ASUU JOURNAL OF SOCIAL SCIENCES
A Journal of Research and Development
Vol. 7, No. 2, December 2020; pp. 1 - 52

Global Corona Virus Pandemic: A Class Analysis of the Nigerian Experience

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Abstract

COVID-19 Pandemic, no doubt, took the global community without exception by storm, at the very conclusion of the second decade of the new millennium as much as it is unrelenting, going into the beginning of the third decade of the same millennium. Environmentalists, in particular, have argued rather ominously and persuasively that our ways of consuming global resources – be they fauna or fossil – unsustainably have made pandemics inevitable occurrences on our planet, especially if we cast our minds back to recall some of the recent pandemics such as Ebola, SARs, and HIV-AIDS, which took their tolls on the humankind. COVID-19 has equally and already begun to take its toll on our health system and lives. Consequently, it is logical to assume that humankind cannot but be at the mercy of pandemics whenever they make their inevi-

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**A shorter version of the paper was earlier published in the Journal of Contemporary International Relations and Diplomacy (Special Issue, December 2020) pp. 130-160

table occurrences. To put the matter in its proper politico-economic and eco-systemic contexts, the capitalist mode of production and the accompanying consumption pattern, particularly its non-sustainability, culminated in climate change and other environmental challenges and the devastation of the ecosystem generally, is to blame. Also, and speaking epiphenomenally, the mode of societal organization, particularly its hierarchical and vertical structure, is likely to exacerbate corona viruses' impact whenever they strike. The situation of non-sustainability of our existing ecosystem, consumption-wise, which is always going to give rise to existing social iniquity and inequality in terms of access, even in the state of non-sustainability in exploitation, has further made the impact of the recent pandemics to be unequally inevitable, spatially and temporally. Of course, the impact of the current pandemic on various countries on planet earth varies from one political entity to another. However, the pandemic's enormous impact on the way humans may have to conduct their affairs going forward calls for serious analysis and recommendation.

Nevertheless, before this future trajectory is calibrated for traction to the right direction, there is a need to look reflectively on the differential nature of not only of the likely impact of the pandemic on social classes in Nigeria but also the need to examine how the development, administration and management of available services in the health sector, as vital social services of unparalleled importance have historically been approached on a class basis, therein. We need to interrogate the inherent class bias strategically. Its understanding may likely help in redressing the inherent class bias so that the new trajectory of enhanced equity and justice can necessarily stick and become the "new normal." These emphasis and approach are desirable because the impacts of the different

pandemics have always been based on how efficient or otherwise the traction in the health sector is determined, in the long run too, by class issue, i.e., the constellation of class forces in society and the respective access to state resources to which they are likely to be privy.

Key Words: Covid-19; Social Classes; Sustainability, Resource Exploitations; Health Services

INTRODUCTION

Health services in political communities are perhaps the most critical pre-occupations in terms of policy options to be taken. This is because of the centrality and relevance of health or healthy living to the survival of the human race, particularly in the political community in reference. Policies on health services are also divisive at the same time in many respects: namely, along class lines and, more crucially, on the affordability and capacities of the services that may be on offer. Invariably, the have-nots are the ones usually at the receiving end. Simultaneously, the haves uses the means at their disposal, whether or not such resources have been acquired legitimately before exercising their "proprietary rights" to access health services, either in situ or off the political shores community under scrutiny. The disproportionate and unequal possession of and/or access to resources in a class organized society, such as Nigeria, is a case for serious attention, especially in the health sector, in coronavirus's current situation. The Nigerian society, drawing from Amilcar Cabral and Frantz Fanon's theoretical frameworks, shall be brought out for analysis. The section's primary concern is to find out what classes are in Nigeria and how each class can afford and access available health services, among other social services. There is also the need to analyse the nature of the development, administration, and management of health services over the years in Nigeria. The way these processes have historically been carried out is a pointer to determine, firstly, whether or not there is an inherent preparation to meet medical exigencies of whatever complexity, as and when they appear in the country. Secondly, depending on what the findings of this approach shall provide, which will add to our stock of knowledge, it will be meant to aid the current generation of the Nigerian citizenry

to understand such knowledge concerning how to internalize the lesson that the advent of the coronavirus (COVID-19 Pandemic) has brought about, which is now calling for radical changes to the traditional ways of doing things. (Without doubt, the Pandemic has buffeted the entire world in its unique way (see some of the worrisome figures in some of the tables below)). The following section shall be devoted to an analysis of the emergence of Covid-19, examining its impact to the extent of its devastation on the lives of the Nigerian people; and looking at the facilities in terms of their adequacy, efficiency, accessibility, equity or otherwise. The penultimate section shall look at, based on the analysis of the pattern of development, administration and management of the health sector services, the need as well as the call for amelioration in the sector, concerning the provisions of facilities and vigorous workforce training as well as ensuring the sector's performance on the normative issues of adequacy, efficiency, accessibility and equity. Indeed, if any social sector requires a democratic agenda, there is none more deserving than the healthcare sector. In short, we are talking of life and how people can be provided with and/or access a fulsome lifestyle. The final section shall provide the concluding remarks.

THEORIZING CLASSES FROM THE REVOLUTIONARY PERSPECTIVES OF CABRAL AND FANON

When Cabral (1966) and Fanon (1967) wrote their respective treatises on the colonization and decolonization phenomena in Africa, they approached the issues from the Marxian dialectics, which is the most appropriate tool to situate the classes and the class struggle process in any society. The most crucial point about the two theorists – as revolutionary thinkers and participants/partisans in the struggles for decolonization in Guinea-Bissau and Cape Verde Island and Algeria, respectively – was their efforts to analyze the social structures of broadly the African societies and, more importantly, the relative capacities and roles of the social classes found therein, in the entire process of contesting power with the colonialists. In classical Marxist-Leninist dialectics, the social classes' roles could have to be looked at from the perspectives of production and the inherent social relations embedded therein. Since the African societies

were under colonial exploitation throughout much of the 20th century, the duos were concerned with the issue concerning which of the classes in the African society could and should be saddled with the historical mission of leading the struggle for total emancipation? Because they were aware of the essence of "total emancipation" from colonial exploitation, it must be emphasized that both Cabral and Fanon understood the distinction between what has been dubbed in the literature on decolonization as "flag" and "genuine" independence struggles and their results. Indeed, they not only wrote with passion, but they were also thorough and insightful in their analyses and the arguments they individually marshalled. (In parenthesis, no one should infer from this point that they could not be or were not criticized. {In the case of Fanon, see, among others, Caute, 1970, *passim*.) To be conceptually precise, "flag independence" is understood to mean a neo-colonialist solution/route to independence, which would, among other things, leave behind the entire colonial structures of exploitation. On the other hand, "genuine independence" means that the total and substantive liberation would free the African countries from the throes and shackles of imperialism and neo-colonialism. [Among others see Nkrumah, 1965; Fanon, 1967; and Cabral, 1966.]

AMILCAR CABRAL

Cabral insightfully analyzed the social structure of Guinean society. He identified, among others, the traditional authority; the petty bourgeoisie; the lumpen proletariat, the *declasses*; the colonists, etcetera. He concluded that the petty bourgeoisie stratum of the society could be the revolutionary class:

> It is obvious that both the effectiveness of this road and the stability of the situation to which it leads after the liberation depend not only on the characteristics of the organization of the struggle[,] but also on the political and moral awareness of those who, for historical reasons, are in a position to be the immediate heirs of the colonial and neo-colonial State. For events have shown that the only social structure capable both of having consciousness in the first place of the reality of imperialist domination and of heading the State appa-

> ratus inherited from that domination is the native petty bourgeoisie. [Cabral, *Ibid*.]

The basis of this selection is made evident in the above quotation. Cabral equally provides a proviso that it must be *prepared to commit class suicide* to fulfil its mission.

Marxists generally would regard this position taken by Cabral to be heretical, especially considering the unsavoury description of the characteristics of the petty bourgeoisie in the Marxist literature:

> In countries where modern civilization has become fully developed, a new class of petty bourgeois has been formed, fluctuating between proletariat and bourgeoisie and ever renewing itself as a supplementary part of the bourgeois society. The individual members of this class, however, are being constantly hurled down into the proletariat by the action of competition, and, as the modern industry develops, they even see the moment approaching when they will completely disappear as an independent section of society, to be replaced, in manufactures, agriculture and commerce, by overlookers, bailiffs and shopmen. [Marx and Engels, 129:1983.]

In other words, the petty bourgeoisie is liable to vacillation. Consequently, it is a class that cannot be relied upon as it is constantly struggling to transit to and nestle with the dominant class. Such a class can hardly be the comrades of the working class – the revolutionary in classical Marxism-Leninism.

However, it must be emphasised that Cabral most probably arrived at his conclusion after considering the objective and subjective realities of the society he wrote for. First and foremost, Guinea-Bissau and Cape Verde Islands (as one country at the point of the anti-colonial struggle) were colonized by Portugal. The colonizer country was up to the eighties in the twentieth century a very backward country. Also, it was most probably on the fringe of European civilization and development during its colonial suzerainty. Portugal was also not a democratic country; it was a dictatorship throughout much of the twentieth century.

Furthermore, among the European nations that possessed colonial territories in Africa, the Portuguese variant of colonial conquest, administration and exploitation were the most brutish and the most bestial by the way the citizens of the three colonies (Angola, Guinea/Bissau, and Mozambique) controlled by her were treated. It was not surprising that only very few of the populations in these colonies went to school. Even those who acquired western education were not given the same treatment in the workplace as the Portuguese of commensurate qualifications and skills. It was also appalling that Portuguese of lower qualifications and skills were more regarded than the African specialists.

As a result of such monumental discrimination and unbridled exploitation, some of the few educated colonized subjects were the ones who developed or were likely to develop what classical Marxism would refer to as the consciousness of the "class-for-itself;" rather than just being a "class-in-itself." In other words, they were the ones who went through a transformational process and had graduated from being an objective class to acquire the quality of a subjective one. According to Cabral, it had become a class that was conscious of its exploitation and would as well as should, consequently, be prepared to organize itself to end the exploitative system. However, it should be emphasized that the material basis of this consciousness must be anchored in a more materialist sense on the production process; secondly, in the political process of organization, i.e., there must be a political party to push forward the revolutionary activities. As Mao Zedong was wont to argue, a revolutionary change is never a tea party and, therefore, is not just voluntary and individual exhibitionism. Instead, it must be well-coordinated and driven by the correct socialist cum communist theoretical paradigms articulated and developed, as mentioned, in the process of production.

