests of external actors often impose inescapably dogmatic views of development on the process.46

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46 Didier Fassin (2012) focuses his discussion on the complex moral web of redemptive responses and strategic empathy that are constitutive of humanitarian action. Contemporary humanitarian interventions have thus taken on the form of a compelling responsibility and they end up producing relationships which allow powerful countries to govern the conduct of smaller ones – a development he refers to as ‘humanitarian government’.
**Chapter Five**

Malaria Control and the Long Road to Modernity

**Introduction**

We have soup that we prepare for people; we call it *ogburu* soup. If you have very serious problem of malaria we’ll prepare that soup for you. We prepare it with *ewuro* which is bitter leaf in Yoruba language; *efinrin* which is scent leaf; then we put small *ogburu* there; then we put small garlic, it is not very essential but we put small also; we put small ginger and we cook it with *iru* which is locust beans. We then prepare it with small cat fish: the original one, not the ones from agricultural [farms]. The ones we do are the natural ones that came from nature not the adulterated ones. So after they have been cooked in specific quantities it will relieve the fever, the feverish condition will cool down and this person will begin to recover. Then along the line we prepare this concoction (this *agbo*) from *oruwo* [*Morinda Lucida*¹] and some other leaves that I use, the fallen ones from the paw-paw tree are also very effective. At times we use the bark of mango depending on the severity of the patient.²

Practically any traditional medicine practitioner in Nigeria can draw up a formulation, like the one described to me above by one of them, for managing almost any disease. It is sometimes basic and in some other cases very complex. Given its geographic prevalence and historical significance, malaria is particularly commonly treated by traditional medicine practitioners. This is especially so for rural dwellers who for reasons of poverty have limited access to modern medicine. But also, due to cultural and historical experience, rural as well as urban dwellers can often show a preference for traditional medicine.

¹ *Morinda lucida* is a tropical West Africa rainforest tree also called brimstone tree. The plant has several names like *Oruwo* in Yoruba; *njisi* in Igbo or *marga* in Hausa languages of Nigeria. Its leaves are widely used in the treatment of malaria, typhoid fever, jaundice and dressing of wounds to prevent infections. A weak decoction of the stem bark is used for the treatment of severe jaundice, cancer, poor or low sperm count and diabetes”. See Sade Oguntola, *Nigerian Tribune*, “ *Morinda lucida* shouldn’t be consumed for more than three weeks –Study”, 29 December 2011, http://tribune.com.ng/index.php/natural-health/33471-morinda-lucida-shouldnt-consumed-for-more-than-three-weeks-study

² Interview 9, traditional medicine practitioner, Lagos, Nigeria, 15/09/2011
The conjuncture between modern biomedical practice and historical healing practices will form the subject of discussion in this chapter. This is so because much as the control of malaria is represented as an extremely important problem on the current global health agenda, and all manner of assistance programmes are designed to help a seemingly helpless and, to all intents and purposes, hapless continent, historically malaria treatment in Nigeria did not begin with the colonial introduction of quinine; there are long standing therapeutic practises that have been devised in the treatment of the disease. There is also evidence that even according to the criteria of Western science, a lot of those practices might well be efficacious (Gessler, 1994, cited in Willecox et.al. 2004). This by itself is an interesting point and it is one that the policy environment in Nigeria is adjusting to as it gets re-crafted and redeployed.

The long history of treatment practises with popularly affirmed efficacy is one thing, but their development into medical regimens that could be more usefully adopted for the control of malaria is quite another. These long standing practices have in general not developed beyond their historically rudimentary forms. But the fact that artemisinin, the global drug of choice against malaria today, is a product of Chinese traditional medicine has renewed the debate about the potential roles that traditional medicine could end up playing in a future Nigerian antimalaria programme or the revenue earning potential that similarly efficacious antimalarials to artemisinin might deliver to the country.

So, this chapter discusses traditional medicine in its current state in Nigeria and attempts to answer questions regarding why, in spite of its long pedigree, it has been unable to evolve to a point where it substantially caters for the treatment of malaria. It will consider the perceptions traditional medicine practitioners have of their relevance and how they claim traditional medicine can be integrated into the national programmes for controlling malaria. It also looks at attempts to modernize the practice of traditional medicine, nationally and internationally and how they show that international development and Western patent regimes form part of transnational dimensions of governance which operate to limit the capacity of countries like Nigeria to deal with medical problems such as malaria. The chapter concludes that important structures of power exist to keep traditional medicine subservient to a biomedical orthodoxy or to

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3 Ityavyar (1987) gives a pre-colonial background to the development of health services in Nigeria. See also Mgbeoji (2005); Oguamanam (2003). See Flint (2008) and Langwick (2011) for traditional healing practices elsewhere in Africa.
acquire its content, reprocess it and ultimately churn it out as part of Western intellectual and material production. The condition that makes this possible is linked to organised regimes of biopiracy, intellectual property rights (Kloppenburg, 1988; Coombe, 1998; Sarma, 1999; Shiva, 2001; Mgbeoji, 2006;) and ‘good manufacturing practices’, GMP (Craig, 2011; Immel, 2000).

**Toward Orthodoxy: Traditional Medicine and the Question of Relevance**

The ‘traditional’ as an analytic category is not as straightforward as is often imagined. Especially in the context of African political organisation or social and economic production, it does not always connote a tenacious connection to a value-laden or normative past that is embraced in order to ensure continuity. It can often refer to particular sets of practices that have been rendered distinct from imposed colonial forms of practice. This distinction can be necessitated by the need to create clear boundaries of difference. It is thus a category that has been variously contested as ‘invented’ (Ranger, 1983; Chanock, 1985; Mamdani, 1996) and not to be taken literally (Berry, 1993; Pierce, 2001; Rao and Pierce, 2006).

The historical team work between Christianisation and colonization had the effect of conjuring alterity. Africans, in a general sense, became induced into a traditional/modern dynamic that enabled what is Western as not just modern but far more capable of producing scientifically verifiable outcomes. Medical practice was not spared. It was a practice that constituted a field of power in the colonial encounter. The diagnosis and management of disease was a source of elite power in pre-colonial African settings and part of the process of establishing colonial power was the wresting of such powers from African practitioners. A power play for legitimization was opened up, necessitating a claim to orthodoxy by Western medicine. Colonial health practice and policy along with its missionary adjunct was therefore very pre-occupied with difference and was largely invested in disabling traditional notions of therapeutic efficacy as well as therapeutic legitimacy (Vaughan, 1991: 12-19). This it did by ascribing nearly all forms of African medical practise to the superstition. Citing Terence Ranger, Feierman and Janzen (1992: 14) note that it was not uncommon to find accounts such as that of a certain missionary who refused to provide medicine for treating a child’s sores until the mother disavowed all charms, which the missionary referred to in his accounts as the

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4 See Vaughan 1991 for how these processes unfolded in Africa and Arnold 1993 for a discussion of similar processes in India.
‘medicine of the devil’. In other cases the disdain for African medicine was reflected in accounts that referred to its practitioners as sorcerers and fetish priests and applied the terms ‘medical profession’ and ‘medical care’ only in quotation marks (Bruchhausen and Roelcke 2002: 78).

The category of medical practice that was ‘invented’ under the label of ‘traditional’ has persisted under the shadow of dominance by bio-medical practice. More recently, the practice appears to be expanding and making strong claims to mainstream spaces. In developing countries such as Nigeria 70% of the population still depend on traditional medicine in one form or the other (HERFON, 2006: 275). The attraction of such a huge market has meant that, in contrast to the colonial effort to repress it, it is now widely embraced by bio-medical scientists as vital to the total package of healthcare delivery today. The World Health Organisation has defined the practice as ‘the sum total of knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures that are used to maintain health, as well as to prevent, diagnose, improve or treat physical and mental illnesses’.

The way traditional medicine is defined even by WHO does not do much to banish the spectre of alterity the practice casts on medical consciousness. But its practitioners are gaining increasing confidence as Chinese traditional medicine increasingly delivers medically affirmed efficacious products to the global pharmaceutical market. Since the International Conference on Primary Health Care, Alma-Ata in 1978, the gaze of health systems in most of Africa has been directed at traditional medical practice. In South-Western Nigeria for instance, this spotlight coincided with the return to democratic rule in the country after a long period of military dictatorship. The promise of free universal health care made by the Unity Party of Nigeria (UPN) could not be implemented in the

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5 Flint’s 2008 study of cooperation between traditional medicine and biomedical practice in South Africa showed that the two operate on divergent ideas but share a history of commercial and ideological competition. They also have gradient relations to state power. Singer and Fisher (2007) have also declared that biomedical co-option of traditional medicine is a tactical strategy to preserve its dominance through control of the knowledge base of other genres; see also Hans Baer and Ian Coulter (2008). This project of integration between global and local spheres has also recently been spreading across many fields; for similar projects in environment and ecology, see Paul Nadasdy (1999) or Deborah McGregor (2005).


7 Kim Taylor’s Chinese Medicine in Early Communist China (2005) gives a brilliant insight into how the rise in profile of Traditional Chinese Medicine (TCM) is the result of a conscious effort on the part of the Chinese Communist Party (CCP) to develop it in support of the Communist revolution. TCM has so successfully held its own against the might of Western medical orthodoxy that Taylor argues its success story is unparalleled anywhere else in the world. The success of TCM has in effect raised the profile of traditional medicine everywhere else. See also Mei Zhan’s Other-worldly: Making Chinese Medicine through Transnational Frames (2009).
states where the party won the election, due mainly to a shortage of health manpower. This saw an increased momentum in the induction of traditional healers into health delivery in the region (Oyebola, 1986: 227) and the taste for professionalization of their practise has not waned since. This interest in professionalizing their practice is even more intense across Nigeria today as the cost of living increases exponentially; traditional healers are no longer content to earn paltry incomes from their practice and yet it is difficult to transcend the long held perceptions of their practice as something of a dark art if nothing else; a perception fuelled in the first place by early Christianisation and intensified even more today by the rapid spread of faith healing churches in the country. The strategy for overcoming these challenges has been to seek recognition at a national level and hence integration into the health delivery system. As will be explored below this has created a struggle for control and ownership.

