GLOBALISATION AND ORAL HEALTH IN NIGERIA

BY

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Abstract

This study is about the issue of Globalisation, its impact on oral health in Nigeria. Globalisation, oral health and foreign policy are themes for consideration in Nigeria as a whole. Globalisation can, at its core be defined as a process of change affecting the nature of human interaction in every aspect of life as boundaries become eroded globally. Possible reasons for the current popularity of the concept of globalisation, are, the magnitude and pace with which it is occurring and the way technology is changing the world rapidly. Secondly, it is now commonly accepted that globalisation is not just the most recent economic craze but that the international environment is changing in profound ways, consequently impacting on developing countries. Globalisation influences Nigeria's economic and trade policies, it has consequences for the sale and consumption of beverages like Coca Cola with subsequent implications for impacts on oral health. The world is indeed becoming a global village. There is increasing awareness of the consequences of our growing interactions in this global village and the importance of extending the appreciation of oral health issues amongst policy makers in Nigeria cannot be overemphasized. Given Nigeria's differences in health, infrastructural development, education, political and economic stability in comparison to other developing countries, the benefits of globalization are not likely to be the same for all. The major processes of globalisation in Africa would give an insight to how globalisation has probably become the new tool of exploitation in a modern form of colonialism.

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Dedication

This study is dedicated to my parents, my family, friends and all those who watched my back while in school.

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Chapter one

Introduction

The aim of this thesis is to explore the underlying relationship between globalisation and oral health in Nigeria. It begins by introducing Nigeria briefly, what the globalisation process means in itself, and it seeks to explore the nature and impact of globalisation on developing countries. The section continues with a discussion on the politics, economics and social impacts of globalisation, the relationship of globalisation with development and its impact on the African continent in general. It further attempts to highlight the consumer products of globalisation and how the globalisation process relates to oral health.

This thesis also considers the major globalisation processes in the African continent with a section exploring the possible impact of Coca Cola on oral health in Nigeria with due consideration of the present oral status in the country. The rationale for engaging on this issue is based on three main developments. There are growing links between health policy and foreign policy, with developments in these fields having many implications for oral health both in Nigeria and globally. Secondly, increasing globalisation has blurred the boundaries between national and international or foreign agendas, and the way we think and act in relation to oral health must adapt accordingly.

Finally, links between health, global issues and development are increasingly been made, reinforcing the need to fully appreciate the place of oral health in the policy agenda. Oral health has always been an issue in foreign policy but as its prominence increases, it is

important to assess whether it is appropriately prioritised and how the Nigerian government interacts with businesses and the civil society on a national, regional and global basis.

In the world today globalisation has been associated with increased access to technologies and knowledge that improve life's prospects. There is a growing global awareness of the need to reduce human suffering, the right to health and good living which can become a reality when governments, industries and nongovernmental organisations participate fully in the process of globalisation.

The incredible benefits which have been bestowed to nearly 5 billion people world wide, through knowledge and improved technologies highlights the associated challenge of bringing these changes to the rest of the people living in sub Saharan Africa who are yet to benefit (Derek 2005). Likewise there is a developing global awareness among people and governments in developed countries about the need to reduce suffering for all. This has led to new initiatives in the last few years. These include new funding systems to address health issues, a global push for debt relief and better trade opportunities for developing countries and the recognition of how global norms that address these issues benefit all, if it is truly beneficial (Derek 2005).

1.1. Nigeria in Perspective

Nigeria 'Niger-Area' the area around the River Niger located in the West Africa sub-region bordering Republic of Benin, Cameroon and the Gulf of Guinea. It became independent in 1960, before then, was originally a British Colony (Infoplease 2007; Ministry 2007; Nigeria-world 2007). It is the most populous African country with a total population of 135,031,164 (2006 estimate) (Infoplease 2007; Ministry 2007; Nigeria-world 2007) people divided into 6 geo-political zones comprising more than 250 different languages and ethnicity, the most populous being Hausa and Fulani 29%, Yoruba 21%, Ibo 18% several minority tribes (32%). There are 36 states in the federation (Infoplease 2007; Ministry 2007; Nigeria-world 2007; World-Fact-Book 2007).

Nigeria is seen as an African Power. This relative power position grew out of the following factors. Firstly, the country's sheer physical size, with a total land area of 910,768 sq km and total water area of 13,000 sq km stretching from longitude 10 00 N and 8 00 E which makes it slightly more than twice the size of California (Infoplease 2007; Ministry 2007; Nigeria 2007; World-Fact-Book 2007). The country is ranked the 9th most populous nation in the world and the most populous Black nation. Secondly, the country is endowed with a wide variety of physical and mineral resources, the most prominent in recent times being crude oil although most are under-developed or not developed at all at the moment. Thirdly, the growing skill and aggressiveness on the part of its human population, fourth, the strong feeling on the part of the country's elite that Nigeria should, or is in fact destined to, play a leading role in African affairs (Infoplease 2007; Ministry 2007; Nigeria 2007). Finally, the history of active if not decisive role

played by Nigeria in crucial African issues, such as, the expulsion of South Africa from the Common-Wealth; participation in U.N Peace-keeping Force in Congo (Zaire); the establishment of Organisation of African Unity (O.A.U) now referred to as African Union (A.U), ECOWAS, and South Africa's illegal occupation of Namibia (Okello 1987). Despite all these, Nigeria's road to success has been bleak, due to various societal and environmental ills.

Population health is affected by infectious diseases which are mostly endemic from food and water sources, e.g. Salmonella typhoid, cholera, diarrhea, hepatitis A. Malaria is the commonest, and HIV/AIDS is on the increase with about 3.6million people living with HIV/AIDS presently, the adult prevalence rate is 5.4% and deaths from the disease amounts to 310,000 people (Infoplease 2007; Ministry 2007; Nigeria 2007). HIV/AIDS has been solely responsible recently for the excess mortality rate with resulting lower life expectancy with high infant mortality and high death rates. However, the maternal and child mortality rate is higher in male (104.05 deaths/1,000live births) than in female (90.02 deaths/1,000live births) and a total infant mortality rate of 97.14deaths/1,000 (Infoplease 2007; Ministry 2007; Nigeria 2007; World-Fact-Book 2007).

Other associated health influencing factors are multi-factorial in nature and regionally based which includes; air and water pollution, poor sanitation, overcrowding, poor housing etc which are due largely to poverty (60% of the population) and rural- urban migration, with Net migration rate 0.27 migrants/1,000 population in search of jobs in the cities at the end of the farming seasons, even though the unemployment rate in the

country is 2.9% (Ministry 2007; Nigeria 2007). The majority of citizens 15 years and above are literate, 75.7% male and female 60.6%, total being 68% of the country's population (Infoplease 2007; Ministry 2007; Nigeria 2007; World-Fact-Book 2007).

1. 2. What is Globalisation?

The Oxford English Dictionary simply defines "globalization" literarily speaking, as the process by which businesses start operating on a global scale (Catherine 2005), from the Latin word "globus" which denotes "the earth" or "the globe" but in context and reality there is much that meets the eye. Globalisation therefore, is considered to be a process that brings about cross border interaction as regards cultural, social, economic and political activities with the sole aim of increasing the level of human interaction.

It is gradually evolving and systematically changing the way nations on earth relate in the real sense. Globalization is also a new belief amongst people that is systematically and slowly taking its toll on the way we think and shape our actions, for example, the way it is addressed in some context as the world becoming a "Global Village". The way it is been defined or interpreted is based on the perspective in which it is approached, and current debates or discussions are either for, or against it.

Edoho (1997) defines it as; as an all encompassing concept that has political, economic, social and institutional dimensions. As a multidimensional construct, globalisation means different things to different people (Edoho 1997).

"Disputes and confusion about globalization often begin around the issue of definition. Indeed, many people invoke notions of globalization without indicating explicitly what they mean by the term. For example, various commentators have described globalization as 'a stage of capitalism' or 'late modernity' without specifying the content of such jargon. Or we face unfocused remarks that globalization is 'a new way of thinking'. Circular definitions are not much help either. All too often we encounter statements like "globalisation is the present process of becoming global" (Archer 1990). 'Globalization' "becomes a label to cover whatever strikes our fancy" (Jan 2000).

Generally speaking, the points gathered from debates all tend towards a unified concept that globalization is believed to be the ultimate conquest of capital over nations. Some argue that; Globalization is a positive or powerful force for the improved material well-being of humankind, that would aid developing countries to "create better economic environments", to "leapfrog" into the information age; improve their access to technology; speed development and enhance global harmony" (Mowlana 1998; Ohiorhenuan 1998; Oyejide 1998; Grieco 1999).

1.3. The political, Social and Economics of globalisation

African states have a track record of severe abuse from depredations of the world economic and political systems. It has been a main drive by the World Bank and the International Monetary Fund alias 'IMF', to constantly weaken developing countries in the guise of market efficiency, for example, the World Bank loan to Nigeria in 1987 and

the consequent devaluation of the naira (Nigeria's currency) with resulting inflation in the country (Noble 2003). The renowned world economist and Nobel Prize winner Joseph E. Stiglitz, argued that, the poorer countries of the world are at the mercy of the IMF (Stiglitz 2003). It is the interest of Wall Street, along with the big financial community that are actually protected by the International Monetary Fund in conjunction with other World leading financial institutions (Joseph 2003).

Navarro (1998) argued that on comparing the positive impact of neoliberal policies and local policies of developing countries, there is very little or no benefit at all to developing countries. The benefits from the neoliberal policies were only appreciated in the sector of business profits and inflation control in a few developing countries. Other aspects of economic growth suffered set backs, for example, reduction in corporate investments, reduced credit and loan facilities, increased social inadequacies and inequalities, high unemployment rate, poor debt management and increased poverty in the population. These neoliberal policies are not any better, nor has it shown any superiority on the local policies they have replaced in developing countries (Navarro 1998).

Society is witnessing a steady economic stimulation from industrialised nations with political undertones. This is happening in place of the so called globalization of commerce and business investments. There is also the belief that it is the capital markets that are determining the public policies in the context of the globalization of capital finance (Navarro 1998). Navarro (1998) further argues that political reasons or explanations should be put forward for a proper understanding of major social problems,

including unemployment, rather than crediting economic determinism as the main focus of globalization (Navarro 1998). The majority of developing countries' populations are worse of in their standards of living with so much disruption, incessant crises and near collapse in the work force of the populace; this is largely due to the policy of deregulation of labour markets.

1.4. Globalization and Development

Globalization in the context of the African continent is typically discussed in two ways. Firstly, "globalization" has clearly realised negative consequences for development, secondly, it is not pursuing benefits in the interest of African citizens (Henriot 1998). The process leads to underdevelopment, especially by its agencies, for example, the World Bank which proposes development plans that are usually drafted for developing countries. The developing countries have to follow to the letter the World Bank guidelines if funds are to be provided for any development plans in these countries. The long-term benefit, in fact, is not really to develop African nations, but to tap more resources from the meagre economies of such heavily indebted countries. It is a case of robbing "Peter to pay Paul", the rich getting richer and the poor getting poorer.

Edoho (1997) tries explaining the bipolarity of globalisation and the world. The world is divided into two parts, the countries that enjoy the benefits of science and technology, and those that do not, the developed and the under developed, Rich and Poor, North and South, Separate and Unequal. The main dynamics of under development result from

discouraging local production, high levels of importation and subversion of local products, currency devaluation and depletion of foreign reserves (Edoho 1997).

Historical facts have been postulated as the reason for third world underdevelopment as a result it has been argued that this has not been the result of natural forces as believed by some (Luisa 1968). Political and economic colonialism was a very inauspicious historic event. It has consigned these countries to one side of the equation, while the rest of the industrialised worlds grew economically in rapid succession (Luisa 1968).

The first world nations are taking measures to reap as many gains as possible from this situation to ease the adjustments globalisation demands, such nations are already deeply ensnared in the concept of globalisation. Most developing countries are in a world apart despite the fact that international trade is moving across wide open borders with liberal and deregulated economies. Global investment and trade passes such countries by on a colossal scale (Halvorson-Quevedo 1997).

The OECD Development Co-operation Directorate reported, in 1997 that there are currently 1.3 billion people living in abject poverty in developing countries of the world. Africa's export potential is on the decline, a paltry 1.8% of the total world exports (OECD, 1997). The current contributions from all developing countries put together are 25% of total world exports. The inadequacies of industry strengths, institutional and human capacities in these very poor developing nations are major setbacks, to deal with the demanding terms required by the global market place (Halvorson-Quevedo 1997).

There are enormous impediments to full participation in globalisation by poorer developing countries. Their exports are limited to commodities which are characteristically undiversified. This is largely due to, non functional or inadequate energy supply, poor transport and telecommunication systems which are the main infrastructure for efficient industrial capability. Also, human resources are equally unbalanced to adequately cater for the skilled labour that is required. The dearths of professionals like managers, scientists, engineers, industrialists, technicians to mention a few, are hindrance to the rapid development expected in globalisation. The developing countries, especially in Africa can compete comparatively in agriculture, textile and metal works, this is where they have a great advantage, however, here they are weighed down by excessive high Tariffs and non-tariff barriers, from the Organisation for Economic Co-operation and Development (OECD) countries. Exorbitant excises directly impact on such upcoming sectors of the economy (Halvorson-Quevedo 1997).

Ebba and Raundi (1997) pointed out categorically, that the key issue to development co-operation between developing countries and industrialised nations is support for the promotion of trade and investments across board. But, due to pressure of globalisation, sustainable development, financial assistance and sincerity to results-oriented output, priorities and approaches of these development co-operations are been revisited by the industrialised worlds and the developing nations themselves. The joint policies of The World Trade Organisation (WTO), the United Nations Conference on Trade and Development (UNCTAD) and the International Trade Centre (ITC) are seriously under scrutiny by the developing countries to establish if indeed there are benefits for third

world countries. Areas of consideration for possible benefits include, strengthening sales on global markets, strong productive capacity, wider market access and expanding measures for a positive development growth in globalisation (Halvorson-Quevedo 1997).

Essentially, developing countries are realising the need to watch carefully the turn of events in globalisation, understand fully the areas of weaknesses of domestic policies as against external policies. The impact of globalisation on other developing countries should be carefully scrutinised especially developing countries in the same continent, which may lead to improvement on the existing local policies in the developing countries.

1.5. Globalization impact on the African continent

The question is at what present stage are we in history? Some argued that there is a shift gradually moving towards what is called a Government of the World characterized by globalization and an international trade policy. Once upon a time, it was The Roman Empire that ruled and now an "Anglo American" Empire is emerging in a similar style. This has significant implications for many countries in African.