The relevance of the notion of the petty bourgeoisie committing "class suicide" should not be understood in its conceptually precise meaning but metaphorically. One is not sure this important theoretical issue has featured prominently in any severe post-mortem analysis of the collapse of the Soviet Union and other East European socialist states in the eighties and the closing decade of the 20th century. Perhaps, the lesson of the East European socialist states' experience has shown somehow poignantly that

there was and still is a good element of sense in Cabral's theorization that should compel the petty bourgeoisie to commit class suicide. If reference is made to most countries where the socialist/communist revolution took place or was programmed to take place, none was led by members of the petty bourgeois class that adeptly mobilized and organized the working class to participate in exercise historic influence. In the classic case of the defunct Soviet Union, this petty-bourgeois class did perform wonders through the transformation of a largely vast, backward and emerging country or empire (as it was during the reign of the Czars) into a sprawling industrial giant within a generation. The Soviet Union, both on the eve of the Second World War and after, up to the point of its decomposition, was able to contest for global dominance in security and peace matters as well as contending for the moral high ground by supporting countries in the Third World countries struggling for their independence and sovereign integrity.

However, what happened to the country's citizens in terms of their independence and freedom to enjoy the benefits of "the dividends of the socialist state" (to put it in the Nigerian parlance, which obfuscates the civilian dictatorship called democracy since May 1999)? Not only did the Soviet leadership from the time of the death of Stalin to the collapse of the socialist experiment in the nineties compromise the ideals of freedom and equality for the citizenry that should be maintained to make them creative as well as to exercise their God-given freedoms to say their minds; and to have a taste of democratic principles. Worst of all the atrocities of the "Soviet Socialist Republics," people would be banished to Siberia to live a solitary life in the cold dungeon, after being declared as enemies of the state instead of being labelled as the enemies of the leaders because of the criticism of the excesses of such leaders. This was not the socialist/communist state/society they fought for with their sweat and blood. In the erstwhile Soviet Union, the socialist leadership refused to commit the "class suicide" prescribed by Cabral. Instead, they were the ones that enjoyed the "Fruits of Socialism," having *dachas* where they would go for summer holidays. Simultaneously, the proletariat continued to labour in the factories to build the economy and the surplus product alienated from them.

This scenario was what most probably led Cabral, after a clinical analysis of the social structure of the Guinean society, to call on the petty-bourgeois elements who might have or who had immersed themselves in the struggle to build the socialist society, regardless of the stage of the mode of production, to shun aggrandizement and cancer that eventually destroy the socialist states of Eastern Europe. He urged them to get reborn by committing class suicide. This, they should do, by renouncing privileges and ostentations and ensuring that the bourgeois mode of production would ultimately be destroyed. The revolutionary petty-bourgeois class should ensure that there would be equitable distribution of the joys and stresses of the socialist/communist construction; and, finally, it is equally important that they would pay attention to the internationalist dimension of how to bring about the new society into being, for the benefit of the whole of humanity.

Apart from the uncomplimentary outcome of the socialist construction struggle in the erstwhile Soviet Union and in the other countries that might have attempted a socialist construction, it should not be forgotten that it was the petty bourgeoisie that led the November 7th, 1917 Revolution that overthrew the Czarist monarchy, as we have already hinted. It is pertinent that, even though this was the reality of the situation that we have stated above, the leadership of the revolution comprised the best in the period concerning their historic comprehension of Marxism to which they also made enormous scholarly contributions, through the production of the literature that was rich in theory, which was also significantly informed by practice. This familiarity with the literature and sincerity of the Bolshevik Revolution leaders led to the building of the necessary synergy with the working class – the real revolutionary class, according to Marx and Engels – and the other objective factors that combined to define the revolution's success. These factors included the defeat of Czarist Russia during World War 1 and, much later, the historic eradication of poverty, diseases, and underdevelopment generally.

Even though there was never any stipulation as to how long socialist construction of society would have to last before it transitions to the communist millennia, the collapse of the Soviet Union as of the time it happened would have been averted if the governance environment, as already ex-

plained above, entertained and expanded the space for freedom of speech; an end to excessive spying of the activities of the citizenry; the creation of an ambience for the effervescence of justice and respect for human rights, instead of the unjust creation of a new social stratum in society from amongst the state *apparatchik*. It would also have served the cause and course of building socialism/communism if more emphasis was placed on consumer goods production instead of defence expenditures that did not benefit the citizens. In short, the petty bourgeoisie in the then Soviet Union and other socialist states in Eastern Europe and other Third World countries did not commit "class suicide."

The absence of "class suicide," a most important theoretical contribution to Marxist philosophy by Cabral, in the end, made the world witness the historic throwing away of the baby with the birth water, in what would have amounted to the double "creation of the new man and his new society." It must indeed be emphasized that it was not just the painful catalytic collapse of the Soviet Union that the world witnessed when it took place that should be seen as the most significant impact in the long run; but, the fact that this unfortunate development has put a terrible break on the reality that such ecumenical and organic body of thought could ever be brought about by the endowed intellects of the likes of Karl Marx, Frederick Engels, Vladimir Lenin, Mao Zedong, Fidel Castro, Amilcar Cabral, Frantz Fanon, Samora Machel, Che Guevara, Ho Chi Minh, etc. In other words, the prodigally and scientifically produced literature by all of these intellectual giants, the course of which led to some of the observed fundamental historical changes in the affairs of humankind in the 20th century, should undoubtedly be the basis of worries of all men and women of the contemporary era, apart from the failure to sustain same. [See Pantham, 1995:58-59.]

FRANTZ FANON

Regarding Fanon, the revolutionary class was defined as the peasantry – another heresy from a committed Marxist, one should say. Again, one is compelled to agree with him that his ideas were empirically based on the African-wide society in which he wrote. To that extent, one would understand the kind of dilemma he faced. It is very likely that if Marx were to

write his philosophy of class struggle on African soil the time he did, the tone, particularly on the revolutionary class, would be different also. Indeed, the production of ideas is never divorced from the empirical (temporal) as well as spiritual referents that would surround the author. Hence, Fanon's choice of the peasantry as the revolutionary force is based on man's following qualities and his other natural endowments: population size; spontaneity, courage; commitment; and faithfulness. These attributes are explained by Fanon as follows:

> The peasant who stays put defends his traditions stubbornly, and in a colonized society, stands for the disciplined element whose interests lie in maintaining the social structure. However, in their spontaneous movements, the country people as a whole remain disciplined and altruistic. The individual stands aside in favour of the community.
>
> The country people are suspicious of the townsman. The latter dresses like a European; he speaks the European's language, works with him, sometimes even lives in the same district, so he is considered by the peasants as a turncoat who has betrayed everything that goes to make up the national heritage. The townspeople are 'traitors and knaves' who seem to get on well with the occupying powers and do their best to get on within the colonial system framework. This is why you often hear the country people say of town dwellers that they have no morals. Here, we are not dealing with the old antagonism between town and country; it is the antagonism between the native who is excluded from the advantages of colonialism and his counterpart who manages to turn colonial exploitation to his account. [Fanon, *op. cit*.:89.]

It is instructive that Fanon stresses the differential "advantages" accruing to the subjects of colonial rule, which invariably cause antagonism between the townspeople and the countryside people. However, it must be taken to heart that everybody may equally be advantaged and/or equally disadvantaged in spatial differentiation. All the same, this spatial differentiation and the "advantages" available to one space, which are not available to the other, have created a fundamental level of consciousness that becomes the basis of the potentially revolutionary vocation of the crowd

of the sub-classes in the rural area. Furthermore, we should not fail to observe that the countryside in Africa, in general, was largely the site of the production of the agricultural export products that supported as well as energized the exploitative objectives of colonialism. The exception would also be the mineral resources that could have been found in both the towns and the countryside. Finally, it is also essential to observe that Fanon has sometimes lumped together with the peasants and the lumpen proletariat (the latter being people living in shanty towns in the urban centers) and the other under-classes, jointly, as the spearheads of the agitation against colonialism. It may therefore be pertinent to also ascribe to them the revolutionary consciousness already ascribed to the peasantry. We would need to find out how this consciousness developed and expressed itself as the decolonization process advanced. To this point, Fanon has, in our view, so succinctly stated that:

> That spectacular volunteer movement which meant to lead the colonized people to supreme sovereignty at one fell swoop, that certainty which you had that all portions of the nation would be carried along with you at the same speed and led onwards by the same light, that strength which gave you hope: all now are seen in the light of the experience of symptoms of very significant weakness. While the narrative thought that he could pass without transition from the status of a colonized person to that of a self-governing citizen of an independent nation, while he grasped at the mirage of his muscles' immediacy, he made no real progress along the road to knowledge. His consciousness remained rudimentary. Above all, we have seen that the native enters passionately into the fight if that fight is an armed one. The peasants threw themselves into the rebellion with all the more enthusiasm in that they had never stopped clutching at a way of life that was in practice anti-colonial. From all eternity, through various tricks and a system of checks and balances reminiscent of a conjurer's most successful sleight-of-hand, the country people had more or less kept their individuality free from colonial impositions. They even believed that colonialism was the victor. The peasant's pride, hesitation in going into the towns, and mingling with the world that the foreigner had built, his perpetual shrinking back

> at the agents of colonial administration's approach: all these reactions signified that to the dual world of the settler he opposed his duality. [*ibid*.:110-111.]

The peasantry's revolutionary potentials would have to be accepted with a pinch of salt, in any case. Fanon was quite aware of this, though, as he has argued that: "It is true that [the] unchanging way of life [of the peasantry], which hangs on like grim death to rigid social structures, may occasionally give birth to movements which are based on religious fanaticism or tribal wars." [Fanon, *ibid*.:89.] In other words, in Africa's multi-cultural countries, micro-level and/or secondary contradictions could vitiate their revolutionary fervour. Furthermore, as a result of the inherent contradictions and/or existential limitations of the peasantry, namely, general poverty, illiteracy, poor health, lacking in land security – the greatest asset of the peasantry – etc., Fanon's ascription of revolutionary consciousness is usually assaulted by other Marxist critics. In his book – *Frantz Fanon*, Caute, provides a couple of such criticisms:

> …the Vietnamese Communist, Nguyen Nghe [argues that]: "the peasant by himself can never develop revolutionary consciousness. It is the militant who comes from the towns who must patiently search out the most gifted elements of the poor peasantry and educate them…." According to Nghe, Fanon's critical analysis of the colonial proletariat foundered on his failure to distinguish between genuinely proletarian elements such as dockers and miners and petty-bourgeois groups such as taxi drivers and clerks. Fanon had been misled by the fact the decisive battles in China, Vietnam, Cuba, and Algeria had taken place in the countryside, with peasants comprising the bulk of the guerrilla forces. However, the leadership of the urban elements – intellectuals and workers – was indispensable. [Caute, 1970:77-78.]

Despite the salience and appropriateness of the criticisms of commentators on Fanon's contribution to the Marxist politico-economic thoughts, the peasants have historically and spatially been involved in a variety of ways in the development of their societies:

> The history of the 20th Century shows that African and other peasantries in China, Cuba, Vietnam, Algeria, Angola, Mozambique, [Nigeria, *a la*, the *Agbekoya* Uprising in the Western Region during the Civil War (1967-70)] are capable of becoming conscious of their status of exploitation and powerlessness and can become highly receptive to the political organization; they can participate in direct political action, aimed at controlling their destinies and, it is hoped, realize developmental goals within their societies. Peasants need no longer be depicted as a stumbling block to historical progress or embarrassing residue. [Chikwendu, 1983:41-42.]

