COMMENTARY

Olikoye O. Ransome-Kuti: A testimony of his achievements in health reforms and public health governance

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Eyitayo Lambo

Former Foundation Professor of Economics and Management Sciences, Bendel State University (now Ambrose Alli University), Ekpoma, Nigeria; Retired Foundation Professor of Business Administration, University of Ilorin, Ilorin, Nigeria; Retired Regional Advisor on Health Economics, World Health Organization Regional Office for Africa (WHO/AFRO), Brazzaville, Congo; and Former Honorable Minister of Health of Nigeria (2003-2007)

***For Correspondence:** Email: *eyitayolambo@yahoo.com*; Phone: +1-678-480-3422

Abstract

The late Professor Olikoye Ransome-Kuti, Nigeria's longest-serving Health Minister since independence to date, has been variedly referred to as a distinguished academic, professional, public servant, technocrat, reformer, change agent, and mentor. His name is widely known not only within Nigeria but in Africa and, indeed, globally. Based on my knowledge of him as a result of working and interacting very closely with him in various capacities during the last twenty-seven (27) years of his life (1976-2003), I have highlighted in this paper some of his efforts and achievements for which he will forever be remembered. *(Afr J Reprod Health 2023; 27 [5s]: 15-26).*

Keywords: Public health governance, Health reforms, Distinguished, Primary health care, Health planning, Better Health in Africa

Résumé

Le regretté professeur Olikoye Ransome-Kuti, le plus ancien ministre de la Santé du Nigéria depuis l'indépendance à ce jour, a été diversement qualifié d'universitaire distingué, de professionnel, de fonctionnaire, de technocrate, de réformateur, d'agent de changement et de mentor. Son nom est largement connu non seulement au Nigeria mais en Afrique et, en fait, dans le monde entier. Sur la base de ma connaissance de lui à la suite de travailler et d'interagir très étroitement avec lui à divers titres au cours des vingt-sept (27) dernières années de sa vie (1976-2003), j'ai souligné dans cet article certains de ses efforts et réalisations pour lesquelles il restera à jamais dans les mémoires. *(Afr J Reprod Health 2023; 27 [5s]: 15-26).*

Mots-clés: Gouvernance de la santé publique, Réformes de la santé, Distingué, Soins de santé primaires, Planification sanitaire, Meilleure santé en Afrique

Introduction – Personal relationship with Olikoye Ransome-Kuti

My first contact with Professor Olikoye Ransome-Kuti was shortly after he was appointed the Director of the National Basic Health Services Scheme (BHSS) Implementation Agency in 1976. I was a young Lecturer in the Department of Economics at the University of Ibadan, Nigeria, then. He organized a workshop on the new Scheme in Lagos, Nigeria, and I was privileged to be invited to participate at the workshop. Before the end of the workshop, a cocktail was organized for the participants that gave me the opportunity to have a one-on-one chat with him[1].

I opened our discussion with, "Congrats, sir, on your appointment and for organizing a very successful workshop. However, something tells me that if you survive more than two years on this job, you should be given a medal." He responded by asking, "Eyitayọ, why do you say so?" and I replied that civil servants would likely frustrate him out of the office. He assured me that he would put in his best in the new assignment. Unfortunately, what I had predicted happened; he resigned within two years of his appointment![1]

There was then a break in communication between us. I had moved from the University of Ibadan to join the services of the University of Ilọrin, Nigeria, before General Ibrahim Babangida,

Nigeria's Military Head of State then, appointed Professor Ransome-Kuti as the Minister of Health in 1985. Following the announcement of his appointment, I obtained his address and wrote him a one-page letter, introducing myself again to him and reminding him of what I had predicted during his first appointment, which had come to pass. Then, I added that it was an irony of life that those people who had frustrated him out of office earlier on were now going to answer to him. I also wished him luck and assured him of my support as and when needed. He wrote back to acknowledge my letter and promised that he would get back to me.

Then, one day, I received a call from one of his aides that the Minister was on his way to Ilọrin and would like to see me whilst there. Unfortunately, I was in Lagos at the time and there was no way I could travel back to meet him in Ilọrin. He was also scheduled to travel out of the country on arrival in Lagos and so I could not see him until he had returned from the trip. When I eventually met with him in Lagos, he reminded me of my earlier pledge and assurance that I was ready to support him in his new appointment. He then told me that he wanted me to support him by coming on board as his Director of Planning, Research and Statistics. He was willing to give me up to a week to consider the offer. I had a ready answer there and then, but I withheld it, promising to get back to him after a week, as he had suggested[1].