Efforts are constantly being made by traditional medicine practitioners to acquire a role in the control of malaria in Nigeria. Government mechanisms such as government funded research institutions are set up to coordinate such efforts. But yet traditional medical practise is not integral to how malaria is controlled. While the government officially claims that the greatest obstacle to this integration is the reluctance of the traditional medicine practitioners to share knowledge about their formulations for purposes of evaluation and standardization, a research team was recently able to secure the cooperation of the Bornu state chapter of the Traditional Medical Practitioners Association in obtaining detailed information on plants used in treating malaria by three main ethnic groups in the state (Ene et al, 2010: 487). The result of the team’s ethnomedical study shows that traditional herbal medicines are highly relevant to indigenous peoples in Nigeria in terms of how they treat ailments such as malaria and the three major ethnic groups in the country share roughly similar platforms with regard to knowledge of plant based medications (see table 7) although there may be culturally specific differences in how the diagnosis of particular ailments are approached. For instance the leaf of the *Vernonia amygdalina* plant may be more commonly used among the Ibo and Yoruba tribes simply because it is more naturally occurring and has persisted historically in those geographic areas than among the Hausas in the North but in general all the cultures resort to the use of plants of different sorts occurring in nature for the cure of malaria. Wild animals are also sometimes used in the cure of disease and this practise may also be distinctive from community to community in terms of which animals are actually used, even for the cure of the same diseases. The distinctions may
be based on religious requirements such as Muslims being forbidden from consuming monkeys and Warthogs (Adeola, 1992: 132) or cultural practices relating to the totemic veneration of some animals such as the Kwale people of the Niger Delta being forbidden from eating Rams.

In spite of these distinctions, the general way in which traditional medicine is practised is largely similar among the various cultures in Nigeria. The Neem tree (*Azadirachta indica*) for instance is common to all the ethnic groups and is known as *Dogonyaro* in most parts of Nigeria. It particularly stands out among plant formulations for malaria therapy in the country; ‘the plant leaves contain the lemonoid gedunum which has demonstrated activity against two clones of plasmodium falciparum (causative agent of malaria) and in laboratory analysis appeared to be as effective as chloroquine. In addition… the oil from this plant has been shown to have insecticidal and insect repellent properties’.\(^8\) The anti-malarial properties of *Vernonia amygdalina*, known among the Igbo of Eastern Nigeria as *Onugbu* and among the Yoruba of the South-West as *Ewuro* has also been reported on in a number of studies (Abosi and Raseroka, 2003; Iwalokun, 2008, both cited in Sha’a et al, 2011). Aqueous extracts of the plant were used to enhance the anti-malarial effects of chloroquine resistant strains in mice and the result permitted the conclusion by researchers that the ‘study validates the traditional use of *V.amygdalina* in the treatment of malaria in Nigeria’ (Sha’a et al, 2011: 7).

It is therefore not so much a case of unwillingness on the part of the practitioners to divulge knowledge but it is, in many cases, how much trust is built up and how convinced they are of the uses to which the knowledge will be put. If the traditional practitioners are convinced of anything, it is that the government is not serving their interests. Rather it serves the interests of multinational corporations and the misuse of international patents will always mean that practitioners get side-lined in the end (Mgbeoji, 2006: 7).\(^9\) One participant at a pharmaceutical research institute explained it this way:

> Both sides have reasons: one is because of this awareness, this new trend in natural medicine, herbs generally; awareness has always been there but there is more of it

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\(^8\) Chukwuma Muanya, “Local Malaria Therapy Shows Promise”, *The Guardian* (Nigeria), April 7, 2011, p. 35

\(^9\) For more on misuse of international patents, see also Anthony Stenson and Tim Gray (1999) as well as Klaus Bosselman (1996)
now. So they have this fear that giving out their information means it is going to be taken away from them. They’ll turn it into something else, change the name, turn it into something big and gain from it while ignoring them. They have that fear, so they don’t usually give out their information easily to those in government except those trained in that area. You know, there are procedures [involving] those of us who work with these groups. Even though we work with them for long periods and gain their trust, you still find one or two that will still not be sincere with you but after some time they are ready to open up based on what is on ground. The herbalists too are also right that they don’t get feedback sometimes because there’s typically some bureaucracy in government agencies. They might supply a plant extract and say it is used for so and so but maybe at that particular moment the model of that is not available; there’s a lot of things involved, maybe materials are not there. It takes some time. So they also have a claim but generally it is just both ways. And you asked that question, is there something put in place? Yes there is, like what our organisation has been able to do for some time: we have an ethno-botany unit. I wish you could talk to [my colleague]. He is somebody who has been in that field for a very long time; he has worked with herbalists, he has worked with international organisations, so he has a lot of experience on how to deal with those people. So based on that, we share the training and experience, some of them can trust us and give out their information. Then there are also interactive forums that we do with them, bringing them together, discussing with them, and telling them the pluses and the minuses: what they can gain and what we can gain…it is not 100% but we kind of enjoy a certain high percentage operation from them. There’s still some level of mistrust here and there though.

What this points to, is that dealing with traditional practitioners requires a level of tact that is not widely available. Because of a high level of mistrust, conventional ways of reaching out to the practitioners do not yield much by way of cooperation and openness. Trust comes from forming enduring relationships with them, which then allows a fuller understanding of their concerns. What the traditional practitioners are most concerned about is the question of ownership of intellectual property rights and how they can be reasonably guaranteed that they will reap commensurate benefits from divulging the

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10 Interview 20, pharmaceutical researcher at the National Institute for Pharmaceutical Research and Development (NIPRD), Abuja, Nigeria, 31/10/2011
<table>
<thead>
<tr>
<th>Local Name</th>
<th>Plant Name</th>
<th>Plant Parts</th>
<th>Uses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hausa</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ayaba</td>
<td>Musa sapientum</td>
<td>Leaf</td>
<td>Honey is added to Plant decoction and taken as drink</td>
</tr>
<tr>
<td>Lemu sami</td>
<td>Citrus limon</td>
<td>Leaf</td>
<td></td>
</tr>
<tr>
<td>Gwanda gida</td>
<td>Carica papaya</td>
<td>Leaf</td>
<td></td>
</tr>
<tr>
<td>Mangoro</td>
<td>Magnifera indica</td>
<td>Leaf</td>
<td></td>
</tr>
<tr>
<td>Sabara</td>
<td>Guiera senegalensis</td>
<td>Leaf</td>
<td>Decoction of guava and lemongrass leaves with potash is taken as drink</td>
</tr>
<tr>
<td>Gwaiba</td>
<td>Psidium gujava</td>
<td>Leaf</td>
<td></td>
</tr>
<tr>
<td>Chiawa sami</td>
<td>Cymbopogen citratus</td>
<td>Leaf</td>
<td></td>
</tr>
<tr>
<td>Tazargade</td>
<td>Artemisia maciverae</td>
<td>Whole Plant</td>
<td>Plant decoction with lemon and red potash is given with local gin</td>
</tr>
<tr>
<td>Dogonyaro</td>
<td>Azadirachta indica</td>
<td>Leaf, stem bark &amp; root</td>
<td></td>
</tr>
<tr>
<td><strong>Yoruba</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ewe Owuro</td>
<td>Vernonia amygdalina</td>
<td>Leaf</td>
<td>Plant decoction is given with local gin</td>
</tr>
<tr>
<td>Ewe okporokporo</td>
<td>Zea mays</td>
<td>Leaf</td>
<td></td>
</tr>
<tr>
<td>Dogonyaro</td>
<td>Azadirachta indica</td>
<td>Leaf, stem bark &amp; root</td>
<td></td>
</tr>
<tr>
<td>Ekpo Mangoro</td>
<td>Magnifera indica</td>
<td>Bark</td>
<td>Plant decoction is taken as drink</td>
</tr>
<tr>
<td>Eweti (lemon grass)</td>
<td>Cymbopogen citratus</td>
<td>Leaf</td>
<td></td>
</tr>
<tr>
<td>Gwava</td>
<td>Psidium gujava</td>
<td>Leaf</td>
<td></td>
</tr>
<tr>
<td>Ibepe</td>
<td>Carica papaya</td>
<td>Leaf</td>
<td></td>
</tr>
<tr>
<td>Ewe ogede paranta</td>
<td>Musa sapientum</td>
<td>Leaf</td>
<td>Plant decoction is taken with lime orange as drink</td>
</tr>
<tr>
<td>Ewe cashu</td>
<td>Anacardium occidentale</td>
<td>Leaf</td>
<td></td>
</tr>
<tr>
<td>Ewe Osan</td>
<td>Citrus limon</td>
<td>Leaf</td>
<td></td>
</tr>
<tr>
<td><strong>Ibo</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gova</td>
<td>Psidium gujava</td>
<td>Leaf</td>
<td>Plant Decoction with pineapple is taken with honey.</td>
</tr>
<tr>
<td>Okwuru</td>
<td>Carica papaya</td>
<td>Leaf</td>
<td></td>
</tr>
<tr>
<td>Ahihia lemon</td>
<td></td>
<td>Leaf and stem bark</td>
<td>Plant decoction is given with local gin</td>
</tr>
<tr>
<td>Dogonyaro</td>
<td>Azadirachta indica</td>
<td>Leaf</td>
<td></td>
</tr>
<tr>
<td>Oloma nkirisi</td>
<td>Citrus limon</td>
<td>Leaf, stem bark and roots</td>
<td></td>
</tr>
<tr>
<td>Mangoro</td>
<td>Magnifera indica</td>
<td>Leaf</td>
<td></td>
</tr>
<tr>
<td>Une</td>
<td>Musa sapientum</td>
<td>Leaf</td>
<td></td>
</tr>
<tr>
<td>Onugbo</td>
<td>Vernonia amygdalina</td>
<td>Leaf</td>
<td></td>
</tr>
</tbody>
</table>

*Source: Ene et al, 2010*
secrets of their trade. An impasse is created as each side in this struggle for relevance tries to claim the moral high ground: biomedical scientists claim traditional practitioners are not yielding to efforts to refine and update their practice while the latter maintain that issues of rights ownership are at the root of the impasse. The meaning of ownership therefore needs to be placed in a critical context in order to unravel the deadlock and understand why traditional medicine is unable to play a major role in the control of malaria.