SYNTHESIS OF THE THOUGHTS OF CABRAL AND FANON: ESTABLISHING THEIR RELEVANCE TO THE NIGERIAN SOCIAL CLASS NARRATIVES

We have gone into the essentials of Cabral and Fanon's theoretical postulations to bring to the fore the need to always put most social issues and policies of any society in their class perspectives. As could be surmised from the discussions on the two theorists of revolution in the African setting during the anti-colonial struggle, this was what they did. Even with the criticisms that have been levelled against their respective revolutionary consciousness assignments to other than the proletarian class in classical Marxism, they achieved an essential contribution to theory-building. In other words, they were able to argue convincingly and empirically for the existence of classes, even if some of them were in their rudimentary or nascent formation/development, compared to Europe at the time of the writings of Marx and Engels. Their period of analysis was from the late fifties to the early seventies. From that period to the twenty-first century's contemporary period, no theorist, especially of the right-wing orientation, can deny classes in Nigeria/Africa. There are classes in Nigeria that may even be considered more solidly developed than what was obtained concerning the proletarian class in England, again, at the time Marx and Engels wrote about them. It is, therefore, apposite to use their methodological insights to delineate the classes in contemporary Nigeria. The only aspect of their analyses that we shall not bother ourselves with is, after the delineation of the classes in Nigeria, to pronounce that this class or that class

shall be the revolutionary one. It is not that we are shy of revolution and/or that we do not envisage that such episodic convulsion may never or cannot occur; instead, based on the main objective of this chapter to identify which class (or classes) is (or are) dominant in the Nigerian society and to what extent polices on the health sector have been made to disproportionately favour the same dominant class, along with the consequences emanating from there. Put differently. We are more concerned with the motive force in developing the healthcare services in Nigeria, the relative access of the classes to the services being rendered, and the consequences of such pattern of development, administration, and management.

The social classes that we have and are identifiable in Nigeria comprise the bourgeoisie (both foreign and local); the proletariat; the petty bourgeoisie (members of the intelligentsia, the lawyers, and other professionals); the bureaucratic bourgeoisie in the civil service top cadre; the agrarian classes; the *declasses* or the lumen-proletariat; etcetera. In the bourgeois class, we can subdivide into the national bourgeoisie and its foreign counterpart. A number of these social groups are found in the private sector of the Nigerian economy. Some of them are the ones that now control some of the keys privatized companies in the economy's critical branches such as banking; manufacturing, agro-allied industries, mineral resources, several import and export businesses; power generation and its distribution; etcetera. They hire the proletariat's labour-power and fire the exploited class members whenever it suits the bourgeoisie and/or when their services are no longer required. The bourgeoisie in Nigeria is not only entrenched in the economy; it has sought, and to a large extent, it is succeeding in expanding its influence into the political realm, as it happened, to give an example in the transition to civilian rule in 1993, when MKO Abiola contested and won the election that year, which was unfortunately later annulled. Besides, these class members are wont to hobnob with the political class members to ensure that most economic decisions of the state shall or can be to favor their capitalist aspirations.

The working class is found in the several branches of the modern economy, such as manufacturing industries, the banking, insurance, and other financial institutions of the economy, mining and the minerals sector, the avia-

tion sector and other transportation business activities, etcetera. In these modern sectors of the economy, the workers are expected to work and produce surplus values that the bourgeois class appropriates. They are found in the modern sectors of the economy, aforementioned, including the agro-allied industries. Until quite recently, when economic trough set in to erode its base, i.e., when they plunged into the unemployment market, the Nigerian working class has been very formidable.

The bureaucratic bourgeoisie is predominantly found working in or for the state. There seems to be a contraction in the class subset because of the state's recurrent fiscal crisis. The most entrenched amongst them, who are also the most serious ones who particularly tend to avidly and corruptly convert the resources of the state into their private property, should be understood to include the top civil servants; the members of the civil public servants; and the security top brass; etcetera. Besides, they are more often than not the workers' enemies and other dominated classes, as they carry out their vocation of state robbery and kleptocracy with reckless abandon. The petty bourgeoisie is also closely related to the bureaucratic bourgeoisie. Unlike Cabral's stipulation, the petty bourgeoisie in Nigeria is not revolutionary; it is likely to side with the bureaucratic bourgeoisie and the intelligentsia to exploit the other lower classes. In recent times, this class has also been affected by the general economic decline in the country. Hence, they struggle to stay afloat and continue to cut corners if the pursuits could land them properly in the class of the bourgeoisie. Some of the peasantry members have been turned into agrarian proletariats in the farms of the emerging agro-allied industries of the bourgeoisie. Quite a large size of this class is still left standing; its members are engaged in subsistence agriculture that is increasingly becoming a vocation to meet their existential needs. Finally, the declasses or the lumpen-proletariat comprise such social groups as prostitutes, the unemployed, petty traders, and the vagabonds.

This class configuration in Nigeria should be seen as not just an amorphous group of people existing in a particular landscape. Some groups have definite roles to perform in the political economy. Furthermore, they enter into definite relations with themselves informally and formally, in which case, as we have already hinted, one class stands to exploit and oppress

the other. The classic case of the bourgeoisie proper and the proletariat proper and their social relations of domination and exploitation in the production process also stand out from the analysis. Perhaps, the resources that accrue to each social class are the likely factors that determine who stands to access a social service, such as in the health sector better than the other.

Furthermore, they are the factors that are likely also to determine the willingness or otherwise by the state to invest adequately in the health sector. In the Coronavirus Epidemic era, it is pertinent to stress the *ad hoc* and panicky approach with which the Nigerian state has so far handled its emergence. As we shall point out later, Providence has had a hand in averting the American and European types of inadequate hospitalization facilities and deaths. The next section of the paper provides a background of the health sector in Nigeria and the extent to which such historic and want of preparation can be discerned and recommended for correction.

THE DEVELOPMENT, ADMINISTRATION, AND MANAGEMENT OF HEALTH SERVICES AS STRATEGIC PROCESSES: CONCEPTUAL ANALYSES

The development, administration, and management of any strategic process are undergirded by and/or approached with policy framework(s). What policy framework has the Nigerian state put in place for the health sector? A framework is necessary because the development process is always complex; it involves many people, many resources, and stringent protocols for coordination and implementation. It is not often realized that Nigeria's health sector, like the country's development in its entirety, is a processual undertaking; speaking, putting one block at a time on one another. Just as the country's development requires the contribution of all and sundry, so also is the health sector. In the health sector, there are the professionals; there are patients; there are structures to be built; and there are programs, with each of them impinging not only on resources but also on the attention of other professionals from other disciplines. In short, the health sector is about every individual, and their lives matter a great deal. If this axiom is well understood, it means that the various interests have to be consulted, and buy-in leverages, which each and everyone must un-

derstand, must be given to every stakeholder for purposes of inclusiveness and success.

Also, the development process is not an ephemeral thing; rather, it should be conceived to span generations whose timelines can exhaust the imaginations of those on whose shoulders the task of laying the rest of the foundational block (at conception). In other words, development is for eternity. This being the case, development should not only be solid. It must contain elements that shall continue to challenge or be challenged by generations yet unborn. The point being made is simply that future generations' rights are, wittingly and unwittingly, intertwined with the current development process. Therefore, it must be remembered that the planning process must make allowance for their objection (or, at least, their inalienable right to carry out tokenistic improvement on what is bequeathed to them) and/or their acquiescence, as the case may be, in the future. There must be a question for every generation to ask and/or to answer, which, in turn, shall also generate its question to be reserved for the next generation to ask, answer, and/or to solve. In one breath, the development process is a relay race; each athlete shall hand over the baton to the next upcoming athlete.

We have used metaphors of generations and athletes to stress the different aspects of the development process. A generation's developmental needs are not always identical at all times; there may be underlying nuances, which those at the helm may not factor therein. It may be factored into the entire planning purposes but becomes antiquated by the quick turnover in thinking that is taking place simultaneously as the developmental project is being executed. Similarly, those "for whom the project is planned" may have been shortchanged, and they are powerless to alter its design details (which is the outcome of the existing unequal power equation). As for athletes' metaphor, they are in competition with one another for their countries' interest, and the least they expect is equitable refereeing! Thus, the metaphors represent the existing divisions, principally, across class lines, apart from other secondary differences such as ethnicity, religion, etcetera. In our clime, they are mistakenly always brought to the front burner. Indeed, development cannot mean the same thing to every-

one in the same polity and cannot, therefore, be divorced from the class interests of those who typically take over the mantle to direct it and those for whom it is planned. What then is to be done since the development process that has gone on in Nigeria has never been inclusive of everyone or, more importantly, the dominated class? As is the case in the health sector, where hospitals, to give an example, are built to treat everybody supposedly. However, the costs of accessing them are prohibitive; one cannot say that development is taking or has taken place. Going forward, it must be understood that underlying the development process is the democratic participation of the people, the location for which a project is being sited or planned; and it should be delivered without blemish. Many hospital, clinic, or dispensary projects have been abandoned because they have been planned and executed ***for*** the people and not. The consequences of such arrogance in the exercise of power by the planners have been wasted resources of the people and the denial of the "dividends of development."

In the development process, there are administration and management issues that are very critical, at least to the resilience of what structural edifice might have been put in place for the "benefit of the taxpayers and other stakeholders." The administration is essentially the "performance of executive duties;" [*Merriam-Webster's Dictionary and Thesaurus*, *op. cit.*:16], while management connotes the "judicious use of means to achieve an end." [*Ibid*.646]. The two words are synonyms of each other; but, we have selected the aspects of their respective tangentially disparate meanings to stress their uniqueness and examine how they are to be operated in health sector provisioning in the country. The central issue is what should constitute the administrative structure of Nigeria's health sector institutions? Should the head be just anyone who is professionally qualified, quite all right, and is therefore competent, or should be someone who can lobby for posts?

When they get into the office, they serve the interest of their principal and/or self? Many administrators in the contemporary era of "locust invasions" precisely seek office for the latter kind of shenanigans. This should stop forthwith, and because we are concerned about the health and welfare of the people, a democratic setup must abide by the norm of admin-

istratively cultured practice. It should never be assumed that the people who know where the shoe pinches will also not know to whom they will have to entrust their health welfare. Healthy welfare is usually the first awareness that even babies instinctively learn through such gestures as closeness and bonding with their mothers. Babies are the first human species to practice democracy by the correct choice (identification) of their mothers as the best representatives and providers of their pristine health and well-being interests! Democratic practice should therefore be nurtured in the administrative structures that are set up to enhance the effectiveness and efficiency of the performance of health institutions. Allowing the beneficiaries of health institutions to partake in how the institutions should be run shall enhance how to practice democratic (good) governance and how administrative policies are to be churned out and implemented. It does not matter having someone to be the head of the medical facility and, consequently, be the one that is entrusted to churn out ideas and policies of running the place; such a head should also be humble enough to submit such ideas and policies to all the members of the administrative committee for their inputs and test of integrity. The culture of impunity that is so pervasive in every aspect of our national life should be jettisoned, or else having escaped the ravages being witnessed in the western European, North American, and Latin American countries in the era of Covid-19, there is a need to "sheathe the sword."