When I got back to Ilọrin, I discussed the Minister's offer with my wife and her opinion was exactly as mine – not to accept the offer for several very good reasons. I thereafter went back to Lagos to see the Minister exactly a week after my first visit to him. When I got to his office, he asked, "Eyitayọ, what good news do you have for me?" I said, "Sir, I am not sure whether it is good news because I have pondered it very carefully and I have seven reasons why I can't take up the job." He was clearly curious to know the reasons[1].

I started with the fact that I was supervising seven PhD students, and that taking up his offer would be like abandoning the students. He immediately cut in to ask that I should not go to the second reason because as a university teacher himself, he considered the first reason I had given strong enough for him to respect and accept my position. Then, he asked me to join him in searching for a good candidate for the job but sought my assurance that I would work closely with whoever was appointed. I gave my word that I would, and we shook hands as I took my leave[1].

Professor Julius Makanjuọla was eventually appointed the Director of Planning, Research and Statistics in the Federal Ministry of Health and I worked closely with him as Professor Ransome-Kuti had earlier requested. I had many opportunities to relate with Professor Ransome-Kuti closely and support his administration during his tenure as the Minister of Health. One of the ways that I supported his administration is worth mentioning. I knew that the Ministry was sending some people to the University of Leeds and some other UK universities for the master's degree training programme in Health Policy and Planning and that the Government was paying over ten thousand pounds sterling per person as tuition fees only then. I suggested to Professor Makanjuọla and the Minister that if they gave only ₦50,000 annually to my Department at the University of Ilọrin, we would be able to develop a three-month Certificate programme in Health Planning and Management and train at least 50 candidates in two batches every year. I added that, with such a programme, the Ministry could put in place, within a few years, the much-needed capacity in health planning and management, not only at the Federal level, but also at the State and Local Government levels, and in the private sector. The Minister and the Director both accepted the idea and we thereafter developed the curriculum for the three-month Certificate Programme in 1989 that was subsequently replicated at the Universities of Ilọrin, Benin, and Maiduguri, with Ilọrin playing the leadership role. I was privileged to be the overall Coordinator of the Programme before I took early retirement from the university system to join the United Nations System (the World Health Organization) in 1990[1].

The third opportunity that I had to relate with Professor Ransome-Kuti closely was when he was appointed by the World Bank to be the Chair of "Better Health in Africa (BHA) Initiatives" in 1994 after his tenure as a Minister ended. He held the position till 1997 and operated from his office at the World Bank in Washington DC. As the Chair of BHA Initiatives, he was responsible for leading advocacy activities for the implementation of the BHA Initiatives in the African countries. I was then in the World Health Organization African Regional Office (WHO/AFRO) in Brazzaville and, more

importantly, I was the focal point in the Regional Office for the BHA Initiatives. We had many opportunities to work together but with some difficulties initially as will be explained later[1].

The fourth and last opportunity that I had to relate with Professor Olikoye Ransome-Kuti closely was when President Olusegun Obasanjo (Nigeria's President, 1999 to 2007) appointed him the Executive Chairman of the National Primary Health Care Development Agency (NPHCDA). As conceived by President Obasanjo at the time, Professor Ransome-Kuti's appointment was designed to reinvigorate the efforts of the Federal Government in strengthening implementation of primary health care (PHC) in Nigeria, a model that Professor Ransome-Kuti had successfully pioneered earlier. In 2001, Professor Ransome-Kuti as Executive Chairman of NPHCDA, invited me and organization which I led (the International Management & Health Consultants) to carry out a study on "Ensuring Better Performance of the Primary Health Care System on a Sustainable Basis in Nigeria." The *general objective* of the consultancy was to identify ways of improving the performance of the PHC system in Nigeria whilst the *specific objectives* were to:

1) Examine the adequacy or otherwise of physical infrastructural facilities and human resources for the delivery of effective PHC services in Nigeria;
2) Determine the health seeking behaviour of Nigerians, particularly with respect to PHC services;
3) Determine household health expenditure, particularly with respect to PHC services;
4) Determine the level of utilization of PHC services and factors affecting this;
5) Determine the current cost of providing the various PHC services;
6) Determine the existing sources of finance for PHC services and the relative importance of the sources;
7) Determine how efficiently the currently available PHC resources (finance and human) are used;
8) Estimate the financial resources that would be needed to provide effective PHC services in an efficient way;
9) Determine what financing gap currently exists for the provision of quality PHC services;
10) Explore alternative financing mechanisms for filling the resource gap,
11) Identify those mechanisms that will be politically feasible for financing quality PHC services on a sustainable and equitable basis; and
12) Develop guidelines for implementing the identified financing mechanisms.

Throughout his tenure as the Executive Chairman of NPHCDA, we were able to interact very closely on how he could revitalize the "decaying" PHC system until his demise in June 2003, which was less than two months before I was fortuitously appointed Minister of Health by President Olusegun Obasanjo.