Racism and Colonialism has been Africa's pain for time immemorial, which is gradually continuing in a new fashion after the Second World War, through Political and Economic colonization. Take for example the saga of the World Bank and The International Monetary Fund (IMF) in the African continent. The World Bank, controlled by the Government of the World, is the "Star" of Economic Reform, Economic Adviser and above all the Worlds Biggest Lender to developing countries. Lending at very high

alarming interest rates, whereby funds are borrowed to these countries, with a very strong policy as regards the funds usage, payment strategy, if at all to the detriment of the local economy. Coupled with the high exchange rate and devaluation of the local currency in the process all determined by the "Star". Like the famous statement "he who pays the piper dictates the tunes" African nations must dance to the tune of the Music, as they are made to believe that, their survival is dependent on these loans and must be part of the evolving trend in globalization.

This puts developing countries, into a perpetual vicious cycle of lending money and crawling back, begging for debt relief because they are bankrupt. The national economic power of African states has been gradually handed over to the government of the world; globalization, deregulation and free trade have become the conquering tools or weapons, which have subsequently, lead to the gradual decay of the African continent.

"Philosophy shapes the politics of a people, and different governments, in the world over, have been reflective of the philosophy they choose" (Oseya 2006).

Historically, it is quite easy to appreciate ideological views and what side a policy tends to lean, usually in favour of the developed countries. Franklin D. Roosevelt demanded to end slave labour at the end of the Second World War, while Winston Churchill and the Nashville Agrarians were reluctant to end slavery, because their concern was that of humanity would be seen as just a tool for the capitalist (Oseya 2006).

International trade has been in existence, as far as history can go and this form of trade became the major route of Africa's involvement in the global economy. The Atlantic slave trade the most common reason for colonisation and the development of these colonies, for continuous supply of raw materials that is needed by the industrialized worlds is of tremendous impact on Africa (Brown 1995).

In supplying the raw materials for the developed worlds, the workers have to be concentrated near the source of the resource materials which lead to the emergence of urban slums, one of the outcomes of globalisation. Africa in a very challenging, daring and unfair competition with the developed nations has become the palatial centres of African village people. Sinking further into malnutrition, poverty, chaos, misery and all the other ills of society, associated with deprivation on a downward trend.

Recently in communication, Africa was lured into an imperialistic cultural realm called "internet connectivity" as simple as it sounds, the result is very obvious. "The world is gradually moving in a unidirectional manner and, the tendency towards uniformity has never been so appealing as it is now…… consequently, there is a serious concern that nations like Nigeria whose contributions to the internet pool is low may lose their identity (Otokhine, 2000; p.21).

From this perspective alone, the African mind is enslaved. A cultural revolution is taking place and the threat is that a generation of future Africans are left cultureless and disoriented with no historical identity. This may eventually lead to a permanent damage,

for example, children would probably hear or read of the real African tradition and they may never experience because of the Cultural Revolution (Otokhine 2000).

Globalization is to Africans a "threat to the poor rather than an opportunity for global action to eradicate poverty" (Obadina, 1998; p.32). Indeed the "concept of absolute freedom that underlies the rationale for globalisation is the same notion" (Obadina, 1998; p.32) which was the justification for colonisation and slavery (Obadina 1998). Furthermore, the "belief that the strong, however defined, should be free to exercise their strength without moral or legal limitations that protect the weak" (Obadina, 1998; p.33) which is clearly different and separate from positive freedom that states that: "People should be free as long as they do not deny the rights and freedom of others. People should not be at liberty to deny others freedom and basic rights. There must be limits on freedom; otherwise the liberty of the powerful becomes the oppression of the weak" (Obadina, 1998; p.33).

In some African countries, one of the manifestations of a negative impact of globalization again, is the replacement of traditions such as fishing, farming, cattle rearing; metal works, hunting, weaving, pottery and all locally based economic resources for sustenance, with the crude oil economy termed as the "Black Gold". Such pressures have driven these nations to further poverty, decreased agricultural productivity, environmental degradation and massive air pollution, chaos and endless war, large scale corruption and political instability. All in the rush for the production of this new raw material within the terms of globalization (World-Bank 1996).

Ajayi (2003) argued that the issues of globalisation in Africa and its economic marginalisation are largely due to Africa's relatively isolationist policies and closed economies which explain why economic opulence has eluded most of the continent. It is the nature of Africa's assimilation into the world economy that matters; this should be in a simple but powerful assertion which is more open economically. Ajayi (2003) further postulated that there are new opportunities from globalisation especially that Africa's macroeconomic performance will improve, market expansions, technological advancement and development of new ideas. Africa's policy measures are what will bring the benefit of globalisation, but with the present indicators of integration into the world economy, the continent of Africa is still far behind and until adequate steps are taking to remedy the deficiencies as the international playing fields are not on a level ground. The evolution and development of a well co-ordinated trade stratagem are the key areas of focus in order to increase trade, attract more capital flow and maximize the gains of total integration into the world economy (Ajayi 2003).

Africa can learn from Asia's integration into the world economy, for example, Malaysia and Indonesia who are gradually improving in their macroeconomic performance, research and technological development particularly in the field of engineering, medicine and dentistry. These Asian countries are reaping the benefits from globalisation by also focusing on improving on the oral health related aspects of the economy.

1.6. Globalization and Oral Health

The gap amid the affluent and deprived people in the world is increasing and abject poverty is the world's biggest killer, with diseases associated with poverty increasing (WHO 1995). Whilst oral health has traditionally been a disease of poverty in the Developed World this is not the case in developing countries where patterns of oral health are subject to other determinants. With the impact of globalisation however it may will be that oral diseases may become diseases of development.

The differences between developing and least developed have broadened in the last 10 years with respect to life expectancy at birth (Subramian 1995). An individual in one of the least developed countries has a life expectancy of 43 years, while life expectancy in developed nations is as high as 78 years (Smith Davey 1990). Quite a large proportion of developing countries in the world, predictably, chose to develop health care systems which relied on the social welfare models derived from Europe immediately post independence. This meant that they opted for centrally organised programmes of planning. The government of these developing countries became the solitary agent responsible for all of these activities the majority of the time (Pine 1997). Private sectors of care provision also exist, purely on commercial basis. Frequently government and private systems, and traditionally and officially trained personnel all work in parallel with little coordination between them (Pine 1997). Patients by and large have to choose where they go. Social factors largely influence people in the developing nations as to whether they go to the traditional healer first or to the formal government sector, with choice being ultimately determined by wealth in most cases because newly imported health from

the globalisation process is not affordable in most cases. This is complicated by limited resources and the inappropriateness of the high-technology curative-based approach of western medicine (Pine 1997).

The conflicts of inverting a western medical model-based system in general health care to developing countries has the potential to make a great impact in oral health care systems in these countries. The fact that over 80% of all oral health personnel (Dentists in particular) are educated and employed in the industrialised world, reflects the much greater prosperity of these countries (Pine 1997). But more predominantly it reflects the history of the commercial production of sugar, which is so much involved with the European Industrial Revolution, colonial expansion and the slave trade (Davidson 1980; Olbrich 1989). These measures are epitomized in the global history of dental caries, mostly since the development and use of the centrifuge in the commercial production of sugar in the 1850s (Moore 1976; Marthaler 1990). This made it so much more voluntarily accessible to industrial populations. Consequently the majority of dental disease, in the form of dental caries, and therefore oral health services originated in the developed world (Pine 1997). This has inescapably led to dentistry and oral health services taking on a particular form, associated to the specific disease pattern prompted by this increased sugar consumption, and the limitations and prospects presented in the rapidly mechanizing world of Victorian Europe. In retrospect the mind set of dentistry, which is encountered in training institutions, research programmes and international organisations, whether or not they are situated in the developed or developing world, is that of the developed world (Hobdell 1981). The principles on which the practice of clinical

dentistry and research, need to be translated into sustainable practice, in ways suitable to the circumstances prevailing in the developing nations, but not directly implementing operating principles from the course of action of globalisation.

From these perspectives, the emerging points that are glaring, are that globalisation from its "heavy constraints" has influenced the minds of major institutional operations both within and across countries. Akindele S.T et al, (2002) noted that, globalization is changing the determinism of the state: its actions and inactions; what firms and people do; where they do it, how they see themselves (their identity) and what they want (their preferences). Also, accompanied by its financial transactions, increasing volume and their decreasing costs, as well as reduction in public sector expenditure have, put strong competitive pressures on governments. This pressure is to reduce their role in the determination of who gets what, when, where, how, and why (Akindele 2002).

Africa's dependence and underdevelopment is further worsened, with lost of control on the policy and decision process. This is constrained by bigger forces, acting from above, in their determination of the way forward, as regards the Oral health System and Policy in general. Especially since development issues are discussed with creditor nations and financial institutions. For example the teaching curriculum have been "globalised", oral health training actually produces personnel for export, in the style of teaching that has an emphasis on an advanced and technological approach to dentistry. There is little relation to what are the essential needs of the immediate populace. Instead curative rather than

preventive approaches are common, since accessibility to oral health centres by the majority of the populace, are not feasible in most cases.

In addition oral health is influenced by cultural forms of imperialism for example the introduction of the "white smile", which forms the example or standard of what people should expect to get or aspire to have in oral health has specific connotations linked to the dominance of the American world view. Another example of the appropriation of oral health in developing nations is through the replacement of traditional hygiene practices from the farm, for example, Chewing Sticks, Charcoal and Salt with the increased use of toothbrushes, toothpastes, and dental floss all products that engender a dependency on development related technologies. The introduction of brushing techniques teaching and the systematic drafting of these into school curricula in nursery and primary schools, has led to a regimented life style that must be adhered to strictly. In this respect there are significant consequences to what was once an African heritage.

1.7. The consumer products of Globalization

"I do not know if coffee and sugar are essential to the happiness of Europe, but I know well that these two products have accounted for the unhappiness of two great regions of the world: America has been depopulated so as to have land on which to plant them; Africa has been depopulated so as to have the people to cultivate them"(Pierre 1773; Mintz 1985). This quote gives an overview of the consequences of some of the consumer products of globalisation.

"Africa has been turned into a dumping ground where people increasingly consume an abundance of products that have little (or no) connection to their struggle for existence", for example, movies, music, foods are guzzled wholeheartedly (Akindele 2002).

Keith Somerville (2002) a BBC News Online reporter noted in his report "Sugar's bitter taste" that a threat is posed by trade policies, which enable foreign sugar exporters to sell sugar more cheaply in developing countries than local producers. This is currently happening in Kenya. Refined sugar and associated products are cheaply imported into the country. Workers are gradually laid off from farming businesses since farmers are becoming poorer or best still grow other crops as an alternative for their survival. The British charity Action Aid, argues that trade liberalization has harmed Africa and continues to show that agricultural produce has been worst hit by the freer trade. This has threatened or destroyed the livelihoods of millions of farmers (Somerville 2002). Kenya's Director of Internal trade, Seth Otieno, says that liberalization of trade has been a disaster for many Kenyans "globalisation is a curse to many sectors, especially agriculture, in this country," he says.

In a small country like Swaziland, Sugar and sugar products importation has severely undermined the very existence of the local industry, especially since the goods are from the European Union countries. The sugar industry has lost 16,000 jobs and a further 20,000 have gone in transport and packing process of local sugar production, according to Action Aid (Somerville 2002). The African director of the International Labour

Organisation, Regional Amadi-Njoku, has claimed that globalization is responsible for the decline in Africa's status in the global economy.

Action Aid and Oxam say that the European Union and U.S financial support for their farmers gives them big advantages in trade. This affects African farmers by subjecting them to unfair competition. Developed countries protect their farmers but demand that African countries cut subsidies to theirs. In a submission to the UK Government, Oxfam called for globalization to "be underpinned by global rules and institutions that place human development above the pursuit of corporate self-interest and national advantage" (Somerville 2002).

The number one soft drink in the world 'Coca-Cola' is an example of a global consumer product. The Coca- Cola Company started about 120 years ago (Lawrence 2007) as a one-man business that peddled the then newly invented Coca-Cola Syrup which later became acclaimed world wide. The company has been doing business in Nigeria since 1953 (Lawrence 2007) and has shared in the remuneration and misfortunes developed by changes in the country's economic reforms. This industrial giant has influenced political and economic reforms to favour its systematic growth. The confidence of Coca-Cola in Nigeria's economy remained unflinching and if anything that confidence has been heightened by ongoing reforms. Take for example, the plan to open the country's multimillion dollar bottling plant in Abuja this year which will be the largest industrial beverage plant in Africa (Lawrence 2007).

MacDonald's, Soft drinks like Coca Cola, Pepsi, Cakes, ice cream, Chocolates, Biscuits, Cereals, Cornflakes are a few of the so called "modern delights" which have gradually surfaced in the menu of the well to do citizens of developing countries. Local dishes have been confined to the position of 'second class foods' which are taken by the locals, or associated with poverty, illiteracy and those unexposed to the new way of thinking, that is a product of globalization. These assorted confectionaries have gradually eroded the traditionally oriented diet of the "Rich" amongst the "Poor" and a set of class difference has evolved making its way throughout society.

The presence of sugar was first acknowledged in England in the twelfth century (Mintz 1985). What was most salient about the English diet at that time was its complete facileness and insufficiency. Then and for a long period thereafter, most Europeans produced their own food locally, as best they could. Most basic foods did not move far from where they were produced. Sugar was essentially an atypical and prized substance, principally consumed by the more fortunate groups. It was carried long distances (Mintz 1985). From the first known introduction of sugar to England until the late seventeenth century, when it became a wanted good consumed repeatedly by the affluent, and soon to be afforded by many who would forgo significant quantities of other foods in order to have it, we are dealing with limited agricultural production and a narrow diet (Mintz 1985).

The introduction of sugar based products in Nigeria is especially striking. The reason for this is because the younger generation look up to these as a notable way of becoming

‘advanced’ or ‘developed’. Young people have completely abandoned local foods with the older generation being at the forefront of a revolution of new consumer products, with their resourceful savour in comparison to what used to be a cultural heritage. These consumer products do not conform to the basic needs and survival of people in communities living in developing countries. Nonetheless they have found their way into the remotest part of the African continent. They have become deeply rooted and preserved in the ideology of the people that it affects.