Regarding the management of our medical facilities, the concern should be on prudent use of resources to achieve set objectives. Economists are wont to argue that resources are scarce; this is to the extent that they are stolen, wasted on irrelevances, or appropriated illegally. Renewability of resources is the vogue at the moment. To the extent that this is becoming the pattern of human beings' intellectual and innovative pastimes, courtesy of such innovative prowess of information and communications technology, resources are therefore inexhaustible given our knowledge of the horizon that humankind can get to. Newer and better resources will be developed or discovered to improve our hospitals and medical centres on services they render to patients. To argue this way does not mean that the human ability to manage and preserve resources must not at all times be brought to bear in terms of how they are or may be used sustainably.

Indeed, the *Brundtland Report* [Brundtland, 1987] on sustainable utilization of global resources has sounded the contingent warning and/or advice that global commons should be consumed with a mindset that shall provide for the next generations. Just like the way we have argued concerning the administrative machinery in the health sector institutions, the management committee must be excellent in planning; be equitable in the distribution of resources to units in these institutions, first and foremost; must be endowed with the ability to recruit the best brains to work in the hospitals, clinics and maternity centres; and, as suggested to the administrative committee, there has to be inclusiveness. Even when the best brains are recruited for the assignment at hand, the management committee must also be partisan in searching for those Nigerians that are democrats in outlook, belief, and work ethics. The management committee of today must be the first and the last in investment in goodwill for the sake of the healthy well-being of the people and, particularly, the patients that may come to be rendered some services.

BRIEF HISTORY OF THE DEVELOPMENT OF HEALTH SERVICES IN NIGERIA

It is pertinent that we have tried to come to terms with the concept of health (see above) for obvious political and ideological reasons. In this subsequent analysis, in point of fact and as we shall see also subsequently, the pattern of development of Nigeria's health services has not made one feel that the approach taken has many prospects for an adequate health service delivery system. Historically speaking, the Nigerian health sector comprises two distinct components: the traditional and the modern orthodox health practices. The former comprises indigenous native healers, and they go in the following nomenclatures where they have been prevalent:

> …*Babalawos*, *Onisegun*, and *Adahunse* among the Yoruba[;] *Dibia* among the Igbo[;] *Nye Dibio* in the Ekpeye ethnic group of Ahoada Local Government Area of Rivers State[;] and *Obo* among Ora of Edo State[;] to name a few. The knowledge base for these healers' practice of medicine derives mainly from their traditional worldview, myths, and beliefs, including healing techniques, which

> have been handed over the centuries from one generation to another. [Erinosho, 2019:51.]

Within the traditional health practitioner group, there are the faith healers who can also be subdivided into two: the Christian and the Islamic faith healers. In his comparison of the two faith healer subgroups, Erinosho points out that:

> [The] Christian faith healers claim [that] they are inspired by the Holy Spirit to embark on their 'ministries.' The leaders or prophets are presumed to be endowed with exceptional spiritual and personal skills, which enable them to mobilize and carry out healing. Some of their members' gifts include speaking in tongues and the ability to 'see visions.' [*Ibid*.]

As for the Islamic faith healers, it is noted that:

> …[they] are knowledgeable in the Koran [*sic*.], and some of them also possess extensive knowledge of traditional herbal medicines. These healers are mostly found in northern and western Nigeria, where their services are utilized by adherents of Islam and others who think they can benefit from their skills. [*Ibid*.52]

From the preceding, it is clear that this chapter's concern to situate the class dimensions of the country's health services provision, access, and affordability shall have to go beyond the traditional and faith healers to orthodox medical practice. This procedure is more relevant because the traditional and faith healers' therapies are based on conjectures and hypnoses, which are not scientific in the word's strict meaning. Making this kind of statement does not mean one is trying to deride the traditional medical procedures. Also, it should not be taken to mean that every social class patients do not still resort to them to solve some of their medical challenges that may be spiritually related. They do so for various reasons, mainly when the procedures are strictly based on their belief systems and practices. The allure and the glue of traditional medical practice and its patrons are the cheapness of services. Practitioners of orthodox medicine appear to have given some space to the faith healers in terms of the veracity of their prescriptions which are more or less based on excerpts from

the Holy Books to which the orthodox medical practitioners also express faith in as well as practice.

The modern (orthodox) medical practice comprises critical components such as trained personnel, drug manufacturers based on verifiable criteria and reliable, dependable, and endless medical supplies, and various equipment for laboratory tests and complex procedures. These features cannot be neglected in modern medical practice, except an agency (whether state or private) is prepared to court disasters and other medical complications. To the best of one's knowledge, these are fundamental issues that the traditional medical practices are not in any way capable of competing with when squared up with orthodox medicine. This is aside from the fact that this paper's objective cannot be adequately handled and/or achieved via the traditional medicine route. This is what we go on to analyze in the following paragraphs of this section.

Orthodox medical practice, which Erinosho also refers to as cosmopolitan medicine (*ibid*.], is the forte of both the state and the private sector practitioners. Both the government and private practitioners are the owners and controllers of the medical facilities and institutions. Orthodox medicine was introduced or brought to Nigeria due to the incursion of imperialism into the Nigerian landscape. The development of its services, according to records, started from the initiatives of the Portuguese Catholic Missions in a small clinic on St. Thomas Island, off the coast of Lagos, in 1504. The clinic was set up to treat Iberian voyagers, sailors, and seamen on India's mission from their bases in Southern Europe. The clinic's services (though skeletal) were extended to the West African towns, including Freetown, El-Mina (Accra), and Benin, during the British anti-salve trade crusade. [Mbaya, *op.cit*.:103.]

In terms of the magnitude trailing the introduction of modern medical services in Nigeria, Mbaya [*ibid*.] draws our attention that it was the British Army that must be given the kudos for starting modern care services on mainland Nigeria. They brought the "off-sea" services by the Portuguese exclusively meant to use the Europeans at an offshore location to the coastal towns and villages. A Jesuit Missionary – Father Barriera – came to Benin in 1605, and, given his appreciation of the terrain, he went ahead to es-

tablish both plantations for agriculture and medical facility. This initiative was bolstered by another Father Alvares – another Jesuit – who established a dispensary in Asaba and later in Badagry. These two missionaries' deaths were said to have created some setbacks in the development of medical services. The mantle was carried forward by Dr E. C. van Cooten in 1850, on his arrival in Nigeria, also for evangelical work. Without a doubt, it was the Christian missions, including such other denominations as the Methodists, Baptists, and the Presbyterians, that spearheaded the evolution of the development of medical services in Nigeria [*ibid*.] before colonialism proper stepped in, initially, to complement services already ongoing. By 1921, these groups established and administered hospitals, maternity homes, and leprosaria that included the Sacred Heart, Abeokuta; the Baptist Mission in Ogbomosho; Church Missionary School Hospital in Iyi-Emu, Qua-Iboe-Etinan Mission, Uyo; Itu Mission, Calabar Province; the Umahia Mission; the Abara Mission-Ogoja; etcetera. [*ibid*.] Mention should also be made that schools were also the responsibilities taken by the missionaries and the Church and medical services. Concerning our objective of establishing the likelihood of class bias in developing the missionaries' health services, one could conclude that there was indeed one, especially if we factor into the analysis that ideology is a massive component of class production and reproduction. The missionary health facilities were introduced with cost that was remarkably underpriced so that patients that accessed the available health facilities would not only see better treatment when compared to the traditional health services discussed above as well as improvement in their existential health conditions, they were subsequently preached to, to embrace Christianity as the ultimate salvation in all life's endeavours.

> The Roman Catholic Mission built the first full-fledge hospital in Ebiraland in Kogi State in the sixties for all patients' manner. There was no discrimination as to patients' faith before treatment was carried out. Like the missionaries' school systems, the clinics, hospitals, and maternity facilities were embarked upon for evangelization purposes, laced with minimal cost recovery policies. [Aliyu, Private Discussion, November 2020.]

The colonial state's pattern of intervention in developing health services in the country follows somehow a different path from these initial initiatives, but the ultimate objectives largely dovetailed. The pattern used by the state comprised building health facilities in central urban centres locations. They were extracting economic resources such as export crops, iron ores, and other mineral resources. These would be areas or locations where there would be European personnel. In addition to the racial outlook of access to the facilities, there was also the dimension that even where there were health facilities for Nigerians, i.e., where they were made available to meet the local inhabitants' needs, their quality would be far below the European par. This pattern was pervasive throughout the country up to the end of the colonial period. Given these foundationally inadequate health facilities, one is not surprised that this country's health sector is still mired in poor development and utter inadequacies. Inadequate or inefficient health services and facilities have many ramifications, and these include patient to doctor ratio; the number of hospital facilities and their distribution; their classification in terms of primary, secondary, and tertiary institutions; and, finally, the availability of the equipment to reflect and/or ensure that the categorizations in the services are rendered effectively, i.e., at each relevant level.

The estimated number of practising doctors in Nigeria is 42,000 by the Nigerian Medical Association (NMA) in terms of human resources. With the country's estimated population size over 202 million currently [National Population Commission, December 2020], it is evident that there are not enough doctors to go around. Although different figures are bandied about by, among others, the government (one doctor to 2,753 patients/people); and the World Health Organization (WHO's) estimate of a ratio of four doctors to 10,000 people), there is no doubt that the country still has a long way to go in terms of meeting the WHO's standard of one doctor to 600 people. It is even wishful thinking to assume that Nigeria shall catch up with such countries as the United States of America with 26 doctors to 10,000 people and/or Canada with a ratio of 28 doctors to 10,000 people. What could be more worrisome than the fact that, at the current estimate, there are not less than 5,000 Nigerian doctors each in the USA and the United Kingdom (UK)? The "brain-drained" doctors

have argued to the effect that the primary reasons for migrating to these two countries plus Canada and Australia were because of the better facilities and work environment; the higher salaries; the career progression; and improved quality of life. It is also a further irony that, as these stark realities face the country, there is a minister of the Federal Republic of Nigeria – Chris Ngige – who makes the spurious claim that "Nigeria has too many doctors." Apart from the statement generally agreed to be spurious. Unfortunately, it has come from a person who regards himself as a trained doctor. One is not sure that his erstwhile colleagues in the profession still regard him as one of them. He has become an all-around failure in his medical professional practice and his latter-day profession, politics. It is worthy of mention that as the minister spewed this false narrative, it did not occur to him that he never bothered to interrogate why Nigeria's pronounced commitment to continuously allocate 15% of the annual budget (during the April 2001 Meeting in Abuja of the member countries of the African Union) has never been up to 5% of the annual budget, except in the budget year of 2015, when it chalked up to 5.72%. [See table 1 below. See also, among others, google.com/search?sxrf=ALeKk02v1j2d7golvuCUXSbG6ETypRdUrg%3A1605841380885&lei=5DG3x_7HNYXgU4vAmYAJ%q=how%20many%20doctors%20are%20in%20nigeria%20in%20usa%ved=2ahUKEwjyoqokZDtAhUF8BQKQtgBpAQsKwBKAF6BAgkEAI&biw=1440&bih=687; eyegambia.org/Nigeria-has-more-than4000-in-the-us-5000-in-uk-alone/; and bbc.com/news/world-africa-45473036. Downloaded on Friday, November 20, at 4.45 Hours and 4.55 Hours, respectively.