Some Achievements of Professor Olikoye Ransome-Kuti

Since independence, Nigeria has had 24 full Health Ministers (i.e., not including the Ministers of State for Health)[2]. Professor Ransome-Kuti served as the 9th Health Minister (1985-1992)[2]. Eight (8) of the Health Ministers served in that position for a period of only one year or less for one reason or the other whilst six (6) of them occupied the office for four (4) years and above[2]. The average "length of stay" in office for all the 24 Health Ministers is 2.4 years. It is, therefore, noteworthy that Professor Ransome-Kuti served as Minister of Health for seven (7) years, making him the Health Minister who had stayed in office for the longest period.

Professor Ransome-Kuti is probably the most mentioned Nigeria's Health Minister within Nigeria, in the Continent and, indeed, at the Global level to date. Also worthy of note is the fact that he was the first Health Minister to develop and implement a meaningful health reform agenda. Professor Ransome-Kuti has been variedly referred to as a distinguished academic, professional, mentor, technocrat, reformer, and change agent within the Nigerian, African and even the Global health space.

In view of the privilege that I had in working and interacting very closely with Professor Olikoye Ransome- Kuti over a period of 27 years (1976-2003) as highlighted in the earlier part of this paper, I provide below some of my knowledge of his efforts and major achievements.

Directorate of BHSS implementation agency

The Third Development Plan Period, 1975-1980, was the period during which the health system

development plan was initiated, with PHC as its cornerstone[3]. Although there was no clear health policy framework, there was a **National Health Implementation Plan for the Basic Health Services Scheme (BHSS),** with a semi-autonomous Implementation Agency. Professor Olikoye Ransome-Kuti was invited to head the Agency in 1976. According to the Third National Development Plan and also its successor (the Fourth National Development Plan, 1981-1985), the BHSS was designed for two reasons: increase the proportion of population receiving health services from 25% to at least 40% during the plan period; and offer a platform to correct imbalances between preventive/curative, and urban/rural areas[3,4]. BHSS was based on the concept of a Basic Health Unit (BHU**)** per Local Government Area (LGA) with a population of about 150,000 people[3,4]. A BHU was to comprise 1 comprehensive health centre, 4 primary health centres, 20 primary health clinics, and 5 mobile clinics. With BHSS, new categories of health workers (i.e., community health workers comprising aides, assistants, and supervisors) were to be trained in 19 Schools of Health Technology whilst the community health officers were to be trained in the Teaching Hospitals to provide leadership to the new categories of Community Health Workers[3,4].

This was what Professor Olikoye Ransome-Kuti was to implement. The Agency was to establish a Basic Health Unit in a Local Government Area in each State so that a model health service could be set up that would later be replicated in other Local Government Areas in each State. Unfortunately, the Agency was not able to do this for several reasons and which led Professor Ransome-Kuti to decide to resign from the post. Some of the reasons for failure to implement the BHSS during the Third Plan Period included the following:

1) Poor commitment on the part of the bureaucrats in the Federal Ministry of Health due to their having a different agenda or priority;
2) Poor budgetary allocation for the implementation of the Scheme;
3) Non-involvement of the community;
4) Refusal of new cadres of staff to work in rural areas;
5) The Schools of Health Technology did not equip trainees with the skills to set up PHC systems;
6) Enormous quantity of sophisticated equipment was purchased contrary to the principles of self-reliance and appropriate technology; and
7) The lack of a policy framework[5].

Olikoye Ransome-Kuti as Minister of Health

Professor Ransome-Kuti was appointed Health Minister by the Military Head of State, General Ibrahim Badamasi Babangida, in 1985. The General had met Professor Ransome-Kuti at the Nigerian Institute of Policy and Strategic Studies (NIPSS) when he was attending a course at the Institute and Professor Ransome-Kuti was there to deliver a lecture. In retrospect, that lecture must have had such a lasting effect on General Babangida that, on becoming the Head of State in 1985, he offered Professor Ransome-Kuti the position of Health Minister in his Cabinet. Professor Ransome-Kuti seized the opportunity to leave his footprints in the health sector to the discomfiture of those who had denied him doing that when he was Director of the BHSS Implementation Agency about a decade earlier.