The bone of contention, is the control of a knowledge based global economy, which Goma (1995) legitimately asked: In which directions do communication flow? Are the benefits distributed equally or proportionately among participants? Who “processes” global issues? That is, who wields influence, control or authority? … Who commands the capabilities – financial, technical and intellectual – to set up or alter the networks of transactions? Whose values are effectively promoted in the endeavour? (Goma 1995)

Technological know-how; culture; education; news; ideology; music; games; pictures; movies; attitudes; and tastes were rightly noted by Amos (2000) as the matters of content which have become most significant and that the controller of the knowledge base holds the key and influences people’s thoughts, for example, the cable network news (CNN) has a huge impact on developing countries and the their media policies is purely to the interest of United States. They ultimately controls the content and all the values and norms that inspire the information policies which inevitably influences the direction of information flow (Amos 2000).

Chapter Two

The major Globalisation processes in Africa

This section seeks to introduce the major globalisation processes in Africa which vary from economic and trade policies to media and advertising agendas in developing countries. Globalisation has influenced the trade in commodities both locally and internationally in developing countries. This new trade pattern in commodities has inevitably altered the existing food and disease policy of the developing countries in Africa and multinational organisations have been at the forefront of development of the current disease policies in majority of Africa, more like a government within a government.

2.1. Economic and Trade Policies in Developing Countries

Majority of WTO membership appear incapable of effective participation even though developing countries account for four-fifths (and increasing) majority in the WTO, only a small minority are actually active in it. This frail participation in the WTO is basically a reflection and extension of policy making deficits nationally. Majority of these developing countries have suffered from bad leadership, misguided policies and basic institutional defects, such as corruption coupled with the weak enforcement of property rights and contracts (Stephenson 2005; WTO 2005; WTO 2006).

Other related issues are the lack of administrative capacity and expertise to deliver and sustain sound, credible trade policies. Nonetheless, the national decision-making setting

is the fundamental delivery mechanism for good or bad trade policies which include achieving a benefit from the WTO or not. Some have made progress in the right direction while the majority languish nationally and in the WTO (Sally 2005; WTO 2006).

Nearly all developing countries excluded themselves from the GATT's mainstay business before the launch of the Uruguay Round. Export market admittance was not considered particularly important in the context of import-substitution policies; and Special and Differential Treatment (SDT) expected that developing countries were not obliged to open their own markets (Stephenson 2005). In the 1980s this changed when successive waves of developing countries liberalised trade with foreign direct investment as part of a comprehensive package of policy reform (Sally 2005; WTO 2006).

National growth strategies were then centred on trade and governments recognized that GATT was needed to negotiate export market access, mainly in highly protected sectors like agriculture and textiles, and to guard against non-tariff protection from developed countries. A few of the developing countries, especially India, East Asia and Latin America countries became more active during the Uruguay Round. These countries were at the GATT negotiating table, bargaining for market access and were surprisingly involved in key rule-making deliberations with the vast majority of developing countries remaining passive and reactive (Sally 2005; Stephenson 2005).

Since the establishment of the WTO in 1995 such deviation between an active minority and an inactive majority has become more distinct. The few of the active developing

countries are mostly in the middle-income category with not insignificant and rising shares of international trade and investment (Stephenson 2005; WTO 2006). They have also undertaken drastic and sustained unilateral liberalisation. The influencing factors may include having well-staffed missions in Geneva with high-profile ambassadors, many of whom chair important WTO committees which makes them active in the formal and informal coalitions where much of the deal making is done. Some even have reasonably well resourced trade policy operations in national capitals.

The other poorer developing countries, some quite large such as Pakistan and Bangladesh, whose vocal ambassadors tend to push "development" issues have limited influence in the WTO's work programme complicated by their serious lack of administrative capacity, in Geneva and in their home countries (Stephenson 2005; WTO 2006). This large group which is about half or more of the WTO membership has a weak-to-minimal involvement. Majority being least developed countries and small island-states without a Geneva mission at all. Most of the others have perhaps one or two representatives in Geneva to cover all the international organisations locally (Sally 2005). The WTO greatly needs these stronger developing countries participation in the GATT negotiation process and in that way least developing countries can succumbed to these policies (Stephenson 2005; Okonjo-Iweala 2007).

The WTO participation starts locally "Global governance," involving a never-ending list of donors and international organisations becomes the order of the day. This misses the point: the simple truth is that good trade policy, like charity, begins at home, not in the

IMF and World Bank, nor indeed in the WTO. Trade policy capability has to be entrenched in the subsoil of nation-states and fostered "bottom-up." The countries can then participate effectively in the WTO (Stephenson 2005; Okonjo-Iweala 2007). Developing countries with a substantially well functioning trade policy management and realistic trade policies partake actively in the WTO and benefit from its rules and obligations, but a vast majority of the developing countries lack these domestic foundations, relatively, in the absence of leadership and capability, trade policies are often driven externally by donors and international organisations (Okonjo-Iweala 2007). These in turn make the countries weak in the WTO and they are bullied by the powerful developed countries in negotiations which eventually happened in the latter stages of the Uruguay Round. These are specifically the countries that have not benefited currently from the WTO system (Sally 2005).

No trade policy works in a climate of macroeconomic instability compounded by widespread corruption and weak enforcement of property rights and contracts. Most lead ministries on trade policy are not high up the pecking order within government and tend to be captured by politically well – connected protectionist forces. Inter-agency co-ordination is habitually bad on traditional trade policy issues i.e. tariffs and quotas on merchandise, intellectual property and environmental standards, which involve regulatory agencies across the range of government. The majority of all WTO operations are under-resourced and do not co-ordinate well with national ministries of the countries (Sally 2005; WTO 2006).

There is no transparency in trade policy especially when it is dominated largely by well-organised "insiders" within and outside government; intelligent public discussion on decisive trade policy choices, informed by independent, economically literate analysis, is conspicuous by its absence (Stephenson 2005). This become obvious when most developing countries are unable to formulate clear and precise national interests in trade policy, lack negotiating competence in international forums, and fall short to implement international agreements in an effective and timely approach (Okonjo-Iweala 2007).

Foreign ministries of most of the developing countries often lack depth in terms of economic analysis and may sacrifice economically informed trade policy priorities to other foreign policy goals. Non-trade ministries and regulators do not have trade policy high up their lists of priorities. Very populous and large developing countries, like Nigeria have a particular problem with inter-agency co-ordination especially when they have complex federal systems (Stephenson 2005; Okonjo-Iweala 2007). However, small countries with relatively slim line, compact administrations fair better with inter-agency co-ordination. For example, the trade-and-industry ministries in Hong Kong and Singapore, co-ordinate strongly with other parts of government, especially on service issues also with the fact that they have well-staffed missions with talented officials and capable, influential heads of mission (Sally 2005).

Even with the active developing country participants in the WTO, business and other non-governmental input in trade policy has been lacking. Undoubtedly, there is much trade policy capacity building to be done in developing countries, although, there are a

few examples of where better trade policy practice exists, across these developing countries (Stephenson 2005). With the lower levels of development and the inadequate political and administrative resources, developing countries most likely have more to learn about good practice from each other, and from advanced promising markets like Hong Kong and Singapore, than they can learn from long-established developed countries in the EU and North America (Sally 2005; WTO 2006).

2.2. Media and advertising in developing countries

America is the home of the world's most successful brands, also one of the world's most powerful, enduring and compelling myths. Brands that are known to have come from America include big names like, Coca – Cola, Nike, McDonald's, Pepsi, Levi's, Disney and a host of other giant names. This is has become a basic part of their international success and the reason why their 'American – ness' has always been, quite precisely, stressed in their advertising messages (Anholt 1999; Simon 1999). In the present day where a brand comes from is habitually one of the very few distinguishing factors amid the confusing variety of apparently identical products bombarding the consumer at every point of purchase (Anholt 1999). We live in an era where products could come from almost literally anywhere on this planet, and the significant part of our decision to buying the products is knowledge of the company and country they're from (Anholt 1999; Simon 1999).

Most consumers gain confidence the minute they sense the presence of that magic name and logo, in a cosmic display of otherwise discrete products: clothes, toys, films, theme

parks, cruises, even an entire ready-made town, (Celebration, Florida) (Anholt 1999). The consumer then begins to see the world through the brand's all-seeing eyes. This makes a brand to become a mighty thing indeed.

The term ‘brand’ technically speaking is the promotion of consumer preference bound up in a familiar commercial name or identity. It becomes the sense of inevitability and quality assurance that attaches a measure of trust and appeal to merchandise sold under those particular names which subsequently permit the owner of the brand name to launch newer products very conveniently at a higher charge that could otherwise be charged by their competitors (Anholt 1999; Simon 1999).

For example, sugary brown liquids marketed under less valuable brands could sell for as little as half a very similar sugary liquid in a Coca-Cola bottle. This brand name is precisely where the major profits of most consumer goods companies come from, which has become their competitive edge and for that they stand out in the mist of so many (Anholt 1999). The GDPs of smaller countries are often smaller when compared to the book values of the genuine global mega brands, which is the value of the whole company minus everything tangible (Anholt 1999; Myers 2007). As long as the value of the brand is maintained through careful marketing, this becomes one of the great advantages of brands over commodities as they are an infinitely sustainable resource. Their real value exists principally in the mind of the consumers not in the factory of the producer, and once this is created, it makes them amazingly difficult to destroy (Myers 2007).

Obviously, the idea of exporting branded rather than unbranded products is compelling (Simon 1999).

Most of the developing countries are trapped in a pattern of economic behaviour that keeps them perpetually in a state of poverty by trading unrefined commodities to wealthier nations at a very low margins and permitting their buyers to add massive "value" by packaging, branding, finishing and retailing to the final consumer. This never ending process repeatedly helps deplete the source country's capital while keeping its foreign proceeds at a break-even level at best (Anholt 1999; Simon 1999). The usual trick of industrialised developed countries is creating and selling international brand names. It is made out of necessity, perhaps, since some of the world's wealthiest countries have few valuable products to export, but it is one that most of the poor countries would do well to emulate (Myers 2007). For it is likely that if consumers in developing countries are given the choice between yet more brands from the G-7 countries, and new brands from "colleague countries" in the developing world with no shady colonial past, they might just feel more comfortable with the latter (Simon 1999).

In today's hypercompetitive global marketplace there are numerous products that are functionally indistinguishable to their many direct competitors, having a potent brand is just about the only remaining legal competitive advantage a company can possess. Global brands have by and large become the ultimate distributor of wealth (Anholt 1999; Myers 2007). Another feature that is particularly important to international brands is the influence that the brand's origins have on the consumer's perception of the brand.

Certain countries behave almost like brands in their own right when one looks at the question of a brand's origin just like commercial brands, "nation brands" which are understood well by consumers all over the world, have long-established identities, and can work just as effectively as an indicator of product quality, a definer of image and aim at market, as the manufacturer's name on the package (Simon 1999; Myers 2007).

The United States apparently is the world's most powerful country brand which is connected with the fact that "Brand USA" also has the world's best advertising agency. In recent times Hollywood has continuously rolled out its 2½-hour cinema commercials for the best part of this century that consumers around the world have passionately paid to watch, and for domestic brand to have a glamorous image, companies around the world attach bogus American values their brands (Simon 1999). This clearly demonstrates the strength of the Brand USA. For example, in Italy, the manufacturer of one of the biggest – selling bubble gum is Perfetti of Milan, but the product has a brand name "Brooklyn" with the package proudly displaying a convincingly precise illustration of the eponymous bridge, the fact that the produce is manufactured by Perfetti of Milan is, from both the consumer's and the manufacturer's point of view, a very trivial issue (Anholt 1999).

Only a few other developed countries, with the exception of the United States have clear, consistent, and universally understood brand prints, most are European countries, e.g. Sweden 'cleanliness and efficiency', Germany 'quality and reliability', England 'heritage and class', Italy 'style and sexiness', France 'quality living and chic', Switzerland

‘methodical precision and trustworthiness’ (Simon 1999). These countries undoubtedly produce successful international brands that are in turn strongly related with the brand qualities of their origin.

One could not imagine building a global brand on an annual budget of less than 50million or 100million dollars, but strictly speaking, as in all exceptionally mature and deeply exploited markets, all media vehicle had its individual value calculated to the n^{th} degree, and there were no rooms for negotiating (Simon 1999; Myers 2007). It would have been the case also to say that building a global brand requires a huge amount of money to buy advertising media but in recent times the “new media revolution” arrived, and it became the sine qua non of building global brands (Anholt 1999) .

The arrival of the internet brought us the internet-driven media revolution which is relatively immature and imperfectly understood (Myers 2007). There are bargains everywhere for those who recognise them in immature markets, even the proprietors of some of the new channels of communication have not appreciated the real value of what they’re presenting (Anholt 1999).

The widespread consumer perception of poor manufacturing quality used to be the biggest obstacle promising country manufacturers had to overcome before introducing their brands courageously onto the international market, it is not properly made if it did not come from countries in Europe, North America or Japan,

Ironically speaking the consumer's mind is gradually changing by the actions or inactions of these wealthy producers (Myers 2007). The consumers, in the last few decades, have become very familiar with those humble little stickers underneath these European or American-branded goods "Made in Thailand", "Made in Taiwan", "Made in Mexico", and "Made in Vietnam", and so on (Anholt 1999; Simon 1999). These consumers have silently absorbed the fact that a large number of the products they purchase, to the high standards required by the European and American giant brand owners are in fact manufactured in poor countries.

These branded giants couldn't have done the poor countries any better favour, as this perception only has to be enhanced a little bit further and brought into the limelight with the consumer appreciating this phenomenon that is repeatedly brought to his attention. This inadvertently would go a long way in eliminating another barrier which prevents the development of global brands from emerging markets (Anholt 1999; Simon 1999).

Another very important issue may well be purely from the psychological point of view, which could be an obstacle standing in the way of promising countries as producers of global brands. This is like the Groucho Marx syndrome "I'd never belong to a club that would have someone like me as a member" (Anholt 1999), this is a simple case of lack of self confidence, where developing countries after several years of acting as mere suppliers to more commercially successful countries, most of these 'third world' countries have become. The syndrome, that someone or somebody from a wealthier

country would be interested or let alone be attracted to a brand originating from a country so poverty stricken and unimportant as theirs is unimaginable (Simon 1999; Myers 2007).

For Kellogg's to launch a new variety of breakfast cereal on the marketplace is just as much to be likely as a new fashion label from Italy or a new wine from France. But for Caterpillar, a heavy duty machinery producer which is earth-moving equipment, to introduce a range of casual footwear on the market, is as amazing and thrilling as a software giant emerging from a place like India (Simon 1999; Myers 2007). Whenever a country manages to develop the daring, insight and ingenuity to move away from the typical paradigm of "national produce" and celebrate the fact that it produces brands that makes one thinks twice about the producing country, the outcome becomes very conspicuous, and thus far more lucrative (Simon 1999).