**The Science of Ownership**

In the view of one traditional practitioner, even when apparently making an effort to develop herbal formulations government biomedical scientists are often cunning in the way they seek the cooperation of traditional medicine practitioners. According to him:

About six years ago we could see some professors, some researchers who would come and say please give us your medicine or your drugs for analysis. By the time you give out, they come back to tell you they want to know the content and by the time you release this content to them they will tell you that during their research they could not find either efficacy or any result. At the end of the day they will claim the ownership of this knowledge; there’s no IPR, what we call Intellectual Property Rights. But if you want me to give you my formula, I must know what will be my benefit because I have no money to develop these drugs. When it gets to public, money will come; but by the time I leave the information to you, you will tell me that during your research there was no result. So that is our mission: if you say bring anti-malaria medicine we have; we will bring it but the magic behind it, we will not tell you. And you cannot expect geographically that the herbs you harvested from the North will be equal to what you find in the West or in the South. Like now in the North the rain is stopping; the medicinal plants are fermenting on the herbs but when you go to the South-South or South-East it is raining so I can give you for example ‘Dogonyaro’ that I use to cure malaria, then you can go to another environment and maybe you find the medicinal content very low there and you use the same Dogonyaro to treat the patient; if I’m treating it for two weeks, there you may spend one month before the result comes out; this is the

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11 The literature is replete with anthropological, legal and environmental discussions about the rights of indigenous people to bio-resources within their domain. See for example: Tom Greaves ed. (1994); Stephen Brush and Doreen Stabinsky eds.(1996); Francesco Mauro and Preston D. Hardison, (2000)
problem. So if the IPR is already out then we’ll give out our secrets very easily: there’s no magic there…Tell me, look, if you give me these drugs I will give you, at the end of the month or at the end of the year, let’s say 20,000 naira or 10,000 naira then I’ll know what I’m bringing to the company and at the end of the month or at the end of the year things will come out for me. Then if the drugs develop efficacy by a pharmacist or a company sponsoring it and it goes [world] wide, then I should know; either way my grandchildren will come and benefit out of it.\textsuperscript{12}

What this practitioner was suggesting is that while the rhetoric of international development assistance in helping to fight disease in the Third World is very strong, there’s always been such underlying discontent with regard to its effect and the forms that it takes, with many local actors remaining convinced that assistance in this area benefits the benefactors more than the beneficiaries. The crux of their discontent is that assistance tends to be more readily available only in the form of opening up local drug consumption to further market penetration by foreign drug manufacturers. In this process, traditional medical knowledge is repressed. If in the 70s and 80s, social scientists were largely focused on ‘critical studies of dubious practices by the pharmaceutical industry such as bribery, fraud in safety testing, dumping, and misinformation (Van der Geest et. al., 1996: 157), today the focus of the debate is more on the issue of biopiracy and global regulatory practices that stifle local pharmaceutical prospects.\textsuperscript{13}

Traditional medicine practitioners may face a bigger fight than is imagined. An international politics of intellectual property rights has been brewing for many decades, especially since leading economies such as the US started to experience declining manufacturing output as a result of competition from emerging global economies. The response of the US was to make intellectual property and patents its major tool for capturing international markets. In 1947, intellectual property was only about 10% of all US exports but had risen to 50% by 1994 (Shiva, 2001: 19). The US International Trade Commission came out with a figure of $43-61 billion a year as representing what the US was losing as a result of the non-uniformity of patent laws globally. The effort to plug

\textsuperscript{12} Interview 21, traditional medicine practitioner, Abuja, Nigeria, 02/11/2011
\textsuperscript{13} For the overwhelming pharmaceutical incursion into the Third World, see also, Silverman, 1976; Melrose, 1982; Muller, 1982; Silverman et.al. 1982.
this gap led to the Trade Related Intellectual Property Rights agreements (TRIPS) which has become the framework for patent laws globally (Shiva, 2001: 20).

With the backing that TRIPS provides, foreign companies are not really looking to cede intellectual property rights where they can insist on owning them. They do not enter domestic territories to make their technology available to indigenous rights owners for a ‘commission’. Rather they enter to prospect for rights and the currency they rely on is their huge research and development budgets as well as their expertise in managing drug development. An example is given by Shiva of Neem (*Azarichdita Indica*), a tree native to India but also found in Nigeria and known locally as *Dogonyaro*: ‘since 1985, over a dozen U.S patents have been taken out by U.S and Japanese firms on formulas for stable Neem-based solutions and emulsions’ (Shiva, 1998: 73). Even though the development of drugs acquired through such patents is based largely on indigenous knowledge, the drug companies argue that the application of new technologies to the production process is an intervention that converts naturally occurring plants into innovative medicines and as such the owners of the intervening technologies should own the rights to the eventual product (Shiva, 1998: 74; Correa, 2004, 2006; Patwardhan, 2005; Oguamanam 2006; Patwardhan and Mashelkar, 2009; Drahos, 2011).

The fact that therapeutic breakthroughs from traditional medicine have not proliferated across Nigeria does not mean that their potential prospect is not officially acknowledged. What it probably points to is the preponderance of rhetoric over action. Now and then, the government or even international development organisations actively engage traditional medicine in processes of advancement with declared objectives of capturing its essence. Hope is built up that some kind of ascendency will result for traditional medicine from the collaboration but it soon becomes obvious that the process by its very nature is enmeshed in mimicry, forming relationships with practitioners that regard them as groups that seek to copy rather than represent modern scientific methods in medicine. One of the practitioners reacted to the widespread condescension in a verbal tirade that did very little to mask his frustration:

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14 The politics of the TRIPS Agreements is a particularly interesting one: before 1994 (the year the agreements were negotiated) events in the global pharmaceutical market had become quite messy, with all sorts of investigations, embargoes, sanctions, tariff barriers and retaliations flying between the United States and the EC on one hand and the emerging economies of Latin America and Asia on the other (see Julio Nogues, 1990). All of this was because countries had different patent regimes. TRIPS and the standardization they introduced were thus pushed as a solution to the prevailing chaos. Analyses of their impact have however pointed to developing countries as the ones that bear most of the brunt (Duncan Matthews, 2002; Carlos Correa, 2000, 2007; Margaret Chon, 2006; Carolyn Deere, 2009).
We are not monkeys; our people are very rich in culture and in healing. Before the advent of Europeans, before the advent of any other people we had been healing ourselves. So we like to leave things for posterity to teach people who are willing, who want to actually develop but we want some certain things.\textsuperscript{15}

‘Certain things’, for these practitioners, meant in particular two things: first, the practitioners want their expertise acknowledged as important in the process of developing traditional medicine. And secondly, they want to be well remunerated for sharing that expertise. Expectations of this kind of reward encourage them to invest their energies in updating their practise and as such it is quite frustrating for them when they end up reaping no gains from the process. My respondent for instance was told that the budget for a particular collaboration scheme could only cover Lagos state but according to him:

I toured throughout the whole federation [even though] they only gave me stipends to circulate Lagos. Because my Association has national spread I had to go to Kaduna; go to Markurdi; go to Okija in the East; go to Enugu; I went to Ibadan, Ogun State and Abeokuta which was not known to them but I used to tell them because they could not fund it. I didn’t worry; I volunteered myself. So I’ve been volunteering and doing free medications all along. I don’t earn money; I and my [traditional] doctor partners at the centre, we don’t earn money.\textsuperscript{16}

He acted as coordinator of a group that collaborated with a WHO centre in the mid to late 90’s in Lagos state, Nigeria and he informed me that issues such as these were central to breeding distrust within the collaboration scheme and ultimately led to its collapse. The collaborating group had to separate themselves from a wider group of practitioners who were sceptical about WHO’s intentions \textit{ab initio}. He ascribed the flexibility of the first group to the desire of their aged leader to ‘leave something for posterity’:

Fortunately I was the coordinator for the traditional doctors there. I joined the centre in 1994 and by 1995 I became the coordinator because I’m educated; majority of our group from our own very association are illiterate but they are very

\textsuperscript{15} Interview 9, traditional medicine practitioner, Lagos, Nigeria, 15/09/2011
\textsuperscript{16} Interview 9, traditional medicine practitioner, Lagos, Nigeria, 15/09/2011
good in their trade. We don’t make false claims; our Baba\textsuperscript{17} [was] old, about ninety-something at the time… So he asked us to cool down, while other associations were jealous of these people, that when they get their recipe, they get their brain, they tap their traditional healing techniques or methods; they will not bring any result which has been the case all along but we continued. Our master asked us to continue to stoop. Rather than them stooping for us let us stoop for them and let us try to get something out.\textsuperscript{18}

The traditional practitioners felt cheated out of their dues and also felt that once the vital information the scientists were after was acquired, they treated them as being of no use to the process anymore. This grossly infuriated the practitioners and heightened tension between them and the Nigerian bio-medical scientists who were heading the centre:

At a point in time they said they were ready to fight but my master continued to pester them that they should not bother, that they should continue to collaborate.\textsuperscript{19} The scientists claimed to us that there was poor funding; they did not even say there was any money, so we were managing to come there without any money. We were volunteers; other groups were against us. Even the Lagos State Board of Traditional Medicine, the major organisers were against our own traditional medicine practitioners association of Nigeria which had a lot of illiterates; a lot of us are illiterates. They were very fortunate to have me.\textsuperscript{20}

It is also interesting that the participant made several references to the illiteracy of many practitioners. Modern influences have created ranks of educated elites among the traditional medicine practitioners which create new divisions of power especially as the educated ones are better able to navigate the route to modernity. They are trusted more by the authorities or by collaborating scientists to be better able to coordinate or manage collaborative projects. This also means that if there are budgets covering project execution the Western educated practitioner is more likely to manage such budgets or to be the liaison between whoever is managing it and the group. The uneducated ones are however much larger in number and are usually totally engaged in the trade. They

\textsuperscript{17} Baba is a Yoruba word for father. In this context it is used to refer to this particular individual as the recognised and respected head of the group.

\textsuperscript{18} Interview 9, traditional medicine practitioner, Lagos, Nigeria, 15/09/2011

\textsuperscript{19} The participant’s frequent use of master is connected to the fact that apprenticeship is the major mode of training of traditional medicine practitioners.