Some of his achievements as Health Minister during his tenure as Health Minister (1985-1992) can be highlighted as follows:

1) Development of the first Comprehensive National Health Policy

In 1985, the African Health Ministers affirmed their commitment to the Alma Ata Declaration, and they decided to strengthen their national health systems adopting the PHC approach[6]. They also agreed with the Regional Director of the WHO African Region, Professor G. L. Monekosso, that community-based health and health-related activities which would provide the much-needed foundation for socioeconomic development, must be supported, and sustained by appropriate operational, technical and strategic support at the local (district), intermediate (provincial/regional), and central levels respectively[6]. This became known as the Three-Phase Health Development Scenario (TPHDS)[7] which influenced the development of Nigeria's first Comprehensive National Health Policy in 1985 and 1986 and promulgated in 1988[6]. The policy document was titled The National Health Policy and Strategy to Achieve Health for All Nigerians[8].

On the new health policy, Professor Ransome-Kuti had this to say in the Foreword to the policy document written by him:

> "For the first time, Nigeria has a National Health Policy which has been prepared with wide participation of health leaders, institutions, and Ministries of Health throughout the Federation. The policy has finally been approved by all of the Federal Military Government of Nigeria and the health sector has been mandated to establish necessary machinery for its effective implementation. The principal aim of the policy is to provide the Federal, State, and Local Government health institutions and their functionaries, other health-related organizations including international agencies, and non-governmental organizations, a formal framework for appropriate national direction in health development in Nigeria from now on." [8]

The development of the comprehensive National Health Policy was, no doubt, a landmark achievement by Professor Ransome-Kuti. The comprehensiveness of the Policy was even acknowledged at the Regional level. The Health for All (HFA) Unit at WHO/AFRO of which I had become a member of the Team in 1990 requested Member States to send in their national health policy documents for assessment. At that time, less than 40% of the countries had developed explicit health policy documents. Using some criteria, the available national health policy documents were evaluated and Nigeria's national health policy document was adjudged to be one of the most comprehensive. That exercise prompted the HFA Unit to develop a Guide for the development of national health policies and the corresponding health plans which was circulated to Member States. One major shortcoming of the 1989/1988 National Health policy, however, was that it lacked an appropriate legal backing. This was a major constraint to its successful implementation subsequently.

2) *Ransome-Kuti's support for implementing PHC in Nigeria*

Under the leadership of Professor Ransome-Kuti, beginning from 1985, Nigeria embarked on a major effort to re-orient its health system[6]. It focused attention to increasing the capacity of the third tier of government (i.e., the LGAs, which is the equivalent of Districts in some African countries) to develop effective and efficient PHC[6]. Professor Ransome-Kuti created a PHC Directorate in the Federal Ministry of Health and organized the country into 4 zones[6].

He decided to pilot the implementation of PHC and, therefore, selected 52 LGAs to be developed as models for primary health care services[6,9]. Each selected LGA was paired with a College of Medicine/School of Health Technology to provide the LGA with technical assistance and act as practice areas for students to acquire necessary skills to provide health services at the community level[6,9]. Village Health Services and Village Health Committees were set up in the selected 52 LGAs and Village Health Workers were selected and trained[6,9].

The implementation of PHC in selected LGAs involved a planning process with the following components: undertaking baseline surveys, situation analysis, and programme formulation; provision of ₦500,000 (then $ 559,284.10; exchange rate of Naira to dollars in 1985=0.894) seed money and facilitators by the Federal Government; setting of village health system followed by the training of voluntary health workers; establishment of essential drug revolving fund in line with the Bamako Initiative; and pursuance and strengthening of monitoring and evaluation. PHC services provision, funding and management was devolved onto the Local Government from 1990 to 1992[5,6,9].

By mid-1991, a lot of progress was made in strengthening PHC in the LGAs in almost all parts of the country[6]. This emboldened Professor Ransome-Kuti to seek an independent review of the Nigerian efforts in LGA-focussed implementation of PHC[6]. Such a review was expected to be useful for consolidating and sustaining the progress that had been made[6]. Consequently, the Federal Ministry of Health led by Professor Ransome-Kuti, invited the World Health Organization to undertake the review[6]. The WHO responded by forming a High-Level Review Team with the following

Terms of Reference:

(i) To analyze the Nigerian Experience in accelerating PHC implementation at the Local Government Area level.

(ii) To recommend means for continuing the strengthening of PHC at the LGA level; and
(iii) To present insights and lessons for other developing countries[6].

The **membership** of the WHO High Level Review Team consisted of:

(i) Dr. M. E. K. Adibo, Director of Health Services, Ghana.
(ii) Dr. Z. K. K. Kuberu, Minister of Health, Uganda.
(iii) Dr. A. Khalid Sahan, Director-General, Ministry of Health, Malaysia.
(iv) Mr. R. Srinivasan, Secretary to the Government of India, Health and Social Services.
(v) Professor Carl Taylor, Professor Emeritus of International Health, Johns Hopkins University, USA[6].