Somewhere in the mystifying processes of consumer logic, these caterpillar shoes or boots made sense, and the resulting brand extension profits both the new business and the company's core business, this has become a case of two plus two equals five. This has become a kind of aid that up-and-coming countries could find truly valuable, the international branding know-how which can create inspiring and unforeseen links between consumers and countries, and which will facilitate countries to launch their own commodities onto the global marketplace with confidence, with a big noise, and above all, with pride in their origins(Anholt 1999).

2.3. Commodities trade in Developing countries

By the start of the new millennium interest in the commodities problem has re-emerged. Commodity issues lost their plea when the efforts to launch a new economic order, including the Integrated Programme for Commodities (IPC) ran out of steam in the 1980s and the effort to regulate commodity markets and prices through international buffer stocks were discarded during the 1990s. Commodity affairs were mostly ignored by the international community in anticipation that a solution to the problems would materialize by itself (World-Bank 1996; CFC-G-77 2005; Okonjo-Iweala 2007).

However, the problems of commodity producers in developing countries continued to persist. The impact of unfavourable trends has been predominantly severe on "commodity-dependent developing countries" (CDDC). In the last decade, the international community opted largely to ignore commodity issues. President Jacques Chirac of France in February 2003 stated that a "conspiracy of silence" encircled the Commodity problem, it is time to break this silence and to bring back commodities to the Centre of the development debate and develop and implement actionable measures in this area to ameliorate the economic conditions of commodity producers"(Amos 2000; CFC-G-77 2005; Okonjo-Iweala 2007).

Commodity issues have a significant bearing on development efforts which is increasingly being recognised as evident from the resolutions on commodities A/57/236 and A/58/481 of the General Assembly of the United Nations, submitted by Venezuela

and Morocco respectively on behalf of the Group of 77 (G-77) and adopted in December 2002 and 2003 (Amos 2000; Morocco 2003).

Commodity Dependence of Developing Countries

It is estimated that about one billion people derive a substantive part of their income from Export commodities from the estimated 2.5 billion farmers in developing countries, which has remained the backbone the economies of these countries. Of the total 141 developing countries, 95 depend on commodities for at least 50% of their export earnings. More or less half of the countries in Africa get over 80% of their stock export income from commodities. Mostly the economies of the least developed countries (LDC) are based on commodities which is roughly 70% of their total stock exports (World-Bank 1996; CFC-G-77 2005).

Almost all of the landlocked developing countries (LLDC) and small island developing states (SIDS) are also commodity-dependent, whereas it is the poorer strata of the population often involved in commodity production in the middle-income countries. Generally, 73% of the poor live in rural areas, where the production of commodities is the main source of livelihood. For example, rural households in Malawi, Vietnam and Ethiopia derive about three-quarters of their revenue from commodity-related activities (World-Bank 1996).

Price Volatility and Declining Prices

The high volatility and constant downward trend of commodity prices has been a major characteristic of the commodity market over the last few decades. The International prices of commodities exported by developing countries have declined since the 1970s. According to the World Bank over the 24 years from 1977 to 2001, real prices declined for 41 out of 46 leading commodities, real commodity prices declined significantly from 1980 to 2002, with the World Bank's index for commodity prices down 47 percent and metal and mineral prices down 35 percent. For example, the 2002 real price of coffee was just 14.2 percent of its price in 1980 (World-Bank 1996; Okonjo-Iweala 2007). A study on 10 major tropical agricultural commodities showed that in 2002 developing countries would have earned USD 243 billion (five times the world's official development assistance) more if real prices of these 10 selected products had remained as high as the 1980 price level (Amos 2000; CFC-G-77 2005).

A decline in commodity prices has also been influenced by constant surplus production this leads to oversupply of some commodities in the international market. Excess surpluses have been mainly acute in the case of beverages (cocoa, coffee and tea). Cocoa production exceeded consumption annually from 1970 to 2000, particularly with excess surplus of more than 20% in the years 1990, 1995 and 1996. Coffee excess surplus was more than 17 percent in 2000 alone (CFC-G-77 2005).

Market Concentration

Agricultural commodity chains are gradually more dominated by Trans national trading, Processing and distributing companies. Only four companies' control 40 percent of the world's coffee trade and 45 percent is processed by just three coffee-roasting firms. This has further aggravated the problem of downward commodity prices as producing Countries and farmers have a smaller share of the proceeds and final retail price derived from commodity trade. For example, 70 billion USD is the current value of retail sales of coffee, but coffee producing countries only receive 5 billion USD of this value (CFC-G-77 2005; NEXIM 2007). Farmers obtain a fraction of the final retail price of the refined commodity product, varying from 4% for cotton to 28% for cocoa. Bananas which normally do not go through processing stages are another example where less than 12% of the final retail prices goes to producing countries and only 2 percent to the farmers (Amos 2000; NEXIM 2007).

Terms of Trade in Developing Countries

A manifestation of the declining commodity prices is the continuous deterioration in the terms of trade of developing countries. The terms of trade of developing countries have declined by more than 20% since 1980 this excludes oil and manufactured goods. In Africa the decline is more than 25%. In relation to the prices of goods imported the prices of Africa's exports have decreased by more than one-quarter (Okonjo-Iweala 2007). In the period between 1980 and 2002, the terms of trade in the commodities division declined by more than 50%.

Most of the least developed countries depend on their commodity exports to invest in food imports (Net Food Importing Countries), largely grains, because they are not self-sufficient. A decrease in the terms of trade means that they have fewer resources to finance food imports, which threatens their food security (Amos 2000; CFC-G-77 2005; NEXIM 2007).

The least developed countries have spent an increasing amount of their limited foreign exchange on importing foods, which gradually increased from 43% in 1970 to 54% in 2001. These deteriorating terms of trade of commodity producing developing countries is also associated with the capability of these countries to service their foreign debt. This becomes obvious that of the 42 countries classified as Heavily Indebted Poor Countries (HIPCs), 37 are considered commodity dependent. Averagely the HIPCs obtain about 84% of their stock export income from commodities (CFC-G-77 2005; NEXIM 2007).

Trade Distorting Measures: Technical Barriers, Subsidies and Tariffs

Market contact for many commodities produced in the developing countries has been relentlessly hampered by market protection in developed countries. Unfortunately, global trade is neither free nor fair. Global trade liberalisation has not been fully extended to agriculture and commodities that continues to undergo alterations on account of subsidies, trade barriers, and in the form of tariff peaks and accelerations (NEXIM 2007).

Agricultural tariffs in industrial countries presently are two to four times higher than tariffs for manufactured goods. The sector which has the most frequent and highest rates of tariff peaks is that of agricultural commodities, especially meat, sugar, cereals, oilseeds,

olive, tropical fruits (mainly oranges and citrus fruits, bananas and pineapples), groundnuts, and fish (mainly sardines and tuna)(NEXIM 2007).

In some countries tariff escalations that increase along the processing chain of the product are imposed, so that the higher the processing stage of the product the higher the tariff imposed. This effectively restricts imports of high value-added products, thereby, protecting the domestic processing industries. This prevents developing countries to continuing to export commodities in primary form, instead of developing a local processing industry and moving up the value chain (World-Bank 1996; CFC-G-77 2005).

The affected products differ according to countries and regions, but are essentially concentrated on sugar, tea, coffee, cocoa, spices, rubber, tropical fruits, cotton, vegetable, fishery, soybeans, tropical nuts, tropical woods, hides and skins, vegetable oils and oilseeds.

Public support, largely in the form of subsidies, also creates distortions in the commodity market. Export and domestic subsidies presented by developed countries have led to price decline for certain commodities through subsidy-induced production. A total of about USD 250 billion in 2000 alone was provided as support to agriculture in OECD countries, which was five times the total official international development assistance in that same year. Domestic support and export subsidies have depressed international prices, grinding down the incomes and market shares of more efficient producers in developing countries where these subsidies are not provided (World-Bank 1996; CFC-G-77 2005).

Subsidies have been predominantly high for milk, sugar, wheat, rice, cotton and meat products. For example, if United States cotton subsidies were abolished, revenues for cotton farmers in Central and West Africa would increase by almost 250 million dollars.

Technical barriers are another major issue affecting commodity trade in the form of sanitary standards, occasionally referred to as agricultural health and food safety. The increasing complexity of sanitary standards coupled with the fact that they are developed with little participation on the part of developing countries and the high costs in meeting up to such standards have strained the capability of developing countries to meet such standards, this serves as a barrier for marketing commodity products from developing countries (World-Bank 1996; CFC-G-77 2005). Even if these standards were not intentionally used to discriminate, their mounting complexity and lack of harmonisation somehow hinder trading efforts of developing countries, also noting that most of the developing countries lack the, technical and scientific ability, financial resources and administrative, to conform with the ever increasing requirements (Okonjo-Iweala 2007).

Non-traditional Commodities

The reconfiguration of international agricultural trade was due largely to most of the measures noted above (technical barriers, subsidies, market concentration and tariffs) and they have had profound impacts on commodity production in developing countries. These lead to the developing countries venturing in new market opportunities by trading non-traditional commodities that do not face the same level of competition and market barriers in developed nations (Okonjo-Iweala 2007).

From the World Bank report it was noted that the biggest decline in export shares for developing countries is due largely to their traditional tropical products, which includes cocoa, cotton, sugar and coffee and the principal gains have been from the non – traditional exports i.e. vegetables, fruits, cut flowers and fish. Presently the non – traditional products represent about 50% of exports in the agricultural trade of developing countries and the share of traditional products has reduced to only just 19% (Oluwasanmi 1996; World-Bank 1996; Okonjo-Iweala 2007).

Rural-Urban Linkages

The major driving forces behind the emergence of urban settlements were the ability of rural areas to provide surplus food to urban areas which has always being the trend historically. Therefore, urban-based activities are vital to rural income generation because these urban centres act as markets for the consumption of commodity products and also as a link to national and export markets (Okonjo-Iweala 2007).

Big towns and cities also provide the manufactured inputs needed for commodity production in the rural areas, for example, pesticides, fertilisers and machinery. It is acknowledged that urban markets are imperative for the survival and improved well-being of commodity producers. Urbanisation therefore plays a catalytic role in the commercialisation of these commodity products, which in turn promotes rural-urban enterprises and increases urban – rural trade (Oluwasanmi 1996). In Africa and most other developing countries, the industrialisation process is primarily resource-based, with

commodities produced in the rural areas becoming the obvious starting point (Oluwasanmi 1996; Okonjo-Iweala 2007).

Though commodity production takes place in rural areas principally, it is in urban areas that commodities are processed, consumed or marketed largely. Rural – urban migration is due to a large extent on the depressed commodity prices and many producers in the developing countries have had to abandon their farms 'down tools' and migrate to urban areas to look for new economic opportunities (Oluwasanmi 1996; Okonjo-Iweala 2007). This creates enormous pressure on urban areas and particularly on basic services like education, housing, drinking water and health. This brings about, congestion, slums, diseases, environmental pollution, poor sanitation and so on. Therefore there is need to have a grip on what processes are taking place as regards food and disease policies in developing countries especially in Africa.

2.4. Disease and Food policy in Africa

In the developing countries, there is a marriage between disease and underdevelopment. This historical roots of this relationship lies, among other economic factors, in the emergence of an international division of labour in the sphere of agricultural production. In this global agricultural 'division of labour', capitalist colonising countries (and their white – settler enclaves and groups) developed a balanced production of cereals and other foodstuffs for calories on the one hand, and cattle, chickens, eggs, fish etc. for protein, on the other (Collins 1989; Oculi 1996; FMOIND 2004).

Consequently, the development of sources of protein for livestock and poultry also had a central and vital role in agricultural policy and agricultural production. In third world countries however, agricultural policy and production, outside of the white settler sector, emphasized non – protein agricultural based on the production of industrial crops (cocoa, sisal, cotton, coffee, tea, tobacco, etc.) for export, notably to the economies of the colonising countries (FMOIND 2004). There was, therefore, a profound neglect of the vital policy – issue of developing sources of protein to be fed to cattle, chicken, sheep, goats, camel, etc., which would be the sources of human protein, despite the fact that these were abundant in colonies such as Senegal, Mali, Nigeria, Uganda, Somalia, and Kenya (Collins 1989; Don 2005). There was also a profound policy – neglect of the production of cereals and other sources of dietary energy. These sectors of the economy came to be labelled collectively as the 'subsistence sector' with the obvious suggestion that it was unmonetarized and of secondary importance, even if it was the lifeblood of the colonised peoples.

This global agricultural division of labour however, meant that while the colonies produced industrial crops for the colonising economies, at the expense of their protein needs, the latter did not assume responsibility for the food needs of colonised societies. Moreover, the exports of the colonised economies were bought at extremely low prices. They could not, therefore, balance their pattern of production by developing the means of purchasing food from the high – protein and cereal – producing economies of their colonisers (Oluwasanmi 1996; FMOIND 2004).

It is this historical relationship that underlies the calorie situation in the world of which Collins once wrote "in all except one of 33 developed countries listed by FAO, more than 2,500 kilocalories of 'dietary energy' are available per head per day. Most have well over 3,000 kilocalories, and almost all countries have a supply 10% surplus to their energy requirements (FMOIND 2004). Of 96 developing countries listed, only 18 exceed 2,500 kilocalories per head per day, and in several countries, the figure is below 1,750; in only a third is any surplus energy available. Moreover, these are national averages; they conceal the fact that in these countries there are thousands, sometimes millions, who do not get even the lowest average national figure of 1,710 kilocalories a day." (Collins 1989; FMOIND 2004)

The historical link of malnutrition, disease and colonialism in Africa falls in two broad categories.

In those African countries such as Algeria, Kenya, Mozambique, Angola, South Africa, Cameroon, etc. where there was white settlement and or the control of land by colonial companies, a dramatic and radical plunge towards malnutrition or disease marked the condition of the African peoples.

In other African countries where the production of industrial crops for export was urged upon African households (the so – called 'cash – crops' economies), the road towards malnutrition or disease was often less dramatic, unless the male population was taken

away in large numbers to provide cheap labour in other territories such as the Upper Volta Mossi going to Ivory Coast, and Rwanda groups to Uganda (Oluwasanmi 1996).