\textsuperscript{20} Interview 9, traditional medicine practitioner, Lagos, Nigeria, 15/09/2011
believe they are equally skilled in traditional medicine if not better skilled and would usually seek to assert themselves in any way they find to be within their capacity. More often than not the threat of *juju* is employed. This often evokes fear and timidity in their educated colleagues whose knowledge of traditional mystiques are often thought to have been adulterated by a foray into western education and other forms of Western orthodoxy. This has also created an atmosphere whereby even though a good number of traditional healers are willing to update, acts that lean too heavily toward Western Science can be seen as ‘selling out’ as it robs traditional practise of its essential character. Part of how my participant tried to make progress within the collaborative effort he was involved in was to organise workshops where notes were supposed to be compared with external participants but the more he did this, the more complex managing the group became even though he had invited a number of outsiders to lend authenticity to the project as something of a modern effort to move the trade forward. As he put it:

I invited my Indian colleagues; they were there. Some white people, some western educated doctors who are amenable to our line or who understood our trade… But some of them came, they are educated [but] when they saw that their colleagues have become professors some of them just left…so it is surprising that our people are jealous and those western people can be also jealous of themselves.\(^\text{21}\)

The problem of remuneration and the levels of suspicion that it breeds is strongly connected to the issue of ownership in traditional medical practice. The much bandied idea that practitioners are reluctant to divulge the secrets of their trade is strongly contested by most of the practitioners I spoke to. Rather they say the problem is that their ownership is not credited. As one of them said:

Later I came to see that not only my master was eager. A lot of other people are eager to give but they felt they needed something because we are too [poor]… you can see I’m very poor.\(^\text{22}\) Our people are poor; many of us are ready to leave things for posterity because after all if we die now some of us don’t even have issues to leave this system to.\(^\text{23}\) So we want people who are ready to be apprentice to us who want to learn from us. Even if they are medical, if they are scientists, if they

\(^{21}\) Interview 9, traditional medicine practitioner, Lagos, Nigeria, 15/09/2011

\(^{22}\) At this point the participant waved his hand across his decrepit lounge to reference his poverty.

\(^{23}\) Issues in this context means offspring
are illiterate, if they are our tribe, if they are not our tribe, if they are our nation, if they are not indigenes or whatever; we are ready to divulge it because we don’t know when we can die. Anybody can die; nobody told God that he will not come. So when we die people will remember us… Not that we are being exploited as such, not by our Western doctors but by our so called government gimmicks that they are using to control us. They will tap our sense: bring this, bring that; come and defend this at the board. And when you defend it you will not see any result. It is very disheartening.\

This problem of losing out in every instance of cooperating with orthodox medical practice and not being credited as owners of medical knowledge acquired through traditional healers is a problem that they ceaselessly highlight. Another respondent made his point about ownership by declaring: ‘we need assistance; we need symposia to create awareness; we need people like you who would sit down and interact with us, not people who would say okay give it to me and when you pass it to him it becomes his own’.\

It thus appears that ownership is supported by a science from which the practitioners are excluded. For Science to have predictable and definable application, it needs to operate within equally predictable and definable boundaries such as weights, measures, time, volume etc. Those boundaries determine the way various forms of knowledge are processed and evaluated. They also allow the reduction of complexities embedded within those knowledges. Proprietary rights to medicines are not conferred automatically on the person who discovered the curative application of their ingredients; he must also be able to render explanation to an epistemic community of scientists. Discovery is marked not by the knowledge of the plant mixtures that will produce curative effect but by an ability to identify and classify the plants and also identify and describe not only the curative effect it offers but as much of all its effects as possible. Citing James Buchanan, Ikechi Mgbeoji noted the example of Angharad Gatehouse, a scientist at the University of Durban who obtained some insect-resistant cowpea seeds that had been developed by local Nigerian farmers. He subsequently left the university and joined Agricultural Genetic Company of Cambridge and they applied for a patent on their ‘invention’ (Mgbeoji, 2006: 14).

24 Interview 9, traditional medicine practitioner, Lagos, Nigeria, 15/09/2011
25 Interview 21, traditional medicine practitioner, Abuja, Nigeria, 02/11/2011
The knowledge and methods of dissemination required for local medicinal products to be ‘established’ is unfortunately disabled in local terrains. It is a different kind of knowledge to the one the traditional practitioners offer: it is an enhanced kind of knowledge and it is also market friendly. It is a kind of knowledge that can be committed to permanent record and distributed; a very vital process in the transitioning of knowledge into markets. Mgbeoji thus also notes that patent law (especially US patent law) and its inherent biases (along with its mercantilist instinct) constitute quite a stumbling block to the advancement of traditional pharmaceutical knowledge and it greatly enhances biopiracy. ‘As an epistemological phenomenon, biopiracy delegitimizes the profound intellectual input of local farmers into the improvement of plants. Within the paradigm in question, centuries-old efforts of indigenous and traditional farmers are diminished by being referred to as ‘informal’ or ‘unorthodox’ or as lacking a scientific basis’ (Mgbeoji, 2006: 121). What this argument indicates is that biopiracy emerges out of a domain of power that is able to assert itself, through the instrumentality of international law, in a way that splits knowledge of medicinal plants into two realms. One realm is labelled crude and unrefined, analysed as being able to deliver very little or no economic value and underscores, by its very nature, the utility of the second realm of knowledge; the realm within which the transformative power of science is produced. The intervention that is made possible from this realm is what amplifies the economic value of the medicinal knowledge of plants.

The relevance of Mgbeoji’s arguments to this chapter is that it modifies our understanding of the seeming helplessness of local actors in dealing with the malaria problem and their consequent reliance on global actors. It is a helplessness that is engendered not by a paucity of knowledge at the local level but one that is maintained by the firm structures of global power.

The situation with traditional medical knowledge is that it is still far from lending itself to the ‘scientific’ archetype. Biomedical scientists are constantly demanding scientific proof of efficacy and safety guarantees from the traditional healers not because they doubt the efficacy of traditional remedies but because a full knowledge of the remedies is as important as, if not more important than, the actual curative outcomes they offer. Many Nigerians, including biomedical scientists, grow up convinced that many of these traditional medicines are quite efficacious. But they are also aware that because the knowledge upon which they are based is so insular the potential for misdiagnosis and
mistreatment is vast. Many of them therefore display a public ambivalence in the way they relate to traditional medicine while privately embracing it. One participant at the Lagos University Teaching Hospital (LUTH) alluded to this ambivalence in a story narrated about an encounter between someone who worked at LUTH and a traditional medicine practitioner:

I remember one of my people telling me about a man that he assisted. He said the man was old and he saw him by the road side. He said “Baba” where are you going” and he replied “Itire” or somewhere like that. He gave him a lift and got him to his house. After the man got out he said “my child you have done well: you did me this kindness”, I will give you something in return and he gave him the preparation for hypertension; at that time he was hypertensive. Not only did he use it, he gave it to a lot of our doctors in LUTH at the time. Those who used it used it and there were those who prescribed it to their patients. Now, that prescription has to be under the table. The average doctor will not tell you go and buy this, this and this, cook it and use it because it’s like they are being traitors to their own profession. But that doesn’t detract people or even themselves from using these things because they know their worth. So [he] said for a long time he wasn’t hypertensive anymore; he forgot about it until he got hypertensive again. He now went to the Baba; he went to his house and asked for him and they said “ah Baba died last year”. He said that was how he lost that thing forever.

This kind of ambivalence persists because traditional medicine practitioners are not only often incapable of articulating the knowledge that supports their practice but are also often reticent when biomedical scientists seek their cooperation and input into scientific methods of articulating and documenting traditional medical knowledge. The reason for this is often that the traditional practitioners are protecting what they imagine as secrets of their trade.

There was even a time [she continued] when we mounted a programme for them, for traditional doctors, to introduce them to basic sciences...with a view to making

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26 This kind of ambivalence is not limited to medical practitioners. Ethnographic accounts show that across Africa medical consumption is underscored by a high degree of ambivalence: see Ojanuga and Lefcowitz, (1982). For elsewhere in Africa, see Kent Maynard’s *The vicissitudes of medical identities in Cameroon* (2007)

27 ‘Baba’ is a generic term for referring endearingly to an old man. Baba in Yoruba language means father

28 An area in urban Lagos

29 Interview 8, medical researcher, Lagos University Teaching Hospital, Lagos, Nigeria, 14/09/2011
it easier for them to understand the activity or action of these things. So they wooed them to get these things from them and those people expected that they would give them something and then they didn’t.\textsuperscript{30} So these people now stopped giving them secrets because they felt that they were just exploiting them. That was more or less what killed that collaboration.\textsuperscript{31}

This ambivalence produces the vicious cycle at the root of the tension between traditional medicine and medical orthodoxy: the former seeks recognition without total divulgence whereas the methods of the latter demands total divulgence in order to confer such recognition. The perception of traditional medicine as crude and unrefined has thus lingered because this tension persists. Even the source or origin of most of the knowledge cannot be determined. Myths and legends attribute the origin in some cases to ‘wizards and witches, while others claim that when in a trance, it is possible to be taught the properties of plants by the spirit of an ancestor who practiced herbalism’ (HERFON, 2006: 277). Hunters have also been said to feature significantly in originating knowledge of medicinal plants. While hunting they may observe the plants eaten by wounded animals and make a mental note of which ones harmed them and which ones healed them (HERFON, 2006: 277). As one participant told me, this kind of direct experience forms the evidential basis of traditional medicine, obviating the need for clinical trials:

As far as traditional medicine is concerned we have gotten to the human testing for centuries so why do you now want to go back to the lab?\textsuperscript{32} People die of anaphylactic shocks from penicillin, but the majority of people don’t. So those individual idiosyncrasies are there for anything, orthodox or traditional. Rhubarb leaves are poisonous but the stalk is edible. How did people decipher that? Two or three people ate the leaves and they died; five or six people would have eaten the

\textsuperscript{30} ‘something’ in this context suggests a form of reward or monetary compensation

\textsuperscript{31} Interview 8, 14/09/2011

\textsuperscript{32} Clinical trials and validation remain central to how the prospect of traditional medicine in the medical mainstream is debated. This requires chemical standardization along with complex and rigorous models of proof. This degree of complexity is already standard practice in pharmaceutical orthodoxy and, strictly speaking, can hardly be labelled as an unfair requirement in the case of traditional medicine. The real problem is that for reasons connected to existing relationships of power, traditional practitioners are certain that this is a system that will displace them and leave them disconnected from the end product of their knowledge. For more on standardization, see Yuan and Lin (2000); Nyika (2007); Homsy et al (2004)
stalk and liked it, so they said we will just adjust: don’t eat the leaves, eat the stalk; that is traditional knowledge.\textsuperscript{33}

This is indeed traditional knowledge. The phrase ‘don’t eat the leaves, eat the stalk’ sums up the tension between traditional medicine and orthodox medicine. The rigorous tenets of modern science have a very limited relevance in the cosmology of the traditional society: advancement has not been traditionally dictated by the adaptation of science as we know it.\textsuperscript{34} Insofar as the embrace of science continues to be seen as the hallmark of modernity, whatever is characterized as traditional will seek to maintain its character and authenticity by eschewing any semblance it might bear to other products of modern science. So while traditional medicine seeks to be elevated unto an orthodox platform and be integrated into current health delivery systems, it paradoxically seeks to retain its traditional character. In cases where traditional remedies are processed and developed through modern scientific trials, such remedies are ultimately seen as having lost their traditional character: science simply acquires it and makes it its own. The struggle between the traditional and the orthodox will thus become less intense if modern science plays a more entrenched role in the lives of the people in a more general sense i.e. in the way they explain, or receive explanation, of the material world around them.