The Review Team was supported by a Technical Team which consisted of: Dr. S.H. Brew-Greaves, A. Bamisaiye and Dr. S.K. Dola of WHO, Lagos; Professor Eyitayo Lambo of WHO/AFRO; Dr. H.M. Kasssay and Dr. G. Dorros of WHO, Geneva; Dr. A.O.O. Sorungbe, Dr. K.S. Oyegbite of the Federal Ministry of Health; and Dr. O. Oshin and Dr. A. Asamoah-Baah as resource persons[6].

The Review Team visited communities (villages) health centres, training institutions, and supporting Agencies in both Oyo and Ogun states of Nigeria and had useful discussions with relevant government officials at all levels as well as with officials of bilateral and multilateral donor agencies between 6th and 13th July, 1991[6]. The Team also reviewed many published and unpublished official documents and a working document containing background information and results of exhaustive analysis of current experience authored by a preparatory team of WHO and Federal Government officials[6].

The High-Level Team then developed a report of the results of their review with 10 Sections and 4 Annexes.

The 10 Sections of the Main Report were:

Background;
Organization;
Resource Mobilization, Allocation and Utilization;
Planning;
Service Delivery; Information Support;
Direct Support to LGA Health Systems;
Collaboration with other sectors and institutions; and Conclusions & Lessons learned[6].

Some major conclusions of the review included:

- Remarkable progress was occurring in Nigeria's innovative acceleration of PHC development focusing on the LGA under the expert and dynamic leadership of Professor Olikoye O. Ransome-Kuti.
- Progress in the last 5 years had placed Nigeria in the fore-rank of countries of the world that had advanced the progress in equitably improving the health and quality of life of its people.
- Nigeria is giving priority to the commitment made at Alma Ata to achieve "Health for all by the year 2000."
- Nigeria's PHC programme is unique in being community-based with real devolution of power to the LGAs as enshrined in the Nigerian Constitution and backed by the National Health Policy and supported with statutory allocation of financial resources[6].

As to be expected, the Review Team made numerous recommendations:

- 5 on Organization of PHC;
- 7 on Revenue Mobilization, Allocation and Utilization;
- 6 on Planning;
- 3 on Service Delivery;
- 1 on Information Support;
- 9 on Direct Support to the PHC LGAs; and
- 2 on Collaboration with other Sectors and Institutions[6].

A key achievement of Professor Ransome-Kuti following the recommendation of the Review Team was the establishment of the National Primary Health Care Development Agency (NPHCDA) as a way of institutionalizing PHC implementation in Nigeria. Another landmark achievement during Professor Ransome-Kuti's tenure was Nigeria's attainment of 80% immunization coverage for fully immunized Under-5 children, largely as a result of community participation. Other indicators of PHC's success during his tenure were: DP3 coverage increased from 10% in 1984 to 56% in 1990, OPV coverage increased from 10% in 1984

to 55% in 1990, and measles coverage increased from 10% in 1984 to 85% in 1990[5].

To bring Professor Ransome-Kuti's achievement into sharper focus, it is relevant to highlight what happened after he left the scene in 1993. The donors withdrew their support to PHC largely because of the unpopular regime of General Abacha who ousted the administration of General Ibrahim Babangida in which Professor Ransome-Kuti served as Health Minister with no corresponding increase in political commitment to PHC implementation by the 3-tiers of Government during the period 1993-1999. WHO, Department for International Development (DFID-UK), and United Nations Children's Fund (UNICEF), however, continued to support NPHCDA and the process of PHC devolution during the period[5]. Other factors that contributed to the collapse of PHC after Professor Ransome-Kuti left the scene included: instability in governance; lack of visionary leadership; low staff morale; and slowness or halt in the support to LGAs to be able to shoulder the responsibility associated with devolution of PHC[5].

3. Professor Olikoye Ransome-Kuti and the development of human resources for health

Apart from training new cadres of community health workers to drive the implementation of PHC at the LGA level, Professor Ransome-Kuti saw the need for increasing the number of health planners and managers. He supported the establishment of Federal Ministry of Health (FMoH) Collaborating Centres at the Universities of Ilorin, Maiduguri and Benin to run 3-month Certificate Programmes in Health Planning and Management. Participants in the programme included officials from the Federal Ministry of Health, the States' Ministries, LGA health officials, the private sector, among others. Thus, it was during his tenure that deliberate efforts were made to build the capacity of staff in health planning and management in Nigeria's health sector. In addition to the 3-month Certificate Programme in Health Planning and Management, the Collaborating Centres later mounted master's degree programmes in Health Planning and Management, Health Information Systems, and Health Statistics, all funded by the Federal Ministry of Health[2].