In white settler and plantation agricultural economies, the very fact of taking land away from Africans drastically reduced the food producing capabilities. Where cattle, sheep, and goats were expropriated from the Africans to form the livestock capital of white settlers as in Kenya for example, the double loss on African resources was clear and profound (Oluwasanmi 1996; Sorrenson 1998)

Moreover, to these resources was added the compulsion of Africans as cheap labour to make these lands productive for white settlers and companies. The loss to the African food sector was therefore threefold: land, livestock and labour. The very low wages, if any, paid out to the African workers meant that they could not rely on the food supplies of the market, or even from the settler sector (FMOIND 2004; NPA 2006). The limitation of land available to Africans meant that in time the soil fertility would be quickly exhausted, yields of crops would decline dramatically, and the most productive labour force (i.e. those between the ages of 18 to 35) would be forced to become permanent cheap labour in the settler and plantation section in order to earn cash incomes for paying taxes and providing food supplements (FMOIND 2004; NPA 2006).

The land expropriated by the settlers and company plantations were used for producing what was to be consumed outside of the African sector. In the main, it was the industrial crops (sugar, coffee, cashew nuts, sisal, cotton, etc.) which were produced, although

cereals such as maize and rice were often produced, too. The cereals were exported to other settler economies and to mines, Kenya, for example, exported maize to the mines of Northern Rhodesia and South Africa where they were used to feed African miners (Oluwasanmi 1996; Sorrenson 1998). The 1951 production figures for Mozambique, for example, illustrate the non food, industrial crop for export character of colonial settler agriculture; even for a colony that was seen as a bread basket for Portugal

In the settler economies where livestock and dairy industry was balanced with cereal and industrial crop production, the high protein products (meat, milk, eggs, etc.) was not consumed by the settler population and the urban commercial groups were exported. The introduction of urbanised African populations to European cereals, combined with the tastes of Asiatic and European groups, paved the way for what could be called "colonialism through the stomach" (McGee 1987; Oluwasanmi 1996; NPA 2006)

Africans acquired a taste for imported cereals and gave the cereals emotive aspects of their status aspirations. In economic terms, this meant the increasing monopolisation of the urban food budget by European cereals, and the expenditure of scarce foreign exchange (which was earned by the households that produced the export crops) for the purposes of importing cereals from outside. That the costs of imported foods have been increasing in African economies is clear. What is more alarming is the rate at which it has been increasing since independence. In Nigeria, for example, the cost of food imports at independence in 1960 was 150,000 US dollars annually, itself alarming for a country which had more than 80% of its population on the land; by 1969 it doubled which is

300,000 US dollars ; and by 1975, it skyrocketed to 1.9million US dollars (Oluwasanmi 1996; FMOIND 2004) What is significant about this is that most of the food is consumed by expatriates and African urban elites who, in effects, are acting as a fifth column on behalf of "colonialism through the stomach," and are continuing to deny their purchasing power to the rural food producers in Nigeria (WTO 2005; NPA 2006). The food business in Nigeria is largely on the influences of multinational corporations which have established there presence in developing countries. These corporations play vital role in economic and trade aspects of their domicile country with underlying selfish interest in the country of abode.

2.5. Multinational Corporations in Developing countries

Multinational corporations control most of the meaningful economic activities in developing countries. This control gives them very wide jurisdiction in the manipulation of the economic policies and circumstances of the host country. Fiscal and monetary policies of the developing countries can be seriously thwarted or badly influenced by the economic power of Trans-national corporations. These in many instances have brought political economic disruptions in the host countries. The overthrow of Allende in Chile and the political upheavals in Nicaragua and El Salvador are examples (Nwankwo 1991; Arthur 1996; Nwankwo 1999).

Actions of multinationals are fully supported by their home governments who give them firm guarantees for their investments in the source countries. The multinationals always

stress economic development theories that preach the indispensability of multinational corporations in the development process of developing economies. Socialist theories and policies are deliberately deemphasized.

Indigenous planners in the source countries, because of limited experience, copy these theories and apply them without full interpretation, justification or recognition of their limitation to the source countries' economies. Apart from indigenous planners, the developed countries export technicians whose determination is to propagate the economic development theories of western nations and thereby firmly cement the foothold of the multinationals (Arthur 1996; Nwankwo 1999).

The actions of the developed western countries are always justified on the grounds that economics is a science, and as such, has universal application (Mazrui 1986).

Two points of consideration in this view:

1- Why should only the western version of the economic development theories be preached, to the neglect of the eastern economic development theories? These are also scientific economic theories which should be given equal weight in exploring the shortest practicable way to solve the problem of underdevelopment (Mazrui 1986).

2- Theories are means, but not end by themselves. Ends should take into consideration the socioeconomic circumstances of where the theory is to be

applied, and research used in deducing the aspect of the theory applicable to the given situation (Mazrui 1986).

There are some elements of economic theory which should not be applicable or suitable, at least in part, to the developing countries but which have justified and enhanced the role of foreign investment and of multinational corporations in these countries (Mazrui 1986).

The role of capital in Development Theory

The three accepted factors of production in economic theory are land, capital and labour. Land and labour are available in developing countries but capital, which is available in developed countries, is scarce in developing countries. Consequently developed countries should assist the developing countries by supplying the scarce capital either as aid or in the form of private investment. It is believed that once this scarce factor is supplied, economic growth will be promoted in developing countries (Mazrui 1986; Arthur 1996).

In order to facilitate this transfer of resources from the developed to developing countries, the latter should generate foreign exchange through the production of export crops and other primary products. Thus developing countries have been producing primary export products which they have been exchanging for manufactured consumer goods, machinery and capital equipment. In this way, an international division of labour has been created and fostered (Mazrui 1986; Arthur 1996).

Hence, multinational corporations which have to produce or procure manufactured products and install and operate the machinery and other equipment in developing countries now occupy a central position in the economic development of developing countries.

But capital is only a means of aiding man in production. So long as man has the technical know how, he can produce the means of carrying out his activities in a better way. This is true regardless of whether capital is thought of in terms of capital goods or in terms of finance for the purchase or production of capital goods. In other words, whoever has the technological know – how for the production of goods or services can be self financed or can get a loan from either banks or private organisations (Mazrui 1986).

Cairncross has argued that expansion goes with market opportunity and efficient management, and that where these are present, financial obstacles can be overcome. This has not been applied to developing countries where technological know how should be substituted for efficient management. Rather, these countries have been encouraged and made to seek the "scarce" factor or production from the developed countries (Arthur 1996). The establishment of subsidiary companies in developing countries by the parent companies or corporations in developed countries, therefore, becomes a convenient and effective means of exploiting the international division of labour that has been fostered.

Developing Planning Methodology

An example of a deleterious economic theory that has been exported from western nations is the Keynesian theory of the 1930s. This was meant to alleviate the great depression in western countries in 1930. Keynes postulated that when there is deflation, resulting from low aggregate demand, government should engage in expansive monetary policy. This will lower the rate of interest, and restrictive fiscal policy (lower taxes), this will have a cumulative effect of pushing the economy back to full employment. On the other hand, when there is demand, i.e. pull inflation, resulting in excess aggregate demand, restrictive monetary policy will raise the interest rate and expansive fiscal policy that will raise taxes should be adopted. These double policies over time wiped out the excess aggregate demand and hence, full employment was restored in the economy (Arthur 1996; Nwankwo 1999).

The Keynesian theory of the 1930s assumes that the productive industries are there and the only problem is that they are producing below their capacity. In the least developed countries, the productive industries are not there and application of this theory will only result in galloping inflation as is evidenced in many Latin American countries and belatedly some African countries (Arthur 1996). Even in the advanced western countries, this theory is obsolete as stagflation and many other economic symptoms not envisaged in the 1930s have set in. Why then the utilisation of this theory as a means of promoting development in developing economies? The multinationals and their powerful technical experts advise the use of this theory which has been discarded since it served its useful purpose in the developed western countries in the 1930s (Arthur 1996).

Another example the deleterious economic theory imported from western nations is the Harrod Domar growth model which is centred on capital. It was a theoretical construct to guide policy makers developed countries. It establishes a relationship between the rate of capital formation, capital output ratio and the rate of increase in national income. The higher the rate of capital formation, the greater is the rate of increase in income. The policy makers then advise developing countries, that since the internal capital formation is low, for there to be a sustained increase in national income, there must as of necessity be an enormous inflow of foreign investment (Arthur 1996; Nwankwo 1999; Okonjo-Iweala 2007).

This model, in fact, has the effect of benefiting developed countries for which the model was originally formulated. Increase in capital formation (or in propensity to save) is expected to result in increase in income from the manufacture of both consumer and capital goods. This increase in income, in turn, results in increase in expenditure on consumer goods or increase in capital formation for investment in capital goods, and a development spiral is promoted. In developing countries, however, capital goods are not produced internally so that the part of income that should be generated from the production of capital goods actually accrues to the developed countries that supply the capital goods.

As a result, the amount of income resulting from a given level of capital formation is decreased by the amount of income generated from the production of imported capital goods. This loss is not compensated for in any way and also results in unemployment. It

is a continuous leakage that is made good only when the capital goods are produced internally. So far, it has been made good by increased foreign investment and foreign aid.

In the same way, a high proportion of the increased income is spent on imported consumer goods and does not promote domestic production of such goods and further increase in income. While such imports could be said to be compensated for by exports, the difference in the nature of goods exchanged makes developing countries sustain a net loss (Mazrui 1986). Expenditure on imported manufactured products has multiplier effects in developed countries and gives rise to much increase in income whereas the expenditure made by the developed countries on imported primary products has a very little multiplier effect in developing countries that lack the technical know how for expansion and for the production of capital goods required for the expansion. Moreover, since agricultural products have low elasticity of demand, expansion of production often results in little increase in income, if any. Sometimes, there is even a decrease in income (Mazrui 1986).

In addition to the income – generating effects lost through the importation of capital goods and manufactured consumer goods, much income is directly lost to the economy of developing countries through the repatriation of income, interest and profits by the foreign investors and their employees. The rate of increase in income is thus decreased by the proportion of income generated that is repatriated by foreigners (Mazrui 1986; Arthur 1996).

The Harrod Domar growth model masks all these losses to the economy of the developing countries, the losses that are, of course, gains for the economy of the developed countries. The developed countries, in effect, give with one hand and take with another, even bigger, hand. The losses make the developing countries to remain under – developed and, as a result, foreign investment is perpetuated and the multi – national corporations see themselves as having a very crucial role to play in the development, more realistically under development, of the economies of the developing countries (Mazrui 1986).

Welfare Effects of Development Concepts

When one thinks of the number of factories that have been established, the advance type of construction work that have been undertaken, the varied types of products that are now manufactured domestically, and the magnitude of the gross domestic product and of the total investment that has been made, one feels that without foreign investment and the multi – national corporations, the developing countries would have remained primitive and backward (Oculi 1996).

The gross fixed capital formation in Nigeria was estimated at 350million US dollars in 1978 – 79 and total investment of 850million US dollars was planned for the 1980 – 85 National Development plan (Adepoju 1991; Obono 2003).We have been made to reject our way of life and consumption pattern and to accept the European way of life and consumption pattern. We follow this up with costly irrigation schemes under – taken with foreign capital and imported technical know – how and capital goods for the production of sugar and wheat. We also import machinery, equipment and technical know – how for

the production of sugar, breakfast cereals, soups and wheat based confectionary, bread and pastries (McGee 1987; Oculi 1996).

Total investment, the gross domestic product, and the number and types of factories all increase, and the economy is said to have a high rate of growth. The same goes for the type and the size of wardrobes, including shoes, a high proportion of which is either imported or made from imported goods including woollen and synthetic materials. It also applies to the size and number of cars and the resulting expenditure on the construction of roads, bridges and streets (McGee 1987; Oculi 1996).

The Role of Technology

The dependence on existing technology is safeguarded and preserved by multi – nationals through restricting transfer of technology to the developing countries. This has not been given adequate attention even by writers on multi – nationals. Indeed, some writers state emphatically that the problem of the developing, or poor countries does not lie in lack of technological know – how alone (Arthur 1996; NASS 2005).

Technology is different from capital goods because without technological know – how, capital goods cannot be utilized. If the developing countries had not been colonized, they would have surely developed their own technology or adopted imported technology. But colonisation has made them desire and become fully dependent on the technology available in developed countries (Arthur 1996; NASS 2005). And obviously, they do not

have the technical know – how required for the production and utilisation of the type of capital goods available in developed countries.

The developed countries know this and they are using it as a means of continual domicile in the developing countries. Not only are they continuing to give emphasis in economic theory to capital but they also regard technology as being embodied in and, therefore, part and parcel of capital goods and have thus hidden its role for economic development.

Yet they know fully well that they can export capital goods to developing countries but if they do not, at the same time, export their technological experts, the capital goods will not be utilized. The practice has been to export technological experts along with capital goods and to ensure that the nationals of developing countries are relegated to the lower and middle level technicians who have and are given no opportunity to acquire technological know – how (MAN 2005; NASS 2005). The developing countries are thus prevented from acquiring the management expertise (and ability for good production decisions) and the technological know – how for manufacture of the capital goods which they need (Arthur 1996). Their dependence on developed countries for the supply of these capital goods is strengthened, and the role of the multi – nationals which is supplying, installing and operating these capital goods is further enhanced (Adepoju 1991; Arthur 1996).

It is therefore, the role given to capital in economy theory and in development planning that has made foreign investment and the multi – national corporations very important for

the development of the economies of the developing countries. The real constraint has been hidden and, along with it, the most appropriate path for economic development in the developing countries. The multi – national corporations take measures to ensure that this situation is maintained and their role preserved (MAN 2005; NASS 2005). It is a role which has been overlooked because the educated elite in developing countries have imbibed without questioning the theoretical construct put forward to them. It is a role which directly militates against economic independence of the developing countries (Arthur 1996). The role of multi – national corporations will continue to appear vital until the basis for that role is effectively questioned and a new path cut out for the development of the economies of the developing countries (MAN 2005).

Policy Measures Adopted for the Promotion of Foreign Investment in Nigeria

When capital is considered crucial for economic development and when this capital is available in developed countries and not in developing countries, it follows that the latter should take measures to attract capital and promote foreign investment. The promotion of foreign investment was, in fact, made the central issue for economic development in African countries (Adepoju 1991; Okonjo-Iweala 2007)

Various policy measures were adapted to this end, and exhortations were made for political stability and the creation of an atmosphere conducive for foreign investment. In other words, foreign investment conditioned economic policy and greatly influenced the political atmosphere (Information 2007; Nigeria-world 2007). This obviously promoted economic colonialism or neo colonialism.