Table 1

BUDGETARY ALLOCATION TO THE HEALTH SECTOR, 2015-2020

YEAR	TOTAL BUDGET (Trillion =N=)	ALLOCATION TO THE HEALTH SECTOR (Billion =N=)	PERCENTAGE OF THE ALLOCATION TO THE HEALTH SECTOR
2015	4.5	257.4	5.72
2016	6.08	221.7	3.65
2017	7.44	304	4.09
2018	9.12	340.5	3.90
2019	8.92	385.76	4.10
2020	10.8	406.88	4.60

Source: *THISDAY*, Sunday, December 13, 2020, p.69.

The newspaper from which these figures were obtained also draws attention to the extremely poor allocation to the health sector as follows:

> **Nigeria has not met this 15% target.** However, the pandemic provides an opportunity to build a robust health care system that will **see reduced child mortality, maternal mortality, and morbidity of communicable and non-communicable diseases** while catering to all citizens' holistic wellbeing. Furthermore, health allocation is not enough. Money must be allocated to the correct elements like preventing sickness through our primary health care system and transparently implementing the budget. [*Ibid*. Emphasis in the original.]

In addition to this newspaper's admonition, adequate and state-of-the-art facilities, after what must have been seen as reasonable attainment of the quantum of medical personnel to cover the population, are the simultaneous supreme requirements for effective medical practice and the promotion of healthy existence. Since the attainment of independence in 1960, the various government levels have tried to build medical facilities, ranging from dispensaries; other primary healthcare facilities to general hospitals and tertiary medical institutions. In table 1 below, from a humble beginning in the fifties when the University College Hospital was established as a tertiary medical institution, the country now boasts of 22, spread across the geopolitical zones into which the country has been divided politically and otherwise. Besides the teaching hospitals, there are two specialized hospitals – the neuro-psychiatry and orthopaedic health services institutions. The other point that needs some minor attention is the pattern of distribution to the extent that virtually all the zones are equal in medical facilities that have been located close to the people. As a federal state, the equity principle appears to be given some consideration geopolitically. What also needs to be stressed is that since the hospitals in the table are federally owned, the states are not foreclosed from establishing their tertiary medical institutions. Indeed, virtually all the federating state have established their universities, some of which also run their teaching hospitals. All said and done; there is a need to interrogate the extent to which the institutions are adequately equipped. As we shall below when we look at

factors triggering medical tourism – a phenomenon that has made health services in the country a painful non-starter as far as priorities are concerned (see below) – the institutions' apparent adequacy and their spread amount to nothing. Nigeria is indeed a place where projects are put up, when they do exist, for showmanship; it is also a place where people saddled with responsibilities fail to perform, woefully and deliberately, and they look at the citizens in the face and proclaim arrogantly that they do not give a damn! (At least, Goodluck Ebele Azikiwe Jonathan once displayed arrogance over the demand to declare his assets and liabilities to stunned compatriots publicly. The arrogance of leadership by Muhammadu Buhari – another instance – is legendary and is also in its class.)

Table 2

SUMMARY TABLE OF FEDERAL TERTIARY HOSPITALS IN NIGERIA ACCORDING TO GEOPOLITICAL ZONES AS AT OCTOBER, 2020

S/N	ZONE	TEACHING HOSPITALS	FEDERAL MEDICAL CENTRES	FEDERAL NEURO-PSYCHIATRIC HOSPITALS	NATIONAL ORTHOPEADIC HOSPITALS	SPECIAL HOSPITALS	TOTAL BY GEO – ZONES
1	SOUTH-SOUTH	5	2	2	0	0	9
2	SOUTH-EAST	3	2	1	1	1	8
3	SOUTH-WEST	4	3	2	1	0	10
4	NORTH-CENTRAL	4	5	0	0	0	9
5	NORTH-EAST	3	4	1	0	1	9
6	NORTH-WEST	3	4	2	1	3	13
TOTAL BY FACILITIES		**22**	**20**	**8**	**3**	**5**	**58**

Source; The Federal Ministry of Health (Headquarters), Abuja, 2020.

In table 3, we have the list of the federating states with the number of medical facilities that are functioning *in situ*, according to the survey conducted by the Federal Ministry of Health, Abuja. The facilities reported by the Ministry have different nomenclatures: they are severally called health facility; family support program centre; maternal and child clinic; dispensary; secondary school clinic; health centre; health post; health clinic; general hospital; maternity home; etcetera. Most of these facilities dispense at best what the primary and secondary medical institutions routinely do. As stated earlier, a number of these facilities are either owned by the government and its agencies, corporate (public) bodies, private companies, medical practitioners, and non-medical practitioners involved in the medical line of business. The concern that one should ventilate is whether or not the regulatory bodies that are supposed to monitor the extent to which they comply with ethical and professional standards genuinely carry out their functions. One is aware of the existence of the National Agency for Food and Drugs Administration and Control (NAFDAC); the Nigerian Medical Association (for medical practitioners primarily); the National Medical and Dental Council (meant essentially for the regulation of medical education); and the Pharmaceutical Council of Nigeria (mainly concerned with the professional practice of pharmacists and, maybe, occasionally showing concerns about the quality of drugs being sold in the market place). However, a regulatory body like what is obtainable in the education sector – the National Universities Commission (NUC) (for the healthy operations of the university institutions) –shall conduct visitations to the hospitals, clinics, and other health centres, on a routine basis, to sanction and/or accrediting such medical facilities to practice is, to the best of one's knowledge, sorely missing; it is non-existent. It is essential to stress this point about having a proactive regulatory agency to monitor and regulate the facilities, several of which may even be located in rural areas. These are the ones that are likely to be manned by quack doctors. These similar other medical operators may not have the requisite qualifications, especially the traditional birth attendants (TBAs), and/or commitment to the best-professionalized services.

The discovery in the 2018 Nigeria Demographic and Health Survey is pertinent to be brought at this point. It reported that: "61 per cent of

live births do not take place in a health facility…" and this was due to inadequate facilities, sexism, poverty, ignorance, and other factors, according to the Survey. This is the point that has been emphasized in this study, and it is despite what the picture of a multitude of health facilities as depicted in Table 2 below may portray. As the Survey has also pointed out, "Without a strong national maternal death surveillance and response system, the number and causes of maternal deaths taking place in facilities and communities are poorly understood." [See premiumtimesng.com/news/headlines/429266-despite-having-highest-maternal-mortality-in-africa-nigerias-situation-still-underreported-report.html.mc_cid=3aBc265f67&mc_eid=1f9f5ae885. Downloaded on Saturday, December 4, 2020, at 03.45 Hours.] This is one major issue that would have to be considered given the crucial role the health sector facilities play.

Table 3

NUMBER OF HOSPITALS AND OTHER HEALTH FACILITIES IN STATES OTHER BAUCHI IN THE COUNTRY

SERIAL NUMBER	STATE	NUMBER OF LOCAL GOVERNMENT AREAS	NUMBER OF HEALTH FACILITIES
1.	Abia	16	953
2.	Adamawa	20	895
3.	Awka Ibom	31	580
4.	Anambra	21	879
5.	Bauchi		No Data Published for the State
6.	Bayelsa	8	288
7.	Benue	23	1378
8.	Borno	25	819
9.	Ebonyi	12	608
10.	Cross River	18	1273
11.	Delta	25	777
12.	Edo	11	716
13.	Ekiti	16	490
14.	Enugu	17	937
15.	FCT	6	507
16.	Gombe	10	658
17.	Imo	26	1400
18.	Jigawa	26	708
19.	Kaduna	21	1534
20.	Kano	44	1361
21.	Katsina	30	1632
22.	Kebbi	19	825
23.	Kogi	18	1143
24.	Kwara	16	682
25.	Lagos	20	2200
26.	Nasarawa	13	957
27.	Niger	25	1501
28.	Ogun	12	694
29.	Ondo	18	774
30.	Osun	30?	1063
31.	Oyo	33	1381
32.	Plateau	16	1086
33.	Rivers	19	664
34.	Sokoto	23	830
35.	Taraba	16	1131
36.	Yobe	15	560
37.	Zamfara	14	715
TOTAL HOSPITAL AND RELATED FACILITIES IN THE COUNTRY = 34,599			

Source: The Author made compilations and Calculations from the Federal Ministry of Health (Headquarters), November 2020. See also Erinosho, *op. Cit.*, pp.87-94.

The second observation or issue is the number of these health facilities. If the country could boast, on a numerical basis at least, of medical facilities that are no less than 34,599, what volumes would they be speaking about? How many bed spaces are they offering? Are they adequate? Has the health services management ensured that the phenomena of patients sleeping on the floor or of drugs being out of stock to have been overcome? In other words, what capacities of bed space and drug supplies does this number amount to? Is the ratio of Covid-19 infections the country is handling worse than the existing capacity can cope with? The aggregate number of isolation and treatment centres in the country is infinitesimally more minor than the number calculated in tables 3 and 4, in the following sub-section below? Meanwhile, from the evidence obtained by the WHO in its Joint External Evaluation (JEE) of International Health Regulations (IHR) core capacities assessments of Nigeria over whether or not the country could meet emergencies in 2017, the results emanating from there indicate that:

- Nigeria's average score of 1.9 across the 15 JEE indicators on **prevent** category suggested that overall there was limited capacity to prevent biological, chemical, or radiation health risk;

- The country was better prepared in the **detect** category, with an average score of 2.6 across 13 indicators. This score shows that the country has developed some capacities to detect new health risks through real-time surveillance and laboratory capabilities to test the diseases. However, the suitability of these capacities is still in doubt.

- The country performed severely in the **respond** category, with an average score of just 1.5 across 20 indicators. This result suggests that Nigeria has a limited capacity to respond to sudden health risks. [brookings.edu/blog/future-development/2020/07/02/how-well-has-nigeria-responded-to-covid-19/. Downloaded on December/13/2020, at 11.20 Hours. The emphasis in the original.]

In interpreting these scores, what comes out is the fact that:

> …Nigeria is not prepared to respond to the current COVID-19 pandemic. This is most obviously evident from the low testing rates for [the disease] in the country. Nigeria currently can test only 2,500 samples a day. Just half of these are administered each day because of the shortage of human resources, testing kits, laboratories, and case definition for testing that prioritizes symptomatic cases and other contacts. As of June 30, [2020], only 138,462 samples had been tested in Nigeria for a population of [206] million; in contrast, South Africa – a country of 58 million people – has already conducted 1,630,008 tests. [*Ibid*.]