The University of Ilorin was the coordinating institution because it had the critical mass of experts and capacity to manage the collaborative effort. These 3 Universities, however, moderated and peer-reviewed the programmes. Provision was made for constant interactions between the officials of the Federal Ministry of Health and representatives of the three Collaborating Centres to ensure the success of the programmes. In spite of the great value of the programmes, however, the Centres declined progressively in performance after the exit of Professor Ransome-Kuti.

(4) Professor Ransome-Kuti and Development of National Health Insurance Scheme in Nigeria

The first mention of health insurance in Nigeria was in 1962 when the first Nigeria's Health Minister, Dr. Moses Majekodunmi, introduced a Bill in the Parliament in Lagos on the subject but was not passed. Not much happened on the issue of a National Health Insurance Scheme in Nigeria until 1984 when a Committee was set up on National Health Care Financing in Nigeria[10]. The Committee gave its report in January 1985 and stressed the underfunding of Government health services, the increasing demand being made upon public health services, and the poor state of private medical services[10]. The Committee considered a variety of options for obtaining more funds for the health sector and strongly recommended the introduction of a National Health Insurance Scheme[10].

Another Committee was set up in August 1985 and it reported in February 1986[10]. Its terms of reference required it to examine the feasibility of a National Health Insurance Scheme in Nigeria and advise on the modalities for the implementation of such a scheme[10]. The Committee came to the conclusion that such a Scheme was feasible and specified some of the important requirements[10].

Professor Ransome-Kuti built on these earlier efforts during his tenure as Minister of Health by inaugurating a Committee on the Establishment of a National Health Insurance Scheme in Nigeria on January 19, 1988[10]. The Committee was Chaired by Dr. Emma Umez-Eronini (a Consultant Physician) and the other members of the Committee included Professor Brian Abel-Smith, a renowned health insurance

expert from the London School of Economics[10]. The Terms of Reference of the Committee were:

(i) To examine in the light of the recommendations made in the previous reports on the subject, the establishment of Health Insurance Scheme as an option for funding health care services in Nigeria;
(ii) To examine and advise on the type of National Health Insurance Scheme suitable for the Nigerian situation with regard to political, administrative, social, and economic factors;
(iii) To examine specifically the policy implications, planning arrangements and any existing or potential administrative structure that may be required for a timely introduction of the scheme;
(iv) To examine the 'phase in' implementation of the scheme and advise on a time frame for its implementation; and
(v) To make recommendations on the modes of operation and other matters as may be considered relevant to the establishment of the scheme[10].

The Committee submitted its report in two volumes in September 1988. Volume I was the Main Report and Volume II contained the Appendices[11]. The Committee recommended the template for the establishment of Nigeria's National Health Insurance Scheme which was approved by the Federal Government in 1989[11]. The implementation of the recommended template was, however, not done during his tenure.

It was not until 1999 that the Federal Government signed an agreement with the United Nations Development Programme (UNDP) and the International Labour Organization (ILO) for the planning and implementation of the Scheme[12]. The draft of the law for establishing the Scheme was prepared and the Military Head of State then, General Abdulsalami Abubakar, signed the draft law on NHIS into law on 10 May 1999 as Decree 35 (now Act 35) of 1999[12]. It was, however, not until June 6, 2005, that the formal sector programme of the Scheme flag off was done by President Olusegun Obasanjo with Professor Eyitayo Lambo as the Minister of Health. Commencement of provision of services to the enrollees started in September 2005.

(5) Professor Ransome-Kuti's participation in Regional & Global Health Bodies

As Minister of Health from 1985 to 1993, Professor Ransome-Kuti led the Nigerian delegation to the meetings of the WHO African Regional Committees, the meetings of the African Health Ministers, and the World Health Assembly. Throughout his tenure, Nigeria sent quality delegation to these meetings and, therefore, the voice of Nigeria was very well respected during discussions in the meetings. Nigerian delegates were always punctual to the meetings and always on their seats for most of the meetings largely because Professor Ransome-Kuti was always on his seat too.

Professor Ransome-Kuti was appointed the General Chairman of the Technical Discussions held at the Forty-Second World Health Assembly in 1989. He also became the Chairman of the Executive Board of the World Health Assembly from 1992 to 1993, and he was very highly respected. He certainly made Nigeria proud on the Global and Regional Bodies during his tenure.