The Nigerian government policy for promoting foreign private investment is stated in the National Development Plans (Adepoju 1991; NASS 2005) One of such plans, "A New Industrial Charter"(MAN 2005) it states that:

"In order to harness the tremendous potentials of the manufacturing sector and to realise the particular advantages which a dynamic private sector has in this area of economic activity, the government has decided to further open the doors to both indigenous and foreign private investors of Manufacturing" (MAN 2005). In the preceding Plan, political stability and availability of infrastructure were specifically stated to have much influence in attracting investors. Nigeria's policy measures were summarized in that Plan as:

"In the attempt to aid the industrialisation process, efforts have been made to attract desired industries through the granting of tax concessions to pioneer industries, the granting of relief from import duties and the imposition of tariff to protect infant industries" (FMOIND 2004).

These policies have been pursued since the 1950s. And as early as 1952, Aid to Pioneer Industries Ordinance was enacted. This law granted tax relief and similar concessions to the industries prevailing at that time which were subsequently declared to be pioneer industries. A pioneer industry was defined in Industrial Development (Income Tax Relief) Ordinance, 1958 which superseded the 1952 Ordinance to mean "any industry which is not being carried on in Nigeria on a scale suitable to the economic requirements of

Nigeria, or at all and there are favourable prospects of further development of any (such) industry" (NASS 2005; DFID 2006; NACCIMA 2006)

Since practically no industry was being carried on a scale suitable to the economic requirement of Nigeria, (which phrase could even be interpreted to include export requirements), nearly all industries were subsequently declared to be pioneer industries. The tax relief granted to such industries was for at least the first two years of production. When the industries eventually became subject to tax, they had capital allowances and allowance for losses. Some of their dividends were also exempted from tax, there were some remissions of income tax on profits (NASS 2005; OTAL-Nigeria 2006).

In addition to these reliefs, all the inputs, machinery and equipment imported by the industry were exempted from import duty under the Industrial Development (Import Duties Relief) Ordinance of 1957. Moreover, many of the industries were granted the infant industry status. So, protective import duties were imposed on the imported products that compete with the products of such industries (FMOIND 2004).

The Industrial Development (Income Tax Relief) Ordinance, which became an Act at Independence, was replaced by the Industrial Development (Income Tax Relief) Decree of 1971. This Decree extended the initial tax – free period from two to three years (FMOIND 2004). The granting of pioneer status was, however, limited to the companies whose total capital expenditure at the date of marketable production was not less than

25,000 naira (180 US dollars), if an indigenous – controlled company, and 75,000 naira (545 US dollars) for other companies (DFID 2006; OTAL-Nigeria 2006).

Foreign investment was further encouraged through the granting of Approved Status to the industrial establishments in which foreign capital was invested or used for an approved purpose. The granting of approved status was an acknowledgement by the government of the day that approval in principle had been given for the repatriation of the investment capital at a future date. Also, approval was granted in principle for the repatriation of profits and dividends arising from the investment.

Manufacturers in general also benefited from the approved user scheme (MAN 2005) from the Companies Income Tax Act of 1961 and the Companies Income Tax (Amendment) Decree, 1971. With the approved user scheme all imports used in the manufacturing industries were admitted either duty – free or at a concessionary rate of duty fro a period of three years. The Companies Income Tax Act (NASS 2005; DFID 2006; NEXIM 2007) and Income Tax (Amendment) Decree permitted companies, both private and public, to effect a quick write – down of their capital assets in their early period of operation by granting them a high initial amortisation allowance as well as a high rate of subsequent annual amortisation. By this, mining and plantation capital assets and machinery could be written off within six to seven years (FMOIND 2004).

These allowances and concessions resulted in loss of revenue by the government and much gain to the industrialists who have been mostly foreigners. In addition, those

industries that were granted the infant industry status were able to raise the prices of their products to the level of the prices of imported competing products on which protective duty had been paid. This obviously promoted inflation. Moreover, it was generally alleged that the manufacturers produced inferior products, which were sold at artificial high prices; only the producers' gains, and very substantially, the consumers are cheated, and the government sustains loss of customs revenue resulting from protective duty (FMOIND 2004; NEXIM 2007)

With such an opportunity for obtaining high profits, a type of opportunity that did not exist in their home countries, the multi – national corporations and other foreign investors found Nigeria with her teeming population a very fertile ground for their activities. The scramble for oil prospecting which followed the discovery of petroleum (oil) in commercial quantity by Shell BP in 1956 magnified the activities and presented the spectacle that the Nigerian economy was booming (Mazrui 1986; NNPC 2006; Shell-Nigeria 2006; OPEC 2007)

It is not that tax incentives, tariff incentives, provision of infrastructures, etc. to help industrial concerns are not necessary vital measures, but the point is that such industrial relief measures have not stimulated production in the right direction in Nigeria. Infrastructure has speeded the flow of raw materials and agricultural produce to the ports for shipment to the metropolis (NASS 2005; NPA 2006). Tax and tariff incentives have magnified foreign industrial profit. If these profits would have been re – invested productively, there would be no problem by now, because productive industries would

have expanded by leaps and bounds. The reverse is the case, however; hence several well intended policy measures have not been beneficial to the country's populace (NASS 2005).

All the major processes of globalisation impacts on the fundamental conditions and resources for oral health and improvement in oral health requires a secure foundation in the basic prerequisites for health which include, income, education, a stable ecosystem, sustainable resources, social justice, peace, food, shelter and equity. In globalisation therefore, Nigeria along with other developing countries need to have a diverse but complementary approaches to arising issues from globalisation including fiscal measures, legislation, taxation and organisational change. The Ottawa Charter of 1986 (WHO 1986) is an ideal guideline for a positive change in developing countries. The Charter proposes the need to build a healthy public policy, which considers health consequences of all policy decisions, fiscal measures, and taxation and so on. It also involves the creation of supportive environments with good living and working conditions which are safe and health promoting (WHO 1986).

Developing countries must strengthen their community action; community development approaches and empowerment, set own priorities and plan strategies to improve oral health despite globalising influences. Careful organisation of educational systems of developing countries to help develop personal skills and enhancing life skills is very crucial, and finally re-orienting oral health services in order to move beyond providing curative services and focusing on prevention (WHO 1986). In line with these strategies,

consumption of sugar and beverages has become a subject for consideration in Nigeria as food is a prerequisite for health. Coca Cola as a popular soft drink is the subject for discussion in the globalisation process in Nigeria.

In conclusion, policy for oral health is very difficult to implement in Nigeria, due to the complex web of policies in the WTO and the IMF which directly impacts on the funds available for oral health. Also, because of the influence of multinational corporations like the pharmaceutical industry having a major impact on funding for health services and sucking the complete budget away, not only this but oral health is low on the Nigeria's policy agenda and because of the influence of the global institutions it is difficult to get it onto the agenda

Chapter Three

Exploring the possible impact of Coca Cola and Oral health in Nigeria

This section seeks to explore the possible impact of Coca Cola and oral health in Nigeria; it begins with a discussion on the sugar consumption in Nigeria and how the sugar business steadily grew in favour of soft drink companies like Coca Cola Company. This section further discusses the overall Coca Cola trade and its colonisation process in the United States, although there were no substantial data of the Coca colonisation processes in developing countries. The arrival of this product has to a large extent impacted on the oral health of its consumers in Nigeria and slowly gained a considerable amount of political influence in the National politics in Nigeria and other developing countries. Worthy of mention is the fact that, the community funding for corporate interest is also very glaring in America as well as in other developing countries.

3.1. Sugar consumption in Nigeria

A famous Nigerian author Chinua Achebe (1973) once noted in his book "Girls at war" a story narrating briefly the impact of sugar consumption in the then Biafra, secessionist state in southern Nigeria, in which a man's habitual liking for sugar becomes the root of his personal crisis during the Nigerian civil war in 1969 – 73 (Achebe 1986), "Sugar Baby" is a popular story in Nigeria which talks about three friends poring over one of the war casualties and that of a promising couple destroyed by the man's addiction to sugar.

This demonstrates one of the consequences of sugar consumption in Nigeria (Achebe 1986)

Normally sugar is produced from both beet and cane, sugar cane is a perennial crop found in sub – tropical and tropical regions. Sugar mills crush cane and convert the juice extract to raw sugar for exports which is processed further in refineries, while, sugar beet is an annual crop grown in temperate regions, which is processed into refined sugar directly. Both the refined sugar and raw sugar are traded globally (FAO 2003).

The human diet since the development of agriculture has revolved around a nucleus complex carbohydrate "fringe" with complementary textures and tastes to arouse appetite and typically improving nutrition as well, then the precise role of sucrose has played in dietary change is difficult to establish. But if the sweet fringe develops so that the fraction of the complex carbohydrate core is decreased to where it provides perhaps only half of the caloric intake instead of 75% or 90%, then the whole style of the meal itself has been altered (Mintz 1985).

Refined sugar penetrated one cuisine after another and was viewed as a symbol of the modern and industrial, associated or following on "globalisation" or "westernisation" or "modernisation" or "development" especially in Nigeria (Achebe 1986), sucrose has became a revolutionary and accepted sign of "progress" among Nigerians. Normally, individual learn about it in one of two ways: either they exchange their labour or products or wages for it, along with other desired western goods; or else it is given to them as part

of the aid provided by the West. Contributions were usually given after the colonialists recognize the economic disorganisation arising from their prolonged contact with “less developed” traditional cultures especially during the colonial era (Mintz 1985; Achebe 1986).

Initially, sugar was brought from afar, purchased from foreign producers, afterwards, each metropolis developed its own tropical colonies for the production of sugar, which concurrently enriches the state and its financial and commercial classes, stimulating the consumption of both its local manufactures and colonial products, and increasing the market involvement of its own hinterlands (Mintz 1985; Achebe 1986).

In the developed world, direct consumption of refined sugar or household use, thought to be tantamount with purchases of granulated sugar in packages of less than fifty pounds, has declined from 52.1 pounds per year in 1909 to 1913 to 24.7 pounds in 1971; while industrial use in food products, soft drinks and beverages has risen during the same period from 19.3 pounds to 70.2 pounds (Page L and Friend 1974). In developing countries shows a similar trend, though much less significantly (Mintz 1985).

There is consumption outside the home, as far as the consumer is concerned, at snack bars, in restaurants, hotels, theatres, etc. which has risen along side other developmental indicators; and the ever increasing use of prepared foods in the home itself. These different forms of sucrose consumption in manufactured and processed foods are related;

both are responses to wider social forces, and they show up in the developing countries (Mintz 1985).

To satisfy demand, Nigeria depends exclusively on sugar imports. In 2004, 70 percent of the imports were refined locally (GAIN 2005) . Guatemala, Brazil and the European Union are the major suppliers, though Brazil is the dominant supplier of brown and refined sugar. Sugar consumption is increasing steadily by four percent annually in step with growth in population and in industries utilizing sugar as raw material; the major users are the confectionary, pharmaceutical, soft drinks industries, along with food and beverages industries (GAIN 2005). In January 1, 2005, the federal government of Nigeria banned imports of sugar not fortified with Vitamin A, with the duty on raw sugar being five percent and that of refined sugar 40 percent. Theoretically, this directive prevented refined sugar from entering Nigeria legally. The Coca Cola Company and other industrial users of sugar whose operations were affected by the ban have requested import waivers from the federal government (GAIN 2005; GAIN 2006).

In 2006, Nigeria resumed sugar production of approximately 40,000 tons after four consecutive years of depending exclusively on imports. Savannah Sugar Company resumed milling operations in May 2006. The bulk of Nigeria's sugar requirement is imported raw and refined locally (GAIN 2006). Nigeria’s overall sugar consumption 2005/06 was 1.2 million tons, up from 1.1 million tons in 2004/05. This was due largely on the population growth and increasing industrial demand. Trends in the industries

utilizing sugar as a processing input, suggest that sugar demand will continue to rise (GAIN 2005).

Recent forecast of the overall sugar consumption in 2006/07 is expected to reach 1.3 million tons, up from 1.1 million tons in 2005/06, and the demand for sugar will continue to increase gradually, Industrial usage accounts for almost 35 percent of the total sugar consumption in Nigeria. Soft drink production alone accounts for about half of total industrial usage (GAIN 2006).

Presently, the federal government of Nigeria has privatized all its four sugar estates after several years of mismanagement. The new investors have taken over the management of these estates and have embarked on the rehabilitation and expansion of the mills and the cane fields. The government claimed that, the privatization of these estates is a key element of restoring the sugar industry and increasing local production (GAIN 2006).

The local production of sugar in Nigeria has been almost at zero level since 2001 when the federal government initiated the privatization of government-owned sugar estates. In what appears to be a major success story for Nigeria's privatization exercise, Dangote Group, the new owner of Savannah Sugar Company has completely rehabilitated the cane fields and the mill with operation recommenced in May 2006 (GAIN 2006).

The bulk of the sugar consumed in the country is about 80 percent which is imported as brown sugar and refined locally. The remainder is imported in refined form. Nigeria has

only one sugar refinery operating with an installed capacity of 1.5 million tons per annum, sufficient to satisfy total demand. Another investor plans to commission a second refinery later in 2006 (GAIN 2006).

Commodity like Sugar has been on the increase steadily since 1991 with figures to justify this by the world health organization data for centrifugal sugars which includes cane and beet sugars, in 1991 it was 4.8 kg/capita, 1994 and 1997 were constant at 6.2kg/capita each, and only 0.2 kg/capita increase in 2000 as compared to 1997, while almost doubling the 2000 figure in just a two year difference in 2002 with a figure of 11.3kg/capita (GAIN 2005; Dangote 2007).

This consumption level may be attributed to the factor of supply and demand with increase supply by the country's biggest supplier "Dangote Group" which produced a total capacity of 840,000 Metric Tons of refined sugar per year in their first year of production in 1999, hopes to step up production to 4,000 Metric Tons per day in 2007 from their daily current capacity production of 3,000 Metric Tons per day. An annual total capacity of 600,000 Metric Tons per year is set from their newly planned sugar refineries throughout Nigeria (GAIN 2005; Dangote 2007)

Worldwide the pattern of production according to Food and Agriculture Organization (FAO) of the United Nations, from 1970 to 2001, world sugar production averaged 101.2 million tonnes annually (FAO 2003). In the last 30 years, the main sugar producers have been the India, Brazil and European Commission, with an average annual production of

15.7 million tonnes, 10.1 million tonnes and 9.6 million tonnes, respectively. Unlike Brazil, the EC and India are also large consumers (FAO 2003).