What this has created, in essence, is a two-speed evolution for traditional medicine: rather than the practitioners being the drivers of its advancement towards modernity, this role is played by the government’s biomedical scientists, and this remains a source of tension. The scientist who is able to publish details about plant remedies for malaria in the \textit{Lancet} or the \textit{American Journal of Tropical Medicine and Hygiene} for instance, is seen as more important to the process than the traditional practitioner who supplied the knowledge. What this brings into sharper focus is that science plays a significant role in maintaining the nexus between knowledge and power and, as a matter of fact, it plays an equally important role in breaking that nexus i.e. disconnecting power from knowledge. By taking action that reinforces scientific knowledge as a requisite resource for the exercise of power, established bases of power are able to discredit sources of alternate

\textsuperscript{33} Interview 8, 14/09/2011
\textsuperscript{34} This is a reference to science and its epistemic hegemony. It in no way attempts to fall back to Lucien Levy-Bruhl’s \textit{Primitive Mentality} (1923) which seems to suggest that the way traditional societies think is devoid of logic. The view expressed here follows Ogunniyi (1988) for whom “traditional and scientific modes of thought are alternative explanatory modes or organizing metaphors for coping with experience” (p.2). Although both modes of thought are not as incompatible as may be imagined, their respective trajectories are distinct
knowledge as ‘unscientific’ in order for either of two things to happen: such contending knowledges are either permanently repressed and hence disconnected from power or they are acquired and ‘scientifized’ in a process that involves stripping them bare and re-articulating them into more amenable qualities as well as quantities of knowledge. Traditional medical knowledge needs to be epistemologically acquired before its products make it to market and insofar as traditional medicine practitioners are unable to make this transition themselves or organise and facilitate it, all they will own is the curative knowledge internal to their practice; there will be no medicine in the biomedical understanding of it.

**Standardization, Discipline and Alignment: The Epistemic Acquisition of Traditional Medical Knowledge**

The Nigerian government and its retinue of biomedical scientists, putting traditional medical practice under intense scrutiny, are not all that the practitioners have had to grapple with. The World Health Organisation has recently been taking increasing interest in traditional medicine. This kind of global interest means that the operational space within which traditional medicine seeks to emerge into orthodoxy becomes more complex. The WHO recently declared that ‘in some Asian and African countries, 80% of the population depend on traditional medicine for primary health care. In many developed countries, 70% to 80% of the population has used some form of alternative or complementary medicine…Herbal treatments are the most popular form of traditional medicine; [they] are highly lucrative in the international marketplace. Annual revenues in Western Europe reached US$ 5 billion in 2003-2004. In China, sales of products totalled US$ 14 billion in 2005. Herbal medicine revenue in Brazil was US$ 160 million in 2007.’

What is evident in these facts is that there is a steady growth in the global consumption of traditional medicine. This has been so since the 1978 Alma Ata Conference on Primary Healthcare put some spotlight on it. Its profile has also been further enhanced by the recent development of new antimalarial drugs from extracting artemisinin from the plant *artemisia annua*. This rising profile has necessitated the transnational

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35 Biomedical scientists in this ilk are mostly from the ministry of health, to which traditional practitioners often make representations, government funded research institutes or independent academic researchers who are sometimes able to secure grants from international bodies to carry out research in this area.

standardization of the practice of traditional medicine. A series of guidelines and regulations were issued by WHO with indications that member governments should follow suit at the national level as they deem fit. They include the WHO Supplementary guidelines for the manufacture of herbal medicinal products which were issued in 1996; Guidelines for the assessment of herbal medicines; General Guidelines for methodologies on research and evaluation of traditional medicine; Quality control methods for medicinal plant materials, and Guidelines on good agricultural and collection practices for medicinal plants (WHO, 2006). It is a testament to the compulsion to induct traditional practice into the existing body of scientific knowledge that these documents set definitions of the practice itself, its processes, terminologies; measures of quality and what are considered to be good manufacturing practices (GMP).

Barbara Immel’s *A brief history of GMPs* provides a detailed introduction to the historical use of GMPs to deal with nefarious practices in the pharmaceutical industry and ensure consumer protection. The article opens with an interesting declaration that ‘everyone in our industry should know the story of how the good manufacturing practices (GMPs) have come to be. To obtain and maintain GMP compliance, every manager and supervisor should provide frequent, meaningful GMP reminders, train and develop all employees, and fully participate in formal, on-going training programs. Senior management must state publicly and make it clear through their actions that following GMPs is the only way their company does business’ (Immel, 2000). But such processes of elaboration represent one of the ways in which global centres of power, operating through mechanisms of international development, seek to reconstitute internal markets into amenable parts of a globalized economy. This allows the governance of global competition to continue unperturbed (Cammack, 2006, 2010; Taylor, 2010). Bowden and Russell refer to similar practices as global benchmarking which entails a ‘process of production re-norming through the emulation of (and ultimately surpassing of) putative world best practises’ (2000:107; see also Larner and Le Heron, 2004)

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37 Such practices are not usually publicly declared but Storey (2006) has highlighted that leaked documents secured by the World Development Movement (WDM) ‘led that organisation to draw conclusions about the EU’s negotiating stance, including that the EU was targeting the poorest countries in the world in its pursuit of services market access for European companies’ (p.334). The EU had in fact tabled requests to 109 countries in 2002 under the General Agreements on Trade in Services (GATS) asking them to grant EU firms access to their services sector (p.333).
Attempts by global agencies to govern practises such as traditional medicine in the Third World are however analytically problematic. They reveal, as Ferguson and Gupta (2002) have shown, global forms of governmentality in which transnational authority by virtue of appearing to encompass multiple nation states supersedes national authority. What becomes clearer at this point is that the discourses that support benchmarking make it possible for global agencies to rely on states to enforce these standards on individual bodies within their domains. National authorities are coaxed into accepting the need for state practises to be governed by common principles and best practises. This way, global standards become national standards even where the capacity to attain them does not exist, thereby creating local markets for external producers. The case of traditional medicine in Nigeria shows how current governmental and administrative practices, attempting to take advantage of its rising profile, are at one level causing tension between the practitioners and the government’s bio-medical representatives and at another level missing the opportunity to develop traditional medical knowledge into viable pharmaceutical therapies against malaria and other diseases.

In Nigeria, the process of standardization and integration was supposed to be ushered in by the Traditional Medicine Bill but a series of political intrigue have stalled progress on it. The Bill, formally titled ‘Establishment of Nigerian Traditional Medicine Policy and the Bill to establish the Traditional Medicine Council of Nigeria’ was introduced in 2006 but has been under consideration in the National Assembly since then. This is not out of character for Nigeria: another Bill, the National Health Bill was originally proposed in 2004 but took seven years to consider in the country’s two legislative Houses. It was eventually passed into law on May 19, 2011 and has since been awaiting the Presidential assent to make it effective. This hiatus is significant because the Bill is seen even by the practitioners themselves as the basis upon which progress can be made in terms of integrating traditional and orthodox practices. According to a traditional medicine practitioner:

We have been crying out most especially to the honourable minister of health, even Mr President and the committee on health system. We have been telling them that we have a lot of contribution through our practice to help our country. A lot of contribution means that if there is integration between herbal medicine and the medical doctor, we are ready for them to come up and let us start from the

rural areas just like community health development… they make a lot of promises and nothing is done.\textsuperscript{39}

The suggestion this practitioner made above is that the groups of traditional practitioners are not lacking ideas about how to contribute to the public health system in Nigeria, but the efforts the traditional practitioners have made as an Association is often thwarted by the fact that they do not have a strong lobby to advance their interests within government. He therefore added that:

The ministry or the government itself comes out with a Bill on traditional medicine which is still not approved. Since the Bill is still not approved we cannot do anything more. We are calling on the politicians, the lawmakers and the government itself to see that the Bill is approved in the house but our [experience] is that when we go and talk to them in order to approach them to see that, really, that Bill should be presented, they ask who our sponsor is; the Bill must be sponsored. Up till today we are still looking for a sponsor. We have no substantive promise from any group or any agency or any international donors that they are ready to facilitate our Bill\textsuperscript{40}

The connotation of sponsorship, as the practitioner above found out, may have a slightly different dimension in Nigeria. I asked him what it would take to sponsor a Bill and wondered how it was different from legislators who agreed with the spirit of the Bill appending their signatures to it. His response was:

In fact, interests count and what they felt is that maybe we are not going to meet up the expenses incurred because the money has to follow; they have to use money in pursuing the Bill. The Association is still growing; NANTMP is just about five years old now, since the government unified the various practitioners to [have] one name and to operate under one umbrella in Nigeria. So it is NANTMP only in Nigeria, no other associations.\textsuperscript{41}

What he was alluding to is that it will cost the association a huge amount of money to lobby for advancing the Bill in the House of Assembly because of the need to grease several palms. This may well have been understood as regular practise in the country

\textsuperscript{39} Interview 21, traditional medicine practitioner, Abuja, Nigeria, 02/11/2011
\textsuperscript{40} Interview 21, 02/11/2011
\textsuperscript{41} Interview 21, 02/11/2011
but the association simply could not afford to come up with the kind of money required. If there were more associations they could have pooled their resources but as part of the process of standardization the government had directed traditional practitioners to merge into a single association to act as the bridge between the government and practitioners. This produced the National Association of Nigerian Traditional Medicine Practitioners (NANTMP) but the coming together of erstwhile rival associations is yet to be formidable enough to meet challenges like this one.