Professor Ransome-Kuti as Chair, Better Health in Africa Initiatives

The World Bank supported the undertaking of a comprehensive study on "How to Achieve Better Health in Sub-Saharan Africa" during the 1990s. The study report titled "Better Health in Africa: Experiences and Lessons Learned" was written with the active participation of African Health Experts, the World Health Organization, and UNICEF[13]. Indeed, the Foreword to the publication was jointly prepared by Professor G.L. Monekosso (Regional Director for Africa, World Health Organization), Mr. E. V. K. Jaycox (Vice President, African Region, The World Bank), and Mr. James P. Grant (Executive Director, United Nations Children's Fund)[13]. The study sets forth a vision of health improvement that challenges countries in sub-Saharan Africa and their external partners to rethink current health strategies[13]. It stressed the positive experiences and concluded that greater progress be made in improving the health of the people in the region despite the numerous

challenges[13]. Better Health in Africa documented lessons learned and "best practices" in 4 major areas as follows:

(i) Experience indicates that African households and communities have the capacity and will to use knowledge and resources to recognize and respond effectively to health problems. Public authorities with health responsibilities need to give greater attention to providing the information and tools needed by communities and individuals to assume responsibility for their own health improvement[13].
(ii) Experiences documented in Better Health in Africa teaches that much health improvement can be realized through managerial and other reforms in health systems, including reallocation of human and financial resources; better planning and management of pharmaceuticals, health sector personnel, and health infrastructure and equipment[13].
(iii) Experience suggests that cost-effective packages of basic health care services, delivered through networks of local health centres and small referral hospitals in rural and peri-urban areas can go a long way to meet the needs of households. It is estimated that cost-effective packages of health services can meet 90% of the demands of the people for health services and reduce the burden of disability and premature mortality by about 30%. The content of the package will be country specific. For better health to be achieved, substantial increases in efficiency as well as significant reallocations of public and non-governmental resources will be required, particularly away from expensive services that benefit the few towards more cost-effective interventions in a carefully designed package of services made available to all[13].
(iv) Better Health in Africa finds that, with about $1.6 billion in new annual financial resources for health, basic health services should be provided to all Africans living in low-income areas and countries-representing over two-thirds of the people. Necessary resources could be generated through cost-sharing by consumers, increased budgetary allocation and donor funding[13].

The "Better Health in Africa" (BHA) Expert Panel was first constituted in 1993 to review the draft of the BHA document[14]. After the review, the World Bank requested the Panel to take the lead in follow-up activities on the book[14]. Professor Olikoye Ransome-Kuti, former Health Minister of Nigeria and former Chairman of the Executive Board of the World Health Organization, was invited to Chair the Panel most probably because of his antecedents. The Panel members were African health experts who participated in their own personal capacity. The members came from Benin, The Central African Republic, Burkina Faso, Burundi, Chad, Cote D'Ivoire, Ethiopia, Ghana, Kenya, Malawi, Mozambique, Nigeria, South Africa, Senegal, Tanzania, Togo, Uganda, Zaire (now DRC), and Zambia[14]. The Panel was co-sponsored by the African Development Bank, the Swedish International Development Agency, The United Nations Children's Fund, the World Health Organization, and the World Bank and was hosted by the World Bank, Washington DC[14]. Thus, the Chairman, Professor Ransome-Kuti, operated from his World Bank Office in Washington DC.

By the time Professor Ransome-Kuti became the Chairman of the BHA Panel, I was already a staff of the WHO/AFRO in Brazzaville[1]. I was the focal point for BHA as a Health Economist in the Health for All (HFA) unit attached to the office of the Regional Director, Professor G.L. Monekosso, who was actively involved in producing the BHA document. Professors Monekosso and Ransome-Kuti had been colleagues and friends from their days at the College of Medicine, University of Lagos, Nigeria[1]. This coupled with the fact that Professor Monekosso was actively involved in the production of the BHA document would have been expected to elicit Professor Monekosso's close cooperation with Professor Ransome-Kuti when he was appointed the Chairman of the BHA Expert Panel but this did not happen. This was largely because Professor Monekosso felt strongly that Professor Ransome-Kuti's operational base should not be at the World Bank in Washington but somewhere in Africa and, better still, at the WHO/AFRO in Brazzaville. Indeed, Professor Monekosso offered to host BHA in the Regional Office, but Professor Ransome-Kuti and the World Bank declined the offer.

This disagreement certainly negatively impacted the active collaboration of the Regional Office with the BHA Expert Panel in its activities at the Regional, sub-Regional and country levels.

The arrival of the new Regional Director, Dr. Ebrahim Malick Samba, in February 1995 drew the Panel closer to WHO/AFRO[14]. At the Panel's meeting in February 1995, the Regional Director gave the Panel his full support and urged the Panel to work closely with the WHO Representatives (WRs) in countries of the Region[14]. Dr. Ebrahim M. Samba, however, later insisted that the Panel must be African owned in the sense that the Panel's Secretariat must move to Brazzaville, the location of WHO/AFRO[14]. Many donors also clamoured for the movement of the Panel's Secretariat to Africa such that at the Panel's 3rd meeting held in Lisbon, Portugal, 18-21 March, 1996, the Panel agreed that the Secretariat should prepare a plan to move the Secretariat to a suitable place in Africa and that the 4th meeting of the Panel would be held in Africa[14].