Production in Brazil grew increasingly between 1970 and the late 1980s, and since 1990 has had a growth with production reaching 17.3 million tonnes in 2000/01. This considerable increase in production contributed to global oversupply and low prices. Production in Australia and Thailand, the other major producing countries, levelled off in the 1990s after steady growth since the mid 1970s (FAO 2003).

Consumption and trade pattern on the other hand worldwide since 1970, sugar consumption averaged 115.6 million tonnes per year, with the major consuming countries include China, India, America, Russia and the European Commission. Over the last thirty years sugar consumption has been growing on a steady basis. Brazil is leading the world sugar trade. Exports have increased fourfold since 1970 to a total of 8.8 million tonnes in 2000. The European Commission is a major exporter as well as importer. Other major sugar exporting countries are Cuba, India, Australia and Thailand. Major importing countries include the Canada, Korea, Japan, Russia and China (FAO 2003)

"Globalisation" has meant among other things a relatively steady increase in sugar consumption since perhaps the mid nineteenth century. With globalisation comes a higher percentage of sucrose use in prepared foods. In fact, the shift to indirect use, like sugar consumption itself, has become a developmental signal of a kind. Increasing sugar consumption is only one of the ways globalisation changes food habits and choices. While caloric intake probably increases as sugar consumption rises, this increase is partly

achieved by substitutions, one of the clearest being the replacement of complex carbohydrates or starches with simple carbohydrates or sucrose (Mintz 1985).

The apparent connection between fats and sugars – and their effect on the consumption of complex carbohydrates – has nutritional, psychological and economic implications. As food availability has been generalised across modern civilization, the structures of meals and the calendar of diet in daily life have tended to disappear. Tea, Coffee or Coca Cola are now appropriate at any time and with any supplement (Mintz 1985). Coca Cola was able to capitalise on this and reaped a huge profit with a massive annual turnover in trade worth millions of dollars from its ever growing consumers.

3.2. Coca Cola Trade

Coca Cola is the world's most popular soft drink that was invented in 1886 in Atlanta, Georgia, by Dr. John Pemberton as he was looking for a means of making his cough medicines more pleasant. He discovered that the mixture made a refreshing drink when he added sparkling water to sweet syrup, spiked with caffeine and flavoured with coca leaves. A colleague of his later gave it the name 'Coca Cola' (Richard Walker 1997).

The proportion of ingredients was kept secret though the formula was never patented, but the formula remained locked in an Atlanta bank vault. A near identical rival 'Pepsi Cola' was launched in 1903, the bottled Coca Cola had only been on sale for three years then.

Consequently, this contest became one of the great marketing stories of the century (Richard Walker 1997).

The United States armed forces during the Second World War took Coca Cola overseas which resulted in Coke's conquest of the world. Jimmy Carter, the Georgia born American president in 1977 noted that Coca Cola was represented in more countries than the American State Department. Global politics in 'globalisation' were reflected in the form of market share for this concoction. Coca Cola was sold largely in Israel, but Pepsi Cola stole a march when it was first to infiltrate the Iron Curtain, the iron curtain was the boundary which ideologically, physically and symbolically divided Europe into two distinct regions post second world war until the end of the Cold War 1945 to 1991 (Wikipedia 2006) Pepsi would later enjoy a monopoly in the greater part of the Middle Eastern region (Richard Walker 1997).

The sale of Coca Cola nose dived in April 1985 when it decided to change its secret formula, the sweeter 'new' Coke which was originally intended to remedy the decline in market share, this meant disaster for the Coca Cola business. By July of the same year, the decision was taken to restore the original formula in a new 'Classic' brand, which by 1988 had regained much of the loss and they were back on track (Richard Walker 1997).

Generally the growth in soft drinks market is strong and steady, the soft drinks market in Nigeria experienced strong and steady retail volume growth and even stronger value sales increase in the last decade (Euromonitor 2007). This growth was aided by factors

including the increase in advertising activity, the introduction of new products and packaging and better economic conditions for the manufacturers in the country. The hot and humid weather experienced in Nigeria for most of 2005 may have also boosted the sale of soft drinks (Euromonitor 2007).

Coca Cola drinks are popular amongst all Nigerians especially the young. In 2005, Coca Cola led the soft drinks market in volume terms, accounting for about 49% of soft drinks volume sales, probably due also to the lack of running tap water in most cities and the fact that such water is not fit for drinking in areas where it is present. Many Nigerians consume between 2 to 8 bottles a day and remain unaware of the health implications of their actions.

The level of competition among companies in the Nigerian soft drinks market is increasing. These manufacturers even sold soft drinks in plastic 'PET' bottles (Polyethylene terephthalate termed as PET or PETE is a thermoplastic polymer resin of the polyester family and is used in synthetic fibres; beverage, food and other liquid containers (Wikipedia 2007), introduced in 2004, which made it possible for Coca – Cola drinks to be sold in traffic jams and other mobile selling points. The Coca – Cola growth in Nigeria is fuelled by an increase in disposable income, company advertising and heightened competition among key players in the business.

The influence of Coca Cola on Nigeria's government policy is immense, for example, a submission was made by Mr. Lawrence M. Drake II, division president of Coca-Cola

Nigeria and Equatorial Africa at a post event conference, following the just concluded third Business Roundtable with the Federal Government, on “Nigeria’s depleted middle class and small scale businesses”, this was organised by the Economist Conferences in Abuja, Nigeria and had Coca-Cola as the lead sponsor (Euromonitor 2007; Guardian 2007).

Small scale businesses are noted as the backbone of wealth creation in any country and one of the major drivers of any economy is the growth of entrepreneurship. Usually, small businesses generate the highest number of employment and provide people with the platform to harness their talents, visions and energy for value creation in the economy; and, if the environment is conducive, entrepreneurs would be able to grow their businesses, accumulate wealth over time and transit into the middle class (Euromonitor 2007; Guardian 2007).

The Coca Cola Company, which began about 120 years ago as a one-man business that marketed the then newly invented Coca-Cola syrup, has found its way into the nucleus of the Nigerian government cajoling the federal government to take further measures to improve the attractiveness of Nigeria's business environment to foreign investors. Especially issues that relate to tax policies, ban on the importation of some basis inputs when there are feasible alternatives available locally (Guardian 2007). The company agents claimed that by implementing their favoured policies, the Nigerian marketing environment would entail the availability of consumer lending, a favourable interest rate

regime, adequate power supply, visionary political leadership and an honest bureaucracy, all of which, they observed, the ongoing reforms seem intended to address.

The Coca Cola ideals are strategically targeted at the middle class which is the pivot for social and economic development and represent the missing link in most developing countries. The middle class also represents the core group of people with the, financial, intellectual and entrepreneurial capacities to propel the direction and peace of economic growth in the country (Euromonitor 2007; Guardian 2007).

The majority of today's global corporations evolved from small scale and the economic history of the industrialised countries shows that small businesses, which often transit into family businesses and grow over several generations, were and still are the building blocks of the economies (Euromonitor 2007; Guardian 2007).

The Coca Cola Company has been doing business in Nigeria since 1953 and has reaped immensely in the benefits brought about by changes in the country's economic wealth. The Coca Cola system in Nigeria is large and complex, have capitalised on the dynamism of the Nigerian economy and the fact that Nigeria is one of the most profitable target in the world for investors who are willing to wait a little longer for their investments to mature (Guardian 2007).

The company has been steadily growing its business in Nigeria and has opened one of the country's largest bottling plants in Abuja in 2006. The confidence of the Coca-Cola

Company in the Nigerian economy remained undaunted and, if anything, that confidence has been sharpened by the ongoing reforms, which hold the promise of deepening the economy and laying a strong foundation for their sustainable growth in the years ahead (Euromonitor 2007; Guardian 2007). Coca Cola has therefore come to stay in developing economies of developing nations as a form of colonisation.

3.3. The Era of 'Coca-colonisation'

Colonisation is defined as the process of settlement in a new country and subsequently forming a new community which is either completely or partially subjected to the state from which the settlers emigrated. In the past this involved large numbers of people immigrating to an area or country that was already inhabited by the indigenous people usually (JustFocus 2007).

The colonisers then expand their form of civilization into this new community, for example, Europeans into New Zealand and Australia. Presently, Colonisation has a broader application which includes the erosion of a country's indigenous culture, food, drinks, customs, language and way of living, usually from a powerful, industrialized country such as the United States. This is sometimes referred to as "Coca Colonisation" or simply Cultural Imperialism in some cases, which is the erosion of a country's native culture and its replacement with corporate mass-culture, usually American in origin.

In this case people did not necessarily move to the colonized country but the use of the term is metaphorical, but only various kinds of cultural norms where transferred that is only cultural signals, symbols, forms of entertainment, and values need to move to the colonized country (JustFocus 2007) (Wiki 2004).

A New York Times columnist Thalif Deen postulated that globalisation and free market economics had prompted such a wave of economic affluence that there will never be a war between two countries with McDonald's restaurants. His theory was based on the fact that the mere existence of the American fast food chain in developing countries alongside Coca Cola, Kentucky Fried Chicken Pepsi Cola, and CNN is a continuing symbol of open markets (Deen 1999).

United Kingdom, France, Portugal, and the Netherlands for example similarly exploited their colonies in a previous era; the corporate giants of Western Europe and America are now seen as modern day economic colonialists 'coca-colonisation' was coined by the American populace in protest (Deen 1999). The Deputy Secretary General Louise Frechette of Canada at the United Nations argued that like almost everything in life, the globalisation phenomenon has both good and bad sides. "It brings up many opportunities to learn from each other, and to benefit from a wider range of choices. But it can also seem very threatening," (Deen 1999)

Louise also argued that people are suddenly finding their jobs becoming outdated through foreign competition or imported technology as a result of globalisation; parents are

discovering that their children are attracted by role models and products from foreign cultures. She noted that "Instead of widening our choices, globalisation can seem to be forcing us all into the same shallow, consumerist culture - giving us the same appetites but leaving us more than ever unequal in our ability to satisfy them. Many millions of people have yet to feel its benefits at all,"(Deen 1999). All Third World markets have been vulnerable to external manipulation due to globalisation (Deen 1999)

Wherever Coca Cola colonises, it invests millions of dollars each year in order to passionately convince the consuming public that their product is good for you, or at least harmless In fact, the corporation goes to some lengths to convince the public that their product is actually good for you. The company looks to public relations firms as well as some of the corporation's own public relations campaigns and programme; targeted donations, strategic alliances and the creation of research institutes as tools that can downplay the risks of oral diseases e.g. tooth decay or general health e.g. weight gain that results from consuming their commodities (BIHW 2005).

For example, Coke's Beverage Institute for Health and Wellness claims they are "Helping people all over the world live healthier lives through beverages" (BIHW 2005) the company created a research institute in March 2004 with the goal of countering criticism about their role of soft drinks in the obesity epidemic and that the institute will support nutrition research with a primary focus on beverages (BIHW 2005).

They further claim that the institute "will support health professionals and consumer education on diverse topics, such as micro-nutrient deficiencies, sweeteners, hydration, physical activity and weight management"(Polaris 2005). This research institute is obviously a public relations initiative with the goal of convincing the public that Coca Cola is concerned about health issues. The institute reports directly to the Company's Vice President Donald Short (Coke 2005), in the meantime the company continues to target young people with advertisements for their sugary drinks.

The Coca Cola Company uses the media maximally to highlight many of its strategic programmes and projects around the world. The majority of these programs serve as public relations campaigns planned to enhance the corporation's image. For example, the Company internet advert claims that In South Africa the corporation is introducing "model workplace programs aimed at raising awareness of HIV/AIDS for our 1,200 employees and their dependents" (Coke 2007). This was faulted in 2003 by 'Health Gap' which is an American based Aids and human rights group which claimed that the company was yet to implement the initiative (Gap 2003).

Coca Cola claims that they are "committed to helping protect and preserve resources in the communities and watersheds where we operate throughout the world"(Coke 2006). It is obvious that the corporation uses a lot of water, which in India for example, where the corporation has been taking vast amounts of water from local water tables this has resulted in devastating consequences to the lives of villagers and farmers in that locality (Srivastava 2004). The corporation's image was tarnished badly after years of resistance

from groups protesting the Company's use of large amounts of water in their bottling operations and the fact that Coca Cola products in India were found to contain pesticides. They resulted in hiring a public relations guru in India "Perfect Relations" to rebuild the company's already tarnished image in India (Srivastava 2004).

A look at what the Coca Cola Company makes around the world by geographic region is so huge and thus are able exert their influences in any domain, Nigeria inclusive.

Table 1: Coca Cola Revenue by geographic region

Region	2004 revenue	2003 revenue	% change
North America	$6.64 billion	$6.34 billion	4.7%
Africa	$1.06 billion	$827 million	29%
Asia	$4.69 billion	$5.05 billion	7%
Europe, Eurasia and Middle East	$7.19 billion	$6.55 billion	9.7%
Latin America	$2.12 billion	$2.04 billion	3.9%
Corporate	$243 million	$223 million	8.9%

Source: www.polarisinstitute.org/files/coke

A trade so big in the soft drink business is bound to have an effect on people's oral health status as Coke is acclaimed as no one soft drink worldwide, an attempt therefore is to see a probable relationship of this billion dollar drink and oral health.

3.4. Oral Health and Coca Cola

Coca Cola is a master marketer with specific advertising campaigns for hundreds of different products; the Company also packages and markets tap water. The company then convinces consumers through seductive advertising campaigns and packaging that the product is worth the price asked. Coke's marketing strategy shows their desire to hook specific customer groups on their products (MRFH 2004). Children are targeted by coke strategically, for example, the Coke's internet adverts indicate how the company views their markets, one of Coke's top Managers, Mr Pibb statement, "Mr. Pibb appeals to 12 to 15 year olds who are just gaining independence from home and looking for things to call their own. Mr. Pibb enables them to have an uninhibited, fun and unconventional attitude because it has the sweet, refreshing bold taste they need to express their independence" (MRFH 2004). Another example is Fruitopia – "Fruitopia is a noncarbonated fruit beverage for teens and young adults looking to discover new and unique flavour experiences"(Polaris 2005)

Coca Cola like many other soft drinks contain extrinsic dietary acids, citric acid, tartaric acid, ascorbic acid, phosphoric acid, malic acid and carbonic acid. These acids etch away tooth surface which leads to dental erosion, this is a progressive irreversible loss of dental hard tissue. This erosion in severe cases leads to total tooth destruction (Meurman 1996).