The other problem that the Bill has, from the perspective of the traditional practitioners, is that it has evolved slightly away from what they understood it to be. They express that: ‘we saw the first Draft Bill; the second one is something that orthodox practitioners tried to hijack. It is loaded with their own issues which they claim are traditional medicine issues but the real traditional medicine Bill is different from the orthodox one… It seems like somebody wants to enter your house and he is using your name saying that the house belongs to so and so person, at the end of the day when you go in he claims ownership of the house, which means you are not the owner of that house. You see, the interest there is really on orthodox not on herbal medicine as a traditional medicine practice… Actually we went to the House to defend the first draft but, well, we are all Nigerians: in the long run it was hijacked somewhere and another Bill came.’

The sentiment expressed by some traditional practitioners is that this is a cunning way for biomedical scientists to eat their cake and have it. In order to appear serious about home grown development of the pharmaceutical sector in Nigeria the promotion of traditional medical knowledge is placed on the front burner and support for it is widely solicited. However, under its banner, attempts are made to squeeze in reforms more favourable to orthodox medicine. Understandably, this is creating tension between biomedical practice, which is seeking ways of epistemologically refining traditional medical knowledge, and traditional medical practitioners who fear they are being excluded from this epistemological transition. The consequence is that information is being withheld that might better elaborate and elucidate the practice. Hence the opportunity to actually develop medical therapies is missed. My participant explained to me that the association of traditional practitioners had been under a lot of pressure to

\[42\] This was participant’s way of telling me that the behaviour he was describing is quintessentially Nigerian and did not surprise him.
join hands with orthodox doctors to facilitate the approval of the Bill but they fear that by so doing they will cede the upper hand to orthodox doctors rather than taking the opportunity to assert their ranks more strongly. ‘Somebody commented that we should not differentiate [he said], but the interest is that if you want to build a house for traditional medicine, build it for traditional medicine; if there’s any other collaboration we will know it is a collaboration that both the collaborator and the real owner will benefit from.’

What is taking place in Nigeria’s traditional medical practice is, in a way, emblematic of the strong nexus between sources of revenue and the struggle for power in the country. The spectre of a globally formidable enterprise prompts global health authorities to send signals to the national level to pursue standardization, standardization being necessary for organising and controlling the enterprise. Consequently, the state in Nigeria seeks to take control over the process by ‘modernizing’ it and keeping the practice subservient to orthodox medicine. This is necessary because the increasing interest at a global level raises expectations of profitability and exponential revenues. Rather than enable groups within traditional medical practice as new centres of power equipped to harness and manage this emerging source of national revenue, the state is seeking to tame such groups and co-opt them into its own established structures of power.

The traditional medicine practitioners are, on the other hand, continuing to insist not just on the enablement of those new centres of power; they are also angling for such iterations of power to be located well within their own ranks. The tone of their contention is a cooperative one and they do not see themselves as confronting the state. The type of power they seek is not one that challenges the state in any way; it is one that confirms their own ranks as a legitimate part of the apparatus of state; a move that is seen as having the tremendous potential of veritably modernizing their practice. One element of modernity that they are thus very keen to operationalize is discipline. The power to discipline is one of the most eagerly anticipated outcomes of the Traditional Medicine Bill. It will set up the Traditional Medicine Council of Nigeria which in its operation is expected to turn the practice into a legally protected one and allow the sorting of the wheat from the chaff. It will become possible to grant and deny membership of the practice according to the council’s behest. If traditional medicine practice is going to stand any chance of being ‘modernized’ the refinement of its operation has to be made possible by this power to discipline. This view falls back to
the Freidsonian idea of how professions become established and engrained within the body politick and the political economy of everyday life in modern societies. One of Freidson’s great contributions to the sociology of professions is his analysis of how professionals are constrained in their profession work and how their conduct is shaped. Rather than a professional logic, elite cadres within professions tended to function as custodians of professional knowledge through some institutionalized processes internal to each profession, such as systems of accreditation.43

This Freidsonian analysis offers a fitting theoretical framework within which it is possible to fit the traditional medicine practitioner’s anticipation of the power to discipline its rank and file. The move will create structures of power within traditional medicine practice that will expectedly empower the upper echelons to institute the process of changing its image from the way it is currently perceived, as a recent review of Health in Nigeria indicates: the review described traditional medicine practice as having ‘a cultural context, a collective ownership, and is constantly evolving…currently, traditional or indigenous knowledge, an area of original work, has little or no national protection, as do other types of intellectual properties such as literary creations (copyright) or inventions (patent). Anyone can copy traditional knowledge information and use it in any manner without obtaining permission from the originators or owners of such knowledge. Anyone using this knowledge for financial/economic gain is under no obligation to share this gain with the originators or owners.’ (HERFON, 2006: 280). This clearly robs the traditional practitioners of income but more importantly it impacts negatively on how the practice is perceived. It is partly so because elements within the practice that the more established practitioners would rather identify as charlatans are having a free rein to make unsubstantiated claims about medicaments with impunity. Because traditional medicine enjoys most of its patronage from poor and especially rural dwellers many of their unsuspecting clients also fall victim to other unethical practices by some of the unscrupulous practitioners, often with severe consequences.

This image problem has acted more to reduce the level of trust between practitioners and the government or orthodox doctors; it has also acted as a barrier to modernizing the practise and hence limits the ability of practitioners to reap appreciable gains from

it. Consequently the practice is not attracting enough young recruits. As the older generation of practitioners pass on, substantial knowledge of traditional medicine is lost. In order to enhance its disciplinary power therefore and hence be better able to launder the image of traditional medicine, the expectation raised with the impending Traditional Medicine Bill is that the hierarchies within the practice will be accorded some form of legitimation that enables discipline. In a recent Newspaper article for instance, the National Vice President of the Association of Traditional Orthopaedic Practitioners was quoted as declaring that ‘quacks and charlatans in their midst are always proving stubborn and giving the association a bad name because of government’s apathy toward their practice…if the bill is passed, it will ensure the establishment of the Traditional Medicine Council and formal recognition and power to discipline bad eggs’.

As it acquires a disciplinary capacity, the practice of traditional medicine hopes to be able to reform itself to the point that it is able to align with the prevailing global practice and speed up its journey along the road to modernity. Much subtler forms of alignment are detectable in the current form in which it operates: it is continually seeking to rebrand itself through actions such as forming groupings called ethical traditional medicine practitioners or adopting the title of Dr in much the same way as orthodox practitioners even though they have not had the academic training that accords that title. One practitioner expressed the efforts he and his colleagues have made in this direction in the following way:

I’ve been submitting recipes I suspect (or have been told by the herbal medicine gurus who taught me) are good for malaria…my co-ethical traditional doctor collaborators have been researching and collaborating with orthodox medical practitioners who want to verify our claims. We are not making false claims and we are not licensing them: we are collaborating with scientists to verify so that they can actually support us because we are poor people and most of us are illiterate but we are very good in our herbal medicine and traditional medicine.

In instances where a product successfully makes it as a standardized pharmaceutical product, as in the case of Niprisan, its authenticity as a traditional medicine product is

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45 Interview 9, traditional medicine practitioner, Lagos, Nigeria, 15/09/2011
somewhat seen to be watered down.\textsuperscript{46} Just as Science seems to discredit traditional medicine, traditional medicine also somewhat discredits science. Traditional medicine practitioners understand that all of their ingredients occur in nature but they feel empowered by the belief that unleashing the potency of those ingredients requires some ancient secrets which is not accessible to science. They see science as only able to accomplish what is naturally decipherable while traditional medicine on the other hand can access the super-natural. This is why traditional medicine practitioners often claim to be able to cure many ailments that orthodox medicine is yet to find a cure for including HIV/AIDS and Cancer; they in fact never declare an ailment incurable. The Yoruba actually have a proverb that says \textit{ogun ti ko je, ewe re ni ko pe} (if medicine does not work it is only because the herbs in it are incomplete). This proverb would often be invoked by older persons in support of admonitions, especially to younger persons about giving up on any mission and to encourage them to keep trying hard until they encounter a facilitator who can provide the wisdom to make possible whatever is being sought. In traditional medicine, its practitioners have gradient levels of mystical powers: if one practitioner is unable to cure an ailment, it is believed that there would certainly be others, more powerful than him, who are able to. An ailment is never imagined as incurable.

It thus seems paradoxical that traditional medicine seeks to be aligned to biomedical standards at the same time as it strives to retain its essential traditional character. The reality however is that it is struggling to let go of mysticism as a source of its power. As the epistemological penetration of the practice increases the practitioners find themselves less and less powerful. But the process of alignment creates the allure of a different kind of power - disciplinary power. This can be harnessed to produce both economic and political variants of power. Higher education has also played an important role as the more educated elements within the practice are far more inclined towards embracing alignment as the only avenue open to traditional medicine if it is going to contribute meaningfully to dealing with malaria and other health problems in Nigeria.

As the message filters downward WHO is already ahead of individual countries in defining the practice and setting quality control measures within it. At the country level,

\textsuperscript{46} Niprisan was referenced in one of my interviews as an example of a pharmaceutical product that has gained global market penetration from humble beginnings. It was developed in the 90s, based on herbal medical knowledge, by the Nigerian Institute for Pharmaceutical Research and Development (NIPRD)
a number of countries are taking a cue from this and setting up their own national frameworks for managing developments in traditional medicine. In 2006 a committee was established to set up a training and research institute for traditional medicine by the former president Olusegun Obasanjo. The committee was to help develop, promote and commercialise traditional medicine products and was expected to help Nigeria earn at least US$1 billion over its first ten years. This according to the president was borne out of a ‘desire to increase Nigeria’s ‘negligible’ contribution to the global US$60 billion TM (traditional medicine) market’.