Furthermore, the report noted that:

> Nigeria had just 350 ventilators and 350 ICU [Intensive Care Unit] beds for its entire population before the outbreak. In April 2020, the country acquired 100 more ventilators, but this will not be enough given the growing caseload. There has been a continuous rise in the number of cases and deaths in [the country], and no flattening of the curve has yet been observed. [*Ibid*.]

The stark reality from this evaluation exercise from WHO indicates the helplessness and hopelessness of the pattern of the development, management, and administration of the health sector generally. The dominant class that would even have benefited more from a well-planned health sector failed woefully to rise to its responsibility.

MEDICAL TOURISM AS A BANE IN THE DEVELOPMENT OF A SOUND HEALTHCARE SERVICES IN THE COUNTRY

> Apart from the WHO's findings and the evidence from the Demographic and Health Survey earlier mentioned, how else does one judge the standard of the facilities in the country's health sector? One would have to look around to determine whether the facilities were adequate and adjudged to perform at the global standard level that the phenomenon of "medical tourism" would not have been as pronounced as it has been with *nouveaux riches*

and the other members of the ruling class. The obverse of this argument – that "medical tourism, which President Buhari popularized at the height of his series of medical challenges during his first tenure in office, would not have taken place, since this is a logical deduction from the central assumption! In other words, no sane individual would choose inferiority over superiority.

Medical tourism is defined by the World Health Organization (WHO) as: "the travel of patients across international borders to receive some of medical treatment." [See *WHO,* emerald.com/insight/content/doi/10.1108_/JJA-09-2018/full/html, on Saturday, December 05, 2020, at 13,12 Hours.] According to some reports, Nigeria is a significant end-user or consumer of the medical tourism service. For example, in 2013, over sixty thousand Nigerians spent nearly US$1bn in search of medical care abroad. [Makinde *et al*., 2014; and *Punch* Editorial Board, 2014.] Furthermore, the Indian High Commission in Nigeria reported that the number of medical tourists from Nigeria to their country grew from four thousand in 2009 to over eighteen thousand in 2012, with an average expenditure of 15,000 USD per patient. [See Makinde, O. A., B. Brown, and O. Olaleye, 2014.]

The neglect of education by the Nigerian state, which has forced the only civil society organization of note – the Academic Staff Union of Universities (ASUU) – to go on strike for its amelioration routinely, has now come to roost. In other words, destroy education, and you destroy the fabric of any country. A quantum of attention given to education has typically multiplier effects that can never be quantified. India, Malaysia, and other medical tourists' destinations are good examples of how to take care of education. Indeed, sound medical education and practice is a panacea to the health of the citizenry and an incredible boost to the health of the economy that India and other countries are reaping from the Nigerian medical tourists.

THE CONSTITUENTS OF GOOD HEALTH: THE PERSPECTIVES OF THE WORLD HEALTH ORGANIZATION

The World Health Organization (WHO, 1975) has defined healthy existence as the "complete physical, mental and social well-being and not the

absence of disease or infirmity." [Quoted in Mbaya, 2017:3.] While this definition may be adequate from the health expert's professional point of view, it may not be so from the perspective of a non-expert trying to make sense out of the health issues confronting a given community from the radical school of thought. For instance, does the definition really and fully cover the gamut of what should be considered adequate to address good health for the average human being? The critical issue here is as follows: if a person is reasonably considered to be in a state of well-being (as defined and/or to be healthy along the indices mentioned above) and, yet, they are still hungry and/or unable to access medical facilities when faced with one disease or ailment or the other, how is an analyst other than the one holed up in the cosmology of WHO expected to define the individual's state of health? In other words, can an individual be completely healthy (as defined by the WHO) in poverty and want? We are trying to argue that no single individual can be in a "complete physical, mental and social well-being" at any point in time when the world of existentialism is never constructed as such by Providence. The WHO's idea is an ideal that is not corroborated by any empirical evidence. Empirically speaking, what is likely to happen to the individual who is poor and is in ill-health is as follows: it is either to go and steal or cause violent damage to a neighbour or another fellow human being if they cannot get work to do to earn an honest income or the poverty scale is such high that they are unable to redress the situation and decide to commit suicide or wait meekly for the inevitable death to come at its appointed time.

Leaving the realm of philosophy in the interim, what can one understand to be the meaning of well-being? According to the *Merriam-Webster's Dictionary and Thesaurus* (2006:1185), well-being is: "the state of being happy, healthy, or prosperous." Although, linguists may argue that, because the Dictionary has not used the combination – "and/or" in the definition, can it, therefore, be argued that if an individual is only happy and is lacking in healthy existence or is impecunious, that that person's well-being is okay by the WHO's definition. This point of view is better exemplified by the scenario in which the citizens of a state are serially hoodwinked by the political leadership that would promise the delivery of health facilities, the absence of which may remotely be responsible for

their incidence of disease(s) affliction. This might have resulted from the non-availability of equipment to carry out preliminary tests that could have revealed the likelihood of developing the disease(s). It might not have been conducted at about all or in time because the equipment was spoilt and nobody cared to repair it. The WHO's definition may have to be reviewed, in the light of the increasing development and innovations brought about by information and communications technology (ICT), to take care of such intervening variables, which may, by themselves, be the triggers for the disease's rates of infection. The ugliness of the American Coronavirus Pandemic afflictions (see Table 4 below) may not be based on promises of development projects that were never delivered by the American state, but because simple science defined by, among other things, the use of face mask, the observation of social distancing, frequent use of hand sanitisers and the denial of the existence and the deadly nature of the disease. Such absences can be explained by two of the synonyms in the concept of disease infections, i.e., complication (making worse) and disorder (malfunctioning). The Nigerian state is equally well advised to stop looking at health differently from what WHO has defined it to be. It would appear that WHO's conceptualization, which has never been challenged by any member of that primary global health institution, maybe the fog preventing a countless number of countries from developing a realistic approach to health development, administration, and management. Let us now look at how the COVID-19 has impacted some countries in the world, including Nigeria.

COVID-19 PANDEMIC: SOME GLOBAL PICTURE AND THE NIGERIAN EXPERIENCE

Covid-19 is the Christian name for the current pandemic that has come from the family of Coronavirus. Pandemics are a recurring decimal; the last major one was in 1918, called the Spanish Flu. Since then, the world has witnessed the Asian Flu, the Middle Eastern Flu, Ebola, etc., that were not as challenging as Covid-19. The current pandemic is generally believed to have originated in the Wuhan Province in China. There is hardly any country in the world today that is not going through its throes. However, the magnitude of infections in each country differs from one country

to another. The global picture of infection in terms of size recovered cases, and mortalities, according to the Johns Hopkins University in the United States, respectively, stood at 84,830,362; 59,960,858; and 1,841,395. Table 4 depicts the picture of the twenty countries leading the pack of infections along with their mortalities in the world, as of January 2nd, 2021 (same as the *Source* of Table 4 below). By sheer irony and contrary to logic as well as the expectation that it is the poor and underdeveloped countries that are likely to lead the pack with horrible statistics of the volume of infections and deaths, the USA, the global leader in economic, military, and political terms, is instead the leader (see table 4 below). The situation appears to be slipping out of control for her, especially in the pandemic's current second phase of infections. On current count at the time of writing this paper, too, only South Africa, among the fifty-four African countries, is in the league of the twenty leading countries in both the size of infections and mortalities. The regions of the world most affected by the pandemic are North America, Europe, South America, and Asia.

There is no scientific explanation, as such, concerning the mild affliction of the pandemic in Africa, except the usual glib narrative that the tropical climate, particularly its excessive heat aspect, may have been the major factor or reason for the low volume or level of infections and mortalities. Nevertheless, the scientific community has advised that paying much attention to the protocols for fighting the pandemic, such as using face masks; constantly washing the hands with soap for upward of twenty seconds and rubbing the hands also with alcohol sanitiser; sneezing unto to the elbow of one's garment; maintaining social distancing and avoiding crowds of people; are, for now, the surest preventive measures, giving the reality of the situation that the vaccines that have been approved for use in some of the advanced countries in December 2020. Widespread availability, affordability, and use of the vaccines were only seen in Nigeria in March 2021.

For the developing countries, particularly for Nigeria, the pandemic's outbreak is an actual demonstration that health policies should not be played with. Put in its proper perspective, if the most industrially developed coun-

tries can be humbled to this extent by the pandemic, the health of the people (which is argued to comprise due diligence in planning, development, and the installation of advanced medical equipment for laboratory testing of all manner of diseases, not just during the pandemics, the management and administration of health processes effectively, etcetera.) should not be handled with kid gloves. In short, the pandemic has shown that the mightiest can also fall and cry; can, indeed, be humbled. This scenario also points to the fact that the weakest shall simply die, faced with similar challenges. In the final analysis, it would appear that, as far as health issues are concerned, humankind's wisdom has to be the best weapon that everybody, including babies, if it is possible, should have and should at all times be deployed. Wisdom, in other words, should always be on the front burner.

TABLE 4

SELECT COVID-19 PANDEMIC CASES FROM THE MORE AFFECTED COUNTRIES AS OF JANUARY 22, 2021

SERIAL NUMBER	COUNTRY	CASES	DEATHS
1.	United States of America (USA)	25,316,444	422,550
2.	India	10,640,464	153,218
3.	Brazil	8,699,814	214,228
4.	Russia	3,677,352	68,412
5.	United Kingdom	3,583,907	95,981
6.	France	3.011,257	72,647
7.	Spain	2,603,472	55,441
8.	Italy	2,441,854	84,674
9.	Turkey	2,418,472	24,789
10.	Germany	2,122,075	51,783
11.	Colombia	1,972,345	50,187
12.	Argentina	1,843,077	46,355
13.	Mexico	1,711,283	146,174
14.	Poland	1,464,448	34,908
15.	South Africa	1,392,568	40,076
16.	Iran	1,360,852	57,225
17.	Ukraine	1,182,969	21,662
18.	Peru	1,082,907	39,274
19.	Indonesia	965,283	27,453
20.	Netherlands	938,628	13,422

Source: *The Nation* Newspaper, Sunday, January 23rd, 2021, p.6.

Palliative Measures to Cushion the Effects of the Pandemic

Does the country have a fallback position of her own, or does she have to depend on external donors/development partners in an attempt to cushion the effects of the COVID-19 Pandemic? What lessons have now been learned from state perennial unpreparedness to meet challenges, which should now be directing government response strategy and the people at large to other pandemic types going forward? Since the country did not appear and substantively learn any lesson of "putting her house in order" from the Ebola pandemic of fewer than ten years ago, what is the likelihood that the health sector's policy planners are ready to be challenged strategically at this point? We shall look at these issues in our discussion of "palliative measures" that might have been taken to stem the tide of the COVID-19 Pandemic on the citizens.