At the Panel's first meeting in February 1995, it described its role as dissemination of the messages of the BHA study, and advocacy for health reform[14]. It discussed and accepted a 3-year programme of work[14]. The Panel revisited its role from time to time and the following seemed to capture its expanded role: dissemination of the findings of the BHA study; national advocacy activities on health reform; organization of workshops at country, inter-country and regional levels; organization of meetings at country, inter-country and Regional levels; commissioning of special studies on health reform issues; monitoring progress in health reform efforts at country level; and communicating, documenting and sharing successful health reform experiences[14].

Professor Olikoye Ransome-Kuti successfully led the Panel in carrying out its BHA activities. He was not only well respected by the members of the Panel, but he was also well trusted by the Agencies that co-sponsored the Panel, and the political as well as health leaders at the country, sub-Regional, and Regional levels gave him ears. Many countries in Africa embarked of health reform because of the successful implementation of the BHA activities.

Professor Olikoye Ransome-Kuti as Executive Chairman of the National Primary Health Care Development Agency

The great strides that Professor Ransome-Kuti made in implementing PHC in Nigeria were reversed because of factors that had been highlighted earlier[5]. The PHC system and, indeed, the national health system collapsed. Evidences of the collapse included (i) the ranking of the performance of Nigeria's health system in the 187th position out of 191 Member States of the WHO in 2000 ("beating" only Democratic Republic of the Congo, Central African Republic, Myanmar, and Sierra Leone, all war-torn countries); and (ii) poor health indicators in 2000 (only 14% of the children fully immunized; 41% of the children with zero immunization; neonatal mortality rate of 52 per 1000 live births; post-natal mortality rate of 47 per 1000 live births; infant mortality rate of 100 per 1000 live births; under 5 mortality rate of 187 per 1000; and maternal mortality rate of 1000 per 100,000 live births)[5].

President Olusegun Obasanjo who was voted into power to lead the first democratic government after many years of military rule was very keen on resuscitating the concept of primary health care system that Professor Olikoye Ransome-Kuti had successfully implemented before. It was, therefore, very clear why he could not think of any other person but Professor Ransome-Kuti to do this and, therefore, the President invited him to be the Executive Chairman of the National Primary Health Care Development Agency which was established in 1992 during his tenure as Minister of Health. That was a position that he held until his untimely demise on June 1, 2003.

Professor Ransome-Kuti quickly set in motion a strategy and plan to revitalize PHC. He was making some significant progress before his untimely demise. In 2001, the Ward Health System (WHS) was introduced as a response to one of the recommendations of the WHO Expert Review Panel (1991) that the boundaries of the health districts in Nigeria be the same as the electoral ward comprising the 20,000-30,000 that elect a

councillor to the Local Government Area administration for primary health care implementation so as to enhance community mobilization[15,16]. In other words, the political wards became the operational units for the implementation of primary health care programmes, The Local Government Area (LGA)-Ward- Community/Village structure, therefore, replaced the Local Government Area (LGA)-District-Community/Village structure[15,16].

Following the development of the Ward Health System and to ensure equity in the delivery of health care services and improve access, the Ward Minimum Health Care Package (WMHCP) was developed[16,17]. The WMHCP targets the grassroot for the delivery of a minimum set of primary health care interventions needed to meet the basic health requirements of a majority of Nigerians with a view to substantially reduce morbidity and mortality and contribute significantly health development goals[16,17].

Under his leadership, the Agency also embarked on PHC Infrastructural Development through the construction of new PHC facilities and refurbishing existing ones across states with the Health Systems Development Project funding initially and later through allocated funds from the Debt Relief Savings[5].

At the time of Professor Ransome-Kuti's demise, I never knew that I would become Nigeria's Health Minister within 2 months. If he were alive and continued to be the Chairman of NPHCDA during my tenure as Health Minister, I am sure that the Health Sector Reform Programme we developed and implemented from 2004-2007 would have been able to lift up PHC to a level close to where he left PHC when he ceased to be Health Minister in 1992.

Conclusion

From the foregoing, it can be concluded that Professor Olikoye Ransome-Kuti has to date been the most outstanding Nigeria's Minister of Health. His footprints are there for people to see at the national, continental, and global levels. In addition to his sterling professional achievements, Professor Ransome-Kuti distinguished himself by his simplicity, humility, honesty, patriotism, and dedication to duty. I count myself lucky that our paths crossed and that he "infected" me with most of his personal values. I am eternally grateful to him for mentoring me. May his soul continue to rest in eternal glory.

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