A book titled ‘Abstracts of Published Research Findings on Nigeria Medicinal Plants and Traditional Medicine Practice’ was also funded by the Federal Ministry of Science and Technology in 2005 which collates 1,050 research efforts by Nigerian scientists, published in 1,020 international journals since 1972. It was hoped that ‘the work will help make TM more trusted in orthodox medicine and solve the long-standing problem of poor dosage.’

With alignment, traditional practice hopes to target global markets with a series of medicines as it standardizes its training as well as production methods. There is however some element of mimicry in the way that this alignment takes place. Some traditional medicine practitioners have at times refined their medicaments in order to conform to some of the standard packaging in the market and detailed information about ingredients and dosage is provided, all of which mean the medicine can be mass produced. But they soon find that it is a long road to modernity: they are still unable to escape the label of alterity in the sense that their efforts only earn them the status of listed medicines as distinct from registered ones. They are not permitted to label a listed anti-malarial medicine for instance as anti-malarial until it is registered as such. My participant showed me one such medicine which has been mass produced in the form of tea bags and is listed as herbal remedy. Looking at the list of ingredients on the pack, the participant said:

Because I’m familiar with those plants I know they are anti-malarial plants: *Morinda Lucida; Vernonia Amygdalina; Carica Papaya and Magnifera Indica* are anti-malarial plants; they can treat malaria… In fact apart from Morinda Lucida these [other] three are part of the things they put together and boil in our villages.

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48 Abiose Adelaja, “Nigeria boosts research into traditional medicine”
at home when we are sick as kids. Those three are part of what they add; they add so many things together but these three are always part of it; they add them together to boil to make the concoction for us to take and take our bath with, to treat for malaria…I might not be able to talk much on that NAFDAC registration but there is this thing about it; it’s just like what the Americans have, you know, they call it food supplements; it’s something similar, they don’t register it fully as a drug because, like most of them, it’s just based on safety and evidence of use; that’s how they accept them for listing; it is not full registration, for full registration I think you are required to carry out clinical trials.\(^49\)

The need to take traditional medical formulations through the rigorous and hugely expensive stage of clinical trials in order to be registered severely constrains the practitioners who clearly cannot afford to even contemplate the cost of clinical trials. It also means that the development of their formulations can only be assured if international pharmaceutical companies are interested. This unfortunately returns the practitioners to the ownership quandary. The intervention of government might have been useful in mitigating this quandary but the Nigerian government is constrained by funding pressures and other factors such as the impact of corruption and red tape. The donor community might also have played a similar role, possibly in partnership with government but it has also been difficult to engage them in this way.

**Conclusion**

The latest therapeutic effort at controlling malaria, namely Artemisinin Combination Therapy (ACT) is a product of Chinese traditional medicine. Its success has in recent times awakened a much stronger desire in traditional medicine practitioners in Nigeria to play a more integrative role in the way the disease is controlled. The practitioners as well as their clients attest to the efficacy of traditional medicine and continue to beckon to government to shed the widely held perception of the practice as an antiquated and unrefined practice that offers very little when measured against the benefits already accruing from bio-medical sciences.

The response of the Nigerian government so far has demonstrated that public health management is not an entirely technical issue. Political considerations inform the degree

\(^{49}\) Interview 20, 31/10/2011
of access that different groups have to the power structures upon which it is predicated. In the case of malaria control, even though actively backing and investing in the development of traditional medicine will demonstrate a good measure of agency and ownership on the part of the country, the reality is that the expectation that the logical outcome of such a development establishes traditional medicine in a pharmaceutical marketplace makes it necessary for this process of advancement to be a supervised one. That supervision takes place as an orchestra of techniques organised at a global level and partly implemented at the national level. Using the primacy of science as an instrument of legitimation, techniques of standardization, discipline and alignment are deployed to ensure that the refinement of traditional medicine incorporates its practice within the bracket of scientific knowledge and the reaches of power that it allows.

Traditional medicine practitioners are not averse to this supervision. Modernization is embraced to the extent that the currently loose forms of hierarchy within the practice expect to acquire legitimacy and thereby strengthen their power bases. But on the other hand the desired ascendency of traditional medicine has its own built-in conflicts: even though it embraces the need to modernize, the core of its practice remains coded and mystified, not yielding easily to epistemological clarification. Overall, this means that it will take much longer for traditional medicine in Nigeria to develop into a viable pharmaceutical industry with capacity to support the control of malaria and other diseases.
Chapter Six

Conclusion

The current picture of malaria control in Nigeria, beyond traditional medicine, is one of a heightened state of activity. As this connotes a level of seriousness that has not been seen in the country since its political independence, understanding the sources of such infusions of energy into the fight against malaria in Nigeria is useful for understanding the evolution of malaria control policy specifically and public health policy in the country in a more general sense.

The argument informed by the empirical narratives in the preceding chapters has been that international organisations and donor countries have constituted more important sources of public health policy than the state apparatus in the country. The decision to intensify malaria control was part of a global agenda that Nigeria, like many other malaria endemic countries, became enmeshed in because seriousness is encoded into a discourse that is able to elicit, from a general practice of development assistance, a predictable conformity to its rules. The empirical narratives have been anchored in a theoretical framework that advances an understanding of development assistance itself as something that stems out of the operation of global power. It is something that is, in a sense, imposed by virtue of the way it is practised, and it is possible to view development in this way because global power intervenes to ensure development practice follows its preferred trajectories.

If global power is taken out of the practice of development or, in a sense, if countries attempted to develop without international assistance, it is imaginable that an idea of development is possible, which emerges not so much from what Fassin (2012) calls the ‘Humanitarian Reason’ but from an internally generated politics of growth; one that moves its practice away from an arena where empathy is traded for subjectivation; an idea of development that internalizes the economics of aspiration and, above all, one that re-admits popular classes into the construction of its object. This way development would tend to emerge from an endowment granted to the state to organise the politics, the economy and even the sociology of a collective population in a way that minimizes chaos.
The state is adequately equipped in material and coercive forms to carry out this duty and as it does, new techniques of political, social and economic transaction are produced. The comprehensive distribution of these techniques blend into the formation of contemporary culture and they are what allow the population to perceive themselves as developing.

The current formation in Nigerian politics is one in which historically the emergence of dominant groups was inflected by colonial politics and the impact that this has had on postcolonial politics is that the competition and rivalry among dominant classes for primacy has been fierce. Chaos has been one way in which each group shifts attention to itself. The claim to being powerful at the state or regional level can quite often be legitimized by a demonstration of how well placed particular individuals and groups are to manipulate chaos originating from the region. Such individuals or groups can also hope to benefit financially from the political negotiations that such positions of power engender.¹

This is by and large how politics is constructed in Nigeria and yet, now and then, we read that the country is getting serious about development. Seriousness in the real sense is therefore a notion that operates to camouflage the logic of politics in the country. As the findings from the fieldwork carried out in Nigeria for this dissertation show, this new wave of seriousness is motivated and incentivized from outside. Many of the officials I spoke to were guided by the need to organise malaria control in a way that would produce the kind of outcomes expected by the international organisations that constituted the sources of funding for the malaria control programmes operating in the country. The Global Fund is particularly able to influence modes of operation by designing a grading system that rates and publishes performance. The determination of the recipient institutions in Nigeria to ‘make the grade’ according to Global Fund’s caprices therefore equips the Fund with the power to govern the conduct of local control operations; as one official put it, ‘it is so technical and it is time consuming; you have to really put your foot down and say I’m going to work on this result or nothing’.²

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¹ There’s a vast literature on patronage and the formation of political identities in Nigeria and the ways in which this is connected to political crises. Some of the recent writings are Omobowale and Olutayo (2007), Hoffman (2010), Hoffman and Nolte (2013) and Pratten (2013). See also Joseph (1983), Berman (1998) and Reno (2002).

² Interview 16, 25/10/2011
The instrumentalization of seriousness as a technique of development assistance therefore points to an emerging discourse in international development that secures the complicity of recipient states in the depoliticization and bureaucratization of development problems. In a post-Cold War era devoid of the need for political and ideological conditioning, global powers are no longer wary of the competing allure of a Communist East and as such as able to increase the stringency of aid disbursements. The contemporary development market place is thus a ‘donors market’. Donors are able to place the onus on recipients to demonstrate ‘seriousness’ by embracing globally defined best practices or lose access to funding.

For the state, seriousness serves a second purpose: it allows the state to keep up appearances; it is keen to project the image of conforming to what can be expected of a state in modern bureaucratic systems. As such it is able to fulfil the expectation of donors and help to strengthen their role, whereas it is also internally motivated by a corrupting ‘antilogic’ of development.³

This antilogic is the lifeline of the state as it finds itself enmeshed in an intense paradox that compels it to pursue development in order to sustain its legitimacy while at the same time it realizes that the liberating and empowering potential of development may actually pose a significant challenge to its survival as a dominant class. The way the state therefore conceptualizes as well as contextualizes development is a fundamentally technical one that links it to physical projects such as road construction and visible mass campaigns such as drug distribution programmes that are emblematic rather than transformative articulations of development.

This technical view of development, which takes politics out of international development and treats it as a separate domain of international relations, is endorsed by the global development establishment and it actively promotes it in the various ways in which it controls activities linked to the attempts by underdeveloped countries to develop. Some of it is borne out in the way development needs are identified, articulated and communicated whilst other levels of action stem out of multilateral regimes of transnational agreements that limit the action of states and set global standards that some states lack the capacity to attain, thereby creating market disadvantages for them in relation to others.

³ The word antilogic is an adapted one, used here as descriptive of a peculiar rationalizing system of thought which exerts a corrupting influence on the logic; in this case, the logic of development.
It is because international development and the operations that sustain it take these varied forms that it is important that development is thought of as occurring on different registers. Understanding the changes that are precipitated in international development, necessitate an understanding of the different aspects of its entailment. One of the contributions that this dissertation makes in this regard is it establishes that the assistance rendered by development organisations and donors to developing countries in such areas as malaria control is not as altruistic as may be imagined. International development operates in specific spaces of power in which external actors function as dominant forces. The preservation of that power balance is as much a motive for the assistance packages as any altruistic considerations.