Apart from the Economic Stimulus Bill 2020; cash transfers; the Central Bank of Nigeria Stimulus Package; and food assistance during the first phase of the Pandemic (some of these programs were inadequate with the target groups tiny (about 36 million people) – all these were marred by corruption and opaque accountability; the poor handling of the #ENDSARS protests (especially during the looting spree) merely came up to erode the expected impact of the palliative package. What is more, the state still required $330 million to procure medical equipment and medicines for Covid-19 curtailment. Also, there were financial commitments by private, bilateral, and multilateral institutions to raise the remaining funds. The Nigerian National Petroleum Corporation pledged $30 million; the European Union contributed 50 million euros; while the private sector, on March 26, 2020, under its Coalition Against Covid-19 (CACOVID), raised over $72 million meant to purchase food relief materials and to provide medical facilities in different parts of the country. [See brookings.edu…., *op. cit*.]

Other Issues to Take Care of in the Fight Against Covid-19 Pandemic in Nigeria

Table 5 below (designed for illustrative purpose at a particular point in time, in the struggle against the Pandemic), the peculiar situation and challenge of Covis-19 Pandemic in Nigeria are issues for sober reflections. In the first instance, if the country were to be one that was well-governed (it is still not well-governed in the grim situation of the pandemic), at least, the foregoing narratives by the WHO and other instances cited below in this paper of a lack of adequate attention given to the health sector, the index individual who brought the virus to the country on February 27th, 2020 would not have been allowed to get beyond the immigration point at the Murtala Mohammed Airport in Lagos. There is no earthly reason why the frontline workers and working tools to fight the pandemic – the doctors, nurses, and other health workers, plus the personal preventive equipment (PPE) – should not have been mobilized the moment the World Health Organization (WHO) announced the onset of the pandemic. It should be mentioned that the World Health Organization, on the 31st of December, 2019, declared the discovery of a novel coronavirus in Wuhan Province in China. By January 10th -12th, 2020, it published comprehensive documents for countries, covering topics related to managing the outbreak of the new disease. [See who.int/emergencies/diseases/novel-coronavirus-2019/interactive-timeline#! Downloaded on Sunday, November 22, 2020, at 12.00 Hours.]

Table 5

AGGREGATED COVID-19 CASES FOR THE FIRST TWENTY DAYS IN THE MONTH OF NOVEMBER 2020

DATE	TOTAL CONFIRMED	DISCHARGED	DEATHS	DIFFERENCE IN QUANTUM OF INFECTIONS BETWEEN A NEW DATE AND THE PRECEDING DATE
20-11-2020	65,982	61,782	1,165	143
19-11-2020	65,839	61,573	1,165	146
18-11-2020	65,693	61,457	1,163	236
17-11-2020	65,457	65,457	1,163	152
16-11-2020	65,305	61,162	1,163	157
15-11-2020	65,148	61,073	1,163	152
14-11-2020	64,996	61,029	1,163	112
13-11-2020	64,884	60,936	1,163	156
12-11-2020	64,728	60,790	1,162	No previous figure to compare with
11-11-2020	Not available	Not available	Not available	Not available
10-11-2020	64,336	60,333	1,160	152
09-11-2020	64,184	60,069	1,158	94
08-11-2020	64,090	59,910	1,154	300
07-11-2020	63,790	59,884	1,154	59
06-11-2020	63,731	59,844	1,154	223
05-11-2020	63,508	59,748	1,155	180
04-11-2020	63,328	59.675	1,155	155
03-11-2020	63,173	59,634	1,151	137
02-11-2020	63,836	59,328	1,147	72
01-11-2020	62,964	58,790	1,146	No previous figure to compare with

Source: Nigerian Centre for Disease Control (NCDC), Daily Updates for November 2020. Collated and Computed from the routine daily NCDC disclosures by the Author.

Despite this proactive step taken by the WHO, it took the Nigerian government almost two months to set up the Presidential Task Force (PTF) on the Covid-19, after the index patient – an Italian citizen – had brought the "seed of the pandemic" to the country. [See statehouse.gov.ng/covid-19/. Downloaded on Sunday, 22/11/2020 at 12.20 Hours.] This lackadaisical attitude speaks volumes about the selfishness and incompetence of the people managing the country's affairs, particularly those working in the health sector. If the Italian had travelled with the "important figures" in government circles on a fateful day in February and given the protocols developed by WHO, everybody on the flight to Lagos would have been quarantined to avoid community spread of the virus. The much the government asked the fellow travellers of the index patient were asked to quarantine in their homes without any solid assurance that they would observe such simple instruction. Would all this negligence smell the rat of selfish class interest as such? Tell will time.

In the past year of the impact of the COVID-19 Pandemic, most Nigerians did not come to terms with the fact that the Pandemic was a severe health issue. Kogi State, in particular, was very notorious in her transgression against any measure taken to convince the government therein that preventive measures such as wearing of face mask; social distancing; and the use of hand sanitiser should be observed. This is not to mention that there was general opposition to lockdowns, which were meant to curtail the Pandemic spread. What has happened in Nigeria and other countries all over the world has demonstrated that the Covid-19 Pandemic is no respecter of kings, queens, presidents, and/or the most wretched persons. Every class category has been infected with some, unfortunately, dying.

What is evident from the table, ultimately, is that if by late November 2020, the casualty figures were still in thousands and the total figures of infection daily would also still be counted in hundreds, rather than in tens or hundreds of thousands, truly the Providential Hands of God must have saved several lives in Nigeria. (See below also.) One is, however, aware that the rates of testing were also not efficient and widespread enough; thus, there might have also been incidents of under-enumeration in the

figures being put out daily (on infection, recovery, and mortality figures) by the Nigerian Centre for Disease Control (NCDC). This scenario changed slightly when the harmattan season's cold spell accelerated infection and death rates in January and February 2021.

Be that as it may, secondly, there is still the need to interrogate the class interest of the dominant class in the manner the health sector has been developed, managed, and administered, which is central to the argument of the paper, can somehow be looked at from the perspective of other diseases that are also very infectious and dangerous to health as Covid-19. Diseases such as malaria, cancer, HIV/AIDS, cardio-vascularity, maternal mortality, etcetera., are as devastating as the Covid-19, as defined by the scientists. Cardio-vascularity, cancer, and HIV/AIDS may not have had any cure yet; they are generally managed through short-term but intermittent treatments. However, what is it that the three levels of governance in the country are doing or have done in terms of setting up world-class research centres and the installation of state-of-the-art equipment to address their menace? There is none. It is on record that, at the height of the transmission of the Covid-19 Pandemic in the country, the Chairman of the Presidential Task Force, Boss Mustapha, bemoaned the state of healthcare and confessed openly that he never knew that medical facilities were so grossly inadequate in the country. It is also to everybody's knowledge that diseases such as maternal mortality, cardio-vascularity, cancer, and HIV/AIDS are prevalent in the country and are taking a significant toll on the patients' mortality. They and other diseases, no matter how inconsequential they may be, are, therefore, deserving of the government's serious attention more than what is being done at the moment. Since the required attention is not being given to them and those who suffer from deadly diseases and, among them, those who are in the dominant class cadre are the ones most likely to partake in the development of the health sector policies, their management and administration are the ones most likely, once again, to have the means to embark on medical tourism. One is correct in referring to the development, management, and administration of the healthcare services in the country as a process in double jeopardy. In other words, the people in charge of putting in place functional and efficient healthcare services have failed woe-

fully to do so; ironically, they are also the ones who, when the chips are down, are in an advantageous position and/or have the option to jet out to utilize their ill-gotten resources to access better medical facilities in other countries.

At this point, a call for the healthcare sector's democratisation is not a bad idea at all. By not putting in place both the curative and the preventive measures to tackle the pandemics (which unfortunately have come to stay as a recurring decimal) gives us the basis to conclude that, in the health sector (as well as in the other social sectors such as education and the provision of affordable housing, etcetera.), where the most remarkable differences are made in terms of quality of life, upward social mobility, etcetera., of the populace, the case of the selfish expression of the class interest of the dominant and exploitative class by deliberately depressing services in these sectors is established. This is simply because the dominant class has an option that is not available to the downtrodden. One other evidence to support this point comes out from the following WHO statement on maternal mortality that generally affects the poor and the less-resourced people in the Nigerian polity:

> The WHO notes that Nigeria alone accounts for nearly 20% of global maternal deaths. Globally, maternal mortality remains a significant public health concern, especially in poorly resourced and developing countries, including Nigeria. About 295,000 women worldwide reportedly died during pregnancy and childbirth in 2017, with sub-Saharan Africa accounting for 66% of the total deaths. [mail.google.com/mail/u/0/#inbox/FMfcgxwKjdHIKFNqQTGHvkC. Downloaded on Saturday, 28th November 2020, at 12.36 Hours.]

The case of malarial diseases is even more pathetic concerning its known devasting effects and magnitudes. Indeed, malaria is a disease that is a significant drain on many economies as much as it causes much illness and death. According to the World Health Organization, an estimate in 2018 showed that: "…228 million clinical cases of malaria occurred, and 405,000 people died [from the figure], most of them children in Africa."

[See cdc.gov/malaria/about/faqs.html. Downloaded on Sunday, 29th November 2020, at 15.00 Hours.]

Furthermore, "…an estimated 90% of deaths due to malaria occur in Africa south of the Sahara…." [*Ibid*.] These grim pictures are enough to jolt the conscience of Africa's governments and leaders, not just the Nigerian government and leadership, that they should wake up from the entrenched lackadaisical approach to health issues. In one respect and as evidence has shown, since Africa is associated with the massive chunk of the fatalities resulting from malarial diseases, the dominant classes should be concerned, at the very least, with and go after serious determination against eradicating not only the disease but also the mosquitoes that spread it because "…the disease maintains a vicious cycle of disease and poverty." (*Ibid*.) Do they (African governments and leaders) care as the dominant classes in the continent believe that it is a natural phenomenon for the twins' existence – riches and poverty; dominant and dominated classes – in society.

Thirdly, we have already noted that there must have been "Providential Hands" that have controlled the rate of infection, treatment, and mortalities in Nigeria. Otherwise, both the PTF members' attitudes and the Nigerian people at large leave much to be desired. Throughout the outings of the Task Force, one is not impressed by the membership model. For instance, since its nomenclature connotes a presidential insignia, President Muhammadu Buhari should have personally headed it and, in his absence, his Vice President. This was and has not been done; it was left under the Secretary's charge to the Government of the Federation (SGF), Boss Mustapha, a lawyer by profession, whose hands are already packed with other state responsibilities. The appointment was not only nepotistic (the signal philosophy of governance by the current president of Nigeria), but the leadership of the Task Force should have been directed by the Minister of Health and his deputy, both of whom would have brought more science and professional élan to the work of the body, if the naturally proactive ambience of the President could not be tapped, right on the spot. (Compare this suggestion to the situation in the US, where, from time to time, President Trump before the Presidential Elections of No-

vember 3rd, 2020, would show his presence at the daily briefings at the beginning of the pandemic situation in the USA, with the Vice President always around to give a fillip to the work of their version of the committee.) Besides, by the protocol procedure and the best of one's knowledge, the minister should be higher in the ranking than a secretary to the government. Furthermore, the mode of working by the Task Force, which has required daily briefings for a week or two before briefing the president, has indeed not factored in the exceedingly emergency nature of tackling the pandemic. It is shameful how things are done in this clime, especially when in situations that are natural emergency will not be so addressed.