To demonstrate this trend, I examined how European colonial interests framed the malaria problem and how that shaped the response to it. The immediate post-colonial response was thus markedly different from the colonial one in the sense that decolonization diminished the impetus to expend substantial resources on dealing with the problem. By the 1990s the end of the Cold War ushered in a new era of development encounter; an era of global partnerships which increased the role of private companies in the development engagement. The development of new technologies and therapies for controlling malaria brought a number of foreign based private companies into the fray and they became substantially involved in the distribution of these new measures which left the local pharmaceutical companies in the recipient countries at a disadvantage. The way in which such new shifts are admitted as standardized practice in international development have relied on both rhetorical and multilateral forms of legitimizing power. For example the Roll Back Malaria partnership has been highly instrumental in mobilizing a multilateral consensus towards increasing private sector involvement in malaria control, which is calculated to ease the pressure on the public purse in donor countries.

Increasing private sector participation under the rubric of partnership has continued unabated in malaria control and other areas of development assistance. If we are thus going to be able to determine what lurks in the future of development in Africa, we will need the conceptual tool provided by the three spaces of power; we will need to be able to discern what is currently taking place in the separate spaces of power and use them as our searchlight. In the conclusion to chapter three, I provided something of a head start: recent pronouncements by important figures such as US President Barak Obama, former
US Secretary of State Hilary Clinton and Administrator of USAID Rajiv Shah indicate a commitment to the full privatization of international development, meaning a commitment to accelerating the process by which aid disbursements to needy countries no longer involve public sector funds. What is left for academic research to work out is when and how this will be fully actualized. The questions that begin to assume importance are how African economies benefit from this eventuality and how, if it is one that offers Africa a second chance, the continent is going to ensure it is not something that a kleptocratic political elite is allowed to thwart.

Promoting this kind of shift towards increased private participation may work well for donor countries but in Nigeria’s recent experience with external assistance with malaria control, a strong displeasure is expressed by discerning groups against what is perceived as an undue advantage granted to a handful of foreign companies when in fact it is felt that the local pharmaceutical industry is well positioned to partake in the approved drugs market. This is however regarded as a manifestation of the internal logic of development assistance and there is a general sense of helplessness against it. This is especially so as political contestations of development’s methods are easily ascribed to a lack of seriousness. The seriousness that oils the wheels of development is not merely hoped for; it is actually enforced through a discourse articulated around three main formations namely the way in which language is used in very compelling rationalizations of the objectives of development; the idealization of modernity; and the control of development’s reporting process from top to bottom, i.e. the three spaces of power.

This concept, in a sense, extends the idea in post-development theory; a theory which is based largely on the rejection of the premise that the logic of development is reinforced by a set of incontestable scientific facts or that the best way to develop and to demonstrate a seriousness about development is to embrace those scientific facts. It rejects the idea that there is an embedded truth in these so-called scientific facts or that such truths deliver development to any serious-minded country.

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4 As Louis Da Gama’s comments show – see chapter one
5 Post-development theorists are understood to include scholars who, out of disillusionment with development theory, have called for alternatives. They argue that development has outlived its purpose and can no longer actually deliver development. Wolfgang Sachs (1992), in particular, declared that the time has come to write its obituary. He also notably edited a collection of chapters by other such theorists – See Wolfgang Sachs, 1992.
What has been further questioned in this dissertation is why the peddled truths that post-development theory rejects as a discourse harbouring its own systems of rule seem to be more intensely contested in academic circles than in political circles? Ferguson (1990) poses a similar question in the case of academics juxtaposed with development experts. By extension this dissertation prods the agency of Third World political leadership and asks why there is so much acquiescence within their ranks at the same time as academics are busy ripping development discourse apart.

The three spaces of power work together to reinforce the logic of development and to enforce the ‘truths’ embedded in development as we know it. The spaces of power can each be studied independently, but in terms of making development work, they combine together to produce effect. They also produce a notion we may, by way of deferring to Foucault’s governmentality, refer to as ‘developmentality’ to show how Western norms and models of development become enabled in the national psyche in developing countries, not only as scientific ways to develop but as globally networked models of development that function best as multi-level mechanisms.6

Foucault started the elaboration of his notion of governmentality as a specifically historicized form of evolution of state power in Europe from around the 17th Century. He defined the concept as ‘the ensemble formed by institutions, procedures, analyses and reflections, calculations, and tactics that allow the exercise of this very specific, albeit very complex, power that has the population as its target, political economy as its major form of knowledge, and apparatuses of security as its essential technical instrument’ (Foucault and Senellart, 2007: 108). From this definition, governmentality can be understood as an evolutionary process in state formation that aggregates various functions within society into functions of the state and how the power of the state becomes based on the recognition of those functions. A forerunner to governmentality is the Christian pastorate which accorded religious leadership power over their flock based on the recognition of the responsibility of the pastorate to its flock and a need to govern their conduct for the common good. Governmentality was born at the point at which pastoral power intersected with diplomatic-military techniques and the police to usher in the basis of modern government.

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6 See Foucault and Senellart, 2007, Ch.4&5, for a discussion of governmentality.
Human conduct, being at the core of Foucault’s elaboration of the regime of
governmentality has also remained at the centre of the scholarly focus on the concept.
As such more recent interest in governmentality is concerned with the various ways in
which human conduct is organised (Ferguson and Gupta, 2002).

Given the way Foucault has described this history of power, it can be seen that
‘seriousness’, as discoursed in this dissertation, is an emergent form of contemporary
governmentality. This new form expands its target population and it governs their
conduct through a local elite class which is inculcated into a constructed idea of
development that is amenable to instrumental power. Through ever-increasing
pastorality, a form of power is conferred by the humanitarian undertone in development
relationships, which enables the governing of developmental conduct. Fassin suggested
a linkage between this form of power and Foucault’s governmentality as thus:

This dichotomic moral conception of the world and the role that aid workers should
play within it can easily be set within the genealogy of “pastoral power” as Michel
Foucault characterized it, in reference to the Hebrew and the Christian shepherds. In
the French philosopher’s view, what characterizes this power is first that it is
exercised not over a territory but “over a flock”, second that it presents itself as
“fundamentally beneficent” and finally that it is individualizing – leading the
shepherd to be “prepared to sacrifice himself for his flock”. Similarly, the
humanitarian power is exercised over a population that must be aided, essentially for
the good of the collectivity, and even more specifically for the good of each
individual’ (Fassin, 2012: 232-233).

I call this contemporary form of governmentality ‘developmentality’. It is specific to
relations within international development and operates in its own distinct space of
power: the development space. Within this space, developing countries do not merely
embrace multi-level mechanisms but also seek, in the way they operationalize them, to
locate themselves somewhere along a globally governed spectrum. The way that
developmentality is maintained is through the multifarious channels of engagement
between national and global actors. These channels of engagement are in most cases
mediated by international organisations which are dotted around local terrains. Part of
their function is identifying promising young graduates with leadership potential, giving
them high profile jobs and taking them through training regimes that shape their view of
development. In other instances Studentship grants are given to the brightest students to study in Western universities and they are taken through a well-orchestrated pedagogy that also shapes the way they think about development. There are even engagements at the level of political and bureaucratic leadership in which officials in the top echelons of government from developing countries are gathered together and lectured on ‘working’ practices of governance in developed countries. An example is the technical cooperation programme organised by the British government in 1993 for senior level women civil servants in Nigeria. The programme, which took place in the United Kingdom was supposed to inculcate what one Nigerian participant described to me as ‘a rational bureaucratic culture’.  

Researching development assistance in public health or in other areas of state endeavour is therefore really a study of the various ways in which external actors influence and shape the way developing countries understand their development needs. For this particular research into the role of international development in Nigeria’s malaria control, a question that emerged during fieldwork is whether there are ways of circumventing the overbearing presence of international development in Nigeria’s malaria control programme. This question was explored in chapter five, the focus of which was on the knowledge, mechanisms or resources that are internally available to Nigeria which might help it increase its role in the way malaria is controlled in the country. But even here it was found that development does not merely predominate in terms of how diseases such as malaria are conceived; it usurps the available scope for technical responses to them. This is done through an orchestral system of standardization and discipline which very prominently takes the form of strict intellectual property rights regimes and leaves local companies very little choice but to align with foreign ones in order to make impact. In the process, local ownership is often restricted to highly limited local markets.

Finally, it is also worth stating that what was shown in chapter five very aptly contextualizes the multilateral space. The chapter showed how the multilateral regimes of good manufacturing practices, biopiracy and intellectual property rights come together to indicate a regime of power which suggests that what the development world is more concerned about is how development is controlled to the point that if solutions

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7 Conversation with a former bureaucrat on 6th November 2011 in Abuja, Nigeria. She also handed me a copy of the certificate of attendance she received from the programme.
are going to be found to Third World problems, these solutions should largely incorporate intellectual and material production in the developed world, in order that markets are maintained. So, the way in which events in the multilateral space of power are deployed is such that they keep intellectual and material production in the developing countries of the South at a subservient or subjugated level. We begin to see these tendencies more clearly as we begin to see development as separated into these subsets that I have identified. Hopefully therefore, the way that post-development theory progresses will be one that integrates this conceptual framework into its theoretical armoury.

It is especially in this area of local agency and what it is achieving, that further work is required to extend the findings in this dissertation. The present work has shown that seriousness as it currently operates is simply an order in which recipient countries must strive to achieve standards already attained elsewhere. This idea has substantial market implications and has potential for creating future tensions in the international development arena. Policy options are necessary that allow local agency to find expression and interface with the global agenda in a mutually enhancing way.

Remaining with the case study of malaria control, it will be important to continue to study the specific nature and distribution of the disease according to local perceptions in different parts of Nigeria or the regional dynamics in the incidence of the disease and the way different communities understand and respond to the disease. More specifically, the various efforts particular groups have made to develop efficacious cures for malaria into the pharmaceutical mainstream will be an important follow up to this research. The object of such a study would be to increase the level of understanding and trust between international development and local groups as it relates to the internal aspirations of the latter. This way, the obstacles that such groups have faced with such factors as intellectual property rights regimes or good manufacturing practices can form part of the debate that produces policy options for how international development can better engage with the local.
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