Fourthly, the Nigerians' attitude towards the pandemic concerning the "new normal" brought about both formally and informally in interpersonal transactions, too much to be desired. It would appear as if Nigerians are naturally people prone to disasters and are promoters and welcoming receivers of every shade of severe and dangerous phenomena, natural and human contrived. It is simply Nigerians' central DNA to throw caution to the winds in every situation confronting them. There is no sense of urgency in everything Nigerians are asked to do and, when they eventually decide to carry out such responsibility, it is treated with excessive levity. Most Nigerians would take it seriously when there are monies and "palliatives" to misappropriate. The likelihood of the mishandling of the so-called palliatives received its nemesis during the "#EndSARS" protests, during which Nigerians vented their waves of anger and spoke truth to power. Indeed, what has emerged as the likely response to the crass opportunism of the ruling class, going forward, is the reality that, at last, such impunity can indeed be challenged by the combined forces of the working class, the petty bourgeoisie, and the lumpen elements in the society, no matter how much inchoate it may be, organizationally speaking. Both leadership and followership would need to sit up and address the myriad problems in the health sector that face the country. Unfortunately, infantile behaviour that adults double down as leadership manifestation and indiscipline should be brought to a halt as it does not take a community anywhere. The country might have been lucky in the chain of pandemics that might have ravaged it (and the entire world) in recent times; it may never be always that lucky all the time and in all situations.

CONCLUDING REMARKS

In the bid to also add to the existing analysis of the class nature of the Nigerian social formation concerning the development, administration, and management of the health sector, the paper has adopted the framework used by both Amilcar Cabral and Frantz Fanon, essentially, through their respective analysis of the social classes of the countries with which they were involved during the anti-colonial struggles in the sixties and the seventies. The Marxist framework they used is still very relevant to the analysis of the Nigerian social formation. Available evidence indicates that, among others, there are such classes as the bourgeoisie (local and foreign); the proletariat, the petty bourgeoisie; the peasantry; the lumpen proletariat; etcetera. At the same time, the concern of the paper is not to make a pronouncement on the vanguard revolutionary class with which to entrust the leadership of the struggle for a revolutionary change, since it is not a revolutionary situation (in the real sense of the phrase) that is being looked at in the write-up. Instead, the paper's main argument is that in a class-riven society, the enunciation and implementation of public policies are invariably made to promote the dominant classes' interest. This is a constant in every society, although the extent to which it is carried out is likely to differ from one society entity to another. Thus, such selfish pursuit of personal interests is bound to happen because whether it is the dominant class that is taking the decision or its class associates to whom such favourable accruals shall go, the perfidy of compromising the more significant interest of the majority is likely, too, to be in the front burner. This is particularly the case in the health sector of Nigeria. This conclusion is arrived at while tracing the developmental history of orthodox medical practice and its facilities in Nigeria. This is even though the trajectory of any disease's development, spread or prevalence, and affliction is class blind. In other words, mortality levels and/or ratios of affliction are commonly randomized by Providence.

However, development, spread/prevalence, and affliction rates are also based on or bolstered by effective curative and preventive procedures taken to address a disease's trajectory along these lines and features in any community. Thus, the mortality rate does usually signify evidence of

class bias, especially when affliction does open up the floodgate of medical tourism that only the rich, the powerful, and the well-connected can afford. Put differently, what is often responsible for the predominance of one class over another concerning mortality rate is not unconnected with the fact that, while the members of the rich and the powerfully dominant classes are always able to afford the cost of medication (especially in a pandemic era of this magnitude) and the other aspects of healing measures taken, as a result of the *ab initio* advantage conferred on and/or possessed by, the mode of wealth accumulation and the resulting exercise of influence, the less privileged cum the dominated class do and cannot. Perhaps, in the case of the Covid-19 Pandemic, this scenario has not played out this significant role precisely because there has been a global lockdown. As a result, both the dominant and the dominant classes have had to access the available resources for healing locally. Without a doubt, if there had not been the shutdown of airports globally, the class dimension of Covid-19 would have been on display for all to see!

Although the paper has shown with statistics that the rates of affliction and death, as well as the patients who have luckily been healed and have survived, appear to be manageable and commendable so far, the parlous nature of the development and management of the health services of the country would require to be appropriately and thoughtfully re-jigged for better performance. From a close observation, it is clear that institutional frameworks are not in operation to monitor if they cannot sanction the various healthcare facilities that are recorded to be in existence in the various local government areas of the country. Where then is the guarantee that the country can measure the institutional and professional performance of the clinics, hospitals, or by whatever name they may be known, to meet standards that might not have even been defined for them but that are sorely crucial for the attainment of necessary objectives? Nigeria, being a federation, Mbaya {*op. ci*.:94) has observed that:

> The federal government's role is mainly limited to coordinating the affairs of the teaching hospitals[;] while the state government manages the various general hospitals[;] and the local government[s] focus on dispensaries. In this respect, different actors are involved in health policymaking and implementation [*sic*.]

This "coordination stuff" is inadequate because regulatory measures would have brought about sanctions to the malfeasance frequently reported in the media and/or that confront patients when they visit the hospitals.

The reasonable success attained (defined by the meagre rate of infections and death rates) (see the factors responsible above) in the handling (*mark you*, not fighting) against Covid-19 Pandemic has *only* been Providentially dictated and directed. Therefore, the success recorded is not because the Nigerian state is ever fully prepared to tackle any challenge; neither has it been able, historically speaking, to learn lessons from there, leading to the development of strategies to combat any other future invasive pandemic. It is hoped that appropriate lessons shall be learned this time around. Besides, Nigerians should be encouraged to take their health issues very seriously; there may never be a second time "being lucky," as the country has been in this particular pandemic. Both the leadership and the followership cadres need to pose questions of critical self-evaluation that can lead to an end to nepotism, corruption, and the lack of the drive to end all manner of criminality. In the recorded history of humankind, normative issues of adequacy, efficiency, accessibility, and equity are always the drivers of progress, not the other way around.

The protocols of handling this particular Pandemic have also not lent themselves to and/or have allowed for rigorous Marxist analysis to determine the relative gains and/or losses of one class *vis-à-vis* another. Apart from the protocols for the management of the pandemic – its nature of being a novel coronavirus that is not well known; its highly contagious nature to the extent that even when the afflicted patient has died, non-infected people would still have to protect themselves against infection by distancing and protecting themselves from and when handling their corpses except with personal protective equipment (PPE); the absence of vaccine until this very moment, indeed until the very recent breakthrough; etcetera.; very little has been done in the paper to sharpen the Marxist theorization of the Covid-19 Pandemic about infection along class lines. Despite these caveats, which only talk about the Covid-19 Pandemic, there is also enough evidence in the paper from other equally devastating diseases – such as maternal mortality, HIV/AIDS, cardio-vascularity, malaria, cancer, etcet-

era, - by which those with the means frequently jet out of the country to treat themselves from same. Such behavioural responses point to the class bias in the health sector's historical development pattern and the management and administration in Nigeria. This class bias is also eloquently expressed by the sector's utter neglect in terms of improvements and innovations in equipment and service delivery. In connivance with the planners, administrators, and managers, which is another form of class dominance, members of the dominant class invariably have the leeway to escape and go overseas on medical tourism to treat themselves from these and other mortal illnesses.

Finally, although disaggregated statistics on the demographics of the patients (dead and recovered) that could have enabled a more comprehensive study that could also have as well allowed for a more nuanced analysis of even the typical qualitative social science research undertaking were not available; but data on the quantum of available health facilities all over the country were generated that are likely to be useful for future as well as the contemporary comparative analytical study of some other aspects of the Nigerian health sector.

REFERENCE

Aliyu, M. (2020) ,Private Discussion, November.

bbc.com/news/world-africa-45473036.

brookings.edu/blog/future-development/2020/07/02/how-well-has-nigeria-responded-to-covid-19/.

Bottomore, T. (1988), (Editor with) L. Harris, V. G. Kierman, and R. Miliband, *A Dictionary of Marxist thought*, Oxford: Basil Blackwell Ltd., *passim*.

Cabral, A. (1966), "The weapon of Theory," Text of the Speech Delivered at the First Tricontinental Conference of the Peoples of Asia, Africa and Latin America Held in Havana, Cuba.

Caute, D., (1970), *Frantz Fanon*, New York: he Viking Press, Inc.

Chikwendu, E. (1983), "The African Peasantry: Neglected by African Political Science," in Y. Barongo, ed., *Political Science in Africa: A Critical Review*, London: Zed Press.

emerald.com/insight/content/doi/10.1108_/JJA-09-2018/full/html.

Erinosho, O. A. (2019), *Health Sociology for Universities, Colleges and Health-Related Institutions*, Bulwark Consult: Abuja, Ijebu-Ode and Abeokuta, Reprint.

eyegambia.org/Nigeria-has-more-than4000-in-the-us-5000-in-uk-alone/

Fanon, F., *The Wretched of the Earth*, Hammondsworth, Middlesex: Penguin Books Ltd.

google.com/search?sxrf=ALeKk02v1j2d7golvuCUXSbG6ETyp RdUrg%3A1605841380885&lei=5DG3x_7HNYXgU4vAmYAJ%q= how%20many%20doctors%20are%20in%20nigeria%20in% 2 0 u s a % v e d = 2 a h U K E w j - y o q o k Z D t A h U F 8 B Q KQtgBpAQsKwBKAF6BAgkEAI&biw=1440&bih-687.

Hauff, V., ed. 1987, *Our Common Future*, Oxford: Oxford University Press.

mail.google.com/mail/u/0/#inbox/FMfcgxwKjdHIKFNqQTGHvkC.

Makinde, O. A., B. Brown, and O. Olaleye. 2014, "The Impact of Medical Tourism and the Code of Medical Ethics on Advertisement in Nigeria," *Pan-African Medical Journal*, Vo.19.

Marx, K. and F. Engels. (1983), *Selected Works,* Volume 1, Moscow: Progress Publishers, Fifth Printing.

Mbaya, P. Y. (2017), *National Health Policy Administration in Nigeria*, Kaduna: Mike-B. Press and Publication Company, Reprint.

Merriam-Webster's Dictionary and Thesaurus (2006), Springfield, Mass.: Merriam-Webster Incorporated.

National Population Commission, December 2020.

Nkrumah, K. (1965), *Neo-Colonialism: The Last Stage of Imperialism*, London: Panaf Books Ltd., *passim*.

Pantham, T. (1995), *Political Theories and Social Reconstruction: A Critical Survey of the Literature on India*, New Delhi: Sage Publications Pvt. Ltd.

statehouse.gov.ng/covid-19/.

who.int/emergensies/diseases/novel-coronavirus-2019/interactive-timeline#!