Human observational studies have shown an association between dental erosion and the consumption of a number of acidic foods and drinks, including frequent consumption of fruit juice, soft drinks (including sports drinks), pickles (containing vinegar), citrus fruits

and berries (Stabholz 1983; Linkosalo 1985; Jarvinen 1991; Millward 1994). Age-related increases in dental erosion have been shown to be greater in those with the highest intake of soft drinks (Walker 2000).

Experimental clinical studies have shown that consuming or rinsing with acidic beverages significantly lower the pH of the oral fluids (Imfeld 1983). Enamelis is usually softened within one hour of exposure to cola but this may be reversed by exposure to milk or cheese (Gedalia 1991; Gedalia 1991). Animal studies have shown that significantly that fruit juices and soft drinks cause dental erosion (Holloway 1958; Stephan 1966)

The American Academy of Paediatric Dentistry (AAPD), in May 2002 issue a Policy Statement on Beverage Vending Machines in Schools, the AAPD appeared to agree, affirming that, "frequent consumption of sugars in any beverage can be a significant factor in the child and adolescent diet that contributes to the initiation and progression of dental caries... Increased consumption of soft drinks may have a negative impact on children and adolescents' overall nutrition by displacing foods with higher nutritional value." in the same statement, AAPD further noted that, "In exchange for money to the individual school or districts, 'pouring rights contracts' give beverage companies exclusive rights to sell their products at school events and place vending machines on school property, along with other measures that increase student exposure to beverages."(AAPD 2003; AAPD 2004)

According to AAPD, increased exposure could be problematic, especially that there is "easy access to sweetened, acidulated carbonated and non-carbonated beverages by children and adolescents may result in their increased consumption which, in turn, may contribute to increased caries risk and negatively influence overall nutrition and health."(AAPD 2003; AAPD 2004)

The AAPD has been leading professional organisations in America campaigning for children's oral health. On March 3rd 2003 the AAPD press release attests to this, "works closely with legislators, professional associations and health care professionals to develop polices and guidelines, implement research opportunities in paediatric and oral health, and educate paediatric health care providers and the public regarding paediatric oral health."(AAPD 2003)

Though the same AAPD in October 2001 seems to think otherwise in their report which concluded, "Though there is limited epidemiological evidence assessing the association between oral health and soft drink consumption, it consistently indicates that soft drinks adversely affect dental caries and enamel erosion... Moreover, numerous in vitro animal studies have consistently shown enamel erosion with the use of soft drinks... Given this evidence, it would seem appropriate to encourage children and adolescents to limit their intake of soda." (AAPD 2001; AAPD 2004)

Though there are fewer human studies that exist than would be ideal, but when these studies are combined with the considerable animal evidences that are available the

American Dental association established that the full bulk of research were convincing enough to take a strong stand in favour of reduced soft drink consumption. In view of the fact that the American Dental Association took this position, a major longitudinal study was published in September 2003 in the Paediatric Journal by Marshall et al which concluded that for children ages four through seven, "Consumption of regular soda pop ... was associated with increased caries risk" (Marshall 2003).

Presumably this American Coca Cola experiences also obtains in Nigeria, though, in Nigeria there are no available studies or data that relates oral health with Coca Cola, despite the presence of several oral health related professional organisations in the country, for example, the Nigerian dental Association. Coca Cola has in many instances found a means of encroaching into community functions, use of professional associations especially by donating to pursue certain selfish interest to establish their presence and so doing attain popularity among their numerous consumers.

3.5. Community funding and Coca Cola

Coca Cola in 2004 spent $2.2 billion on the production of radio, television, print, and other advertisements. In 2003 approximately $1.8 billion was spent and approximately $1.7 billion was spent in 2002 all on advertising (Girard 2005). In the United States alone the Company spent a total sum of $472 million on advertising in 2003 and was ranked 69th in Advertising Age's top 100 leading National Advertisers. Though in 2002 Coca Cola spent $569 million and was ranked 57th in the world (Polaris 2004; Polaris 2005).

The compensation for such large investments in advertising and branding was what propelled the Coca Cola Company to the top of world's 100 brands and with a monopoly of such position. Business Week magazine fourth annual survey ranks Coke's brand ahead of Microsoft and IBM with value cited as over $67 billion (Polaris 2004; Polaris 2005).

Globally, as is common with most large corporations in the world, Coca Cola, its subsidiaries and joint ventures, donates considerably to candidates during election campaigns in various countries of their interest. The money they donate through their Political Action Committees (PACS) have political undertones, these are political committees organized for the purpose of raising and spending money to elect and defeat candidates (Girard 2005). These PACS represent labour, business, or ideological interests, and funds will go to, gubernatorial, congressional and senatorial or even presidential candidates who will work towards policies that will be favourable to the Company's agenda (Polaris 2004; Polaris 2005).

For example, in 2002 in the United States, strategic donations can be seen in the number of donations the Coca Cola Company made in the election cycle to members of the Senate Committee on Agriculture, Nutrition and Forestry. One of the functions of the committee among other things was to examine food programmes for the needy to assure their availability and nutrition value, as well as encouraging a balanced diet among the general population, and most importantly ensuring that food was safely grown, prepared and delivered (Polaris 2004; Girard 2005; Polaris 2005).

In the United States, out of the 21 Senators on the committee on Agriculture, Nutrition and Forestry, fourteen received a donation of a total sum of $37,000 from Coca-Cola enterprise during that year's election cycle. Other strategic donations include $9,000 from Coke and Coca-Cola Enterprises since 2000 to Florida Republican Ric Keller who tabled a bill banning lawsuits against junk food companies that was passed in the House of Representatives in 2004. Keller commented that "the food industry is under attack and in the cross hairs of the same trial lawyers who went after big tobacco" (Polaris 2004; Girard 2005; Polaris 2005).

Unfortunately, similar occurrence might be taking place in Nigeria, but there are no clear cut evidences to show or proof this, though Coca Cola logos are usually seen displayed along with electoral posters during elections in Nigeria. Human welfare, development and social stability are threatened by unprecedented health crisis the world faces today; while leadership from governments and the international community is essential the Coca-Cola Africa Foundation strategically heeded the call to help safeguard the future of Africa in the fight against Polio and HIV/AIDS. The Chairman, Board of trustees for the Company Alexander B. Cummings was quoted making the pledge "We will leverage our local infrastructure, marketing expertise and be an advocate for workplace policies. Under the "Kick-out Polio in Africa" programme, we are leveraging our local infrastructure and marketing expertise for National Polio Initiatives. To date, we have assisted in the immunization of over 130 million children" (Cummings 2006).

Coca Cola has infiltrated a majority of government's programmes and is gradually influencing issues relating to Oral health, general health and all aspects of human endeavours. A group of concerned dentists in the United States working in collaboration with Stop Commercial Exploitation of Children (SCEC) once protested on the recent funding agreement between the Coca Cola and American Academy of Paediatric Dentistry. They formed a group of, a national coalition that counters the harmful effects of marketing to children through education, research, action and advocacy (AAPD 2002; AAPD 2003).

The same press release announced that the AAPD Foundation (AAPDF) is accepting a million dollar research grant from the Coca-Cola Foundation. It was unimaginable and hard to accept that a research funder less appropriate for the AAPDF than Coca-Cola, the world's most popular brand of soda. This is a troubling message to the public that there is an alliance between AAPD and Coca Cola, because if the defenders of children's Oral health (Paediatric dentists) are teaming up with Coca Cola, surely then soft drinks cannot be harmful (AAPD 2002; AAPD 2003)

By accepting money from the Coca-Cola Foundation, AAPDF absolutely and publicly sanctions The Coca-Cola Company and its products, a position that challenges AAPD's moral authority. Pepsi and Coca Cola are responsible for the proliferation of pouring contracts around the world and in developing countries Nigeria inclusive with massive marketing campaigns encouraging children and adolescents to consume large quantities

of their products. Several other dental professionals worldwide and members of AAPD have reacted strongly to Coca-Cola's funding of AAPD (Burros 2003; NYSDA 2003).

A public campaign and several letters spearheaded by the Centre for Science in the Public Interest were writing asking AAPD to return the $1 million dollars donated to the association in 2003 by Coca-Cola to safeguard its integrity. The Centre for Science initiated a campaign to end this unholy partnership, commented that the AAPD, by partnering with Coca Cola, "is burnishing the reputation of a company whose products cause tooth decay, obesity, and other health problems in children" (CSPI 2003) Coca Cola's affiliation with the AAPD gives them implausible influence over an association that should support a reduction in the consumption of soft-drinks, but the AAPD has ignored all the objections (AAPD 2002; AAPD 2004).

In May 2005 Coca Cola Company was dropped as sponsor for any youth events in New Zealand, particularly was Coke's sponsorship of Rockquest, which they have been associated with for four years. Rockquest is nationwide rock band contest for high school students in New Zealand. The Government of New Zealand found enough funds to allow the event to go forward without the Coke sponsorship. The Government's Health Sponsorship Council, which had always been uncomfortable with the participation of the Company because of evident contradictions in motivation and goals, is now the main funder (AAPD 2002; AAPD 2004).

Coca Cola funded research by the Australian Sports Commission which was released In September 2004; hundreds of thousands of dollars was poured into the research on children and sport. The report hardly mentions dietary intake and its impact on health and obesity. Instead, the research outcome only show that children's poor health conditions and obesity were more likely to be related with decreasing physical activity than diet (ASC 2004; Girard 2005). The conclusions were upsetting for professionals of health and obesity who claim that there was no substantial evidence to say that diet has little to do with child obesity. More troubling is how studies on health issues are being sponsored by the likes of Coca Cola who reap a lot of profit from distracting people from looking at the diets of young people (ABC-Radio 2004).

Coca Cola is known to be one of the sponsors of the American Council on Science and Health (ACSH) which is involved in "consumer education consortium concerned with issues related to food, nutrition, chemicals, pharmaceuticals, lifestyle, the environment and health."(ACSH 2006) ACSH has several sponsors' especially large corporations who all have an interest in presenting themselves as healthy and harmless to the communities they are (Thurston 1999; Gumbel 2004).

The ACSH takes an unrepentant stand with regard to numerous environmental and health hazards created by modern industry. For example, Elizabeth Whelan the ACSH President in 1999 suggested that reports alleging that Coca Cola was making children in Europe ill were based on mass hysteria. According to Thurston "Coke should simply announce:

'There is no health hazard at all from our product. It is a figment of your imagination" (Thurston 1999; Gumbel 2004)

There are such similar occurrences in the developing world, in Nigeria especially, substantial evidence are lacking in this respect. For Nigeria to move forward in oral health and Coca Cola influences on oral in the country there is need to first appraise the current oral health situation in the country and fully understand what are the policies guiding the Nigerian oral health system in total?

Chapter Four

Oral Health in Nigeria: The Status Quo

This section attempts to present the current oral health status in Nigeria along with the primary health care system is especially that Nigeria has undergone several military regimes and what the health system has undergone. Only few oral health data are available in the country which may not necessarily be a representation the whole country. These data are convenient data that were collected especially in areas where the major health institutions are located. For example, there are a lot of data in Lagos state which has the Lagos University Teaching Hospital; another area with a lot of data is Ibadan in Oyo state where the University College Hospital is located. The data issue is evident in most publications from Nigeria as majority of information are available from the western part of the country where most of the research facilities are located. The section ends by highlighting the activities of existing non governmental organisations in Nigeria and the relationship of these non governmental organisations and oral health.

4.1. Oral Health in Nigeria: The current situation

Presently, the state of oral health of the population is progressively deteriorating most especially that, oral health has received little or no attention from the government and still remains low in the list of priorities of health problems. At all levels of government dentistry is as a diminutive unit within medical services. In many instances there is no dentist at the highest policy making level and decisions are taken by supervising officers

who lack basic knowledge of oral health (Jeboda 1997; Akande 2000; Adebola 2005; Aderinokun 2005).

The majority of both public and private oral health services centres are situated in the urban areas to the detriment of the rural areas, where the majority of the population dwell. More than 90% (Jeboda 1997; Adebola 2005; Aderinokun 2005) of the populace has never been in contact with any form of oral health care. The majority of patients seen at the scanty dental facilities in the urban centres, regrettably present with advance stages of oral diseases with very bad prognosis and are typically treatable.

Contemporary dental practice came to being in Nigeria about 66 years ago, between 1935 and 1937 in the colonial era, with merely two expatriate dentists namely Dr. Pearson and Dr. Cunningham (Aderinokun 1999; Akande 2000; Akande 2004). Hollist (1995) reported that, the total number of patients seen then was about 1,858 patients, 45% were Nigerians while 55% non-Nigerians (Hollist 1985; Akande 2004). Christian missionaries during the same period in other parts of the country, in providing general health care to the community were also offering dental services, for example the Baptist mission Hospital, located at Ogbomoso, Southern Nigeria (Aderinokun 1999; Akande 2000; Akande 2004).

Medical practice has been in existence long before dentistry with the establishment of the first medical institution in Nigeria in the year 1948 (Jeboda 1997; Akande 2004; Shehu 2005). University College Hospital, Ibadan became the pioneer health training institution

in Nigeria, while the oldest school of dentistry in Nigeria and certainly the foremost to be established in the continent of Africa was founded in Lagos in the September of 1966, headed by a British Dental Surgeon, Professor N.W. Fox Taylor (Hollist 1985; Aderinokun 1999; Akande 2000; Akande 2004).

Oral health care programmes practically do not exist in primary health care in Nigeria; consequently oral health issues are unevenly addressed. In view of increasing local needs and demands for essential dental services, three additional dental schools in separate states of the federation were established; Osun, Oyo and Bendel States respectively (Jeboda 1997; Akande 2004; Shehu 2005). There was an imbalance of health delivery to the whole populace compared with the region where the few dental schools where located and compared with the total number of twenty four medical schools in existence when these dental institutions where established (Akande 2004; Aderinokun 2005; Shehu 2005). Records from the Nigerian Medical and Dental Council (MDCN 1976) showed that there were 168 dentists listed in the country; 99 (58.0%) were in Lagos and Ibadan, 45 (26.8%) in the rest of southern Nigeria and only 24 (14.3%) in all the then 10 northern states (Hollist 1985; Akande 2004; Aderinokun 2005). However, by the turn of 1992 there was a rapid increase in the total number of registered dentists, which currently stands at 2,995 fully registered dental surgeons. This is a significant rise but very low increase relative to a 16 year span. There was a decline in 1997 to 1,728 probably due to brain drain especially with very poor wages from the military regimes at the time (Jeboda 1997; Aderinokun 1999; Akande 2004).

There is an obvious shortage of dentists and other oral health manpower in Nigeria, with a dentist population ratio of approximately 1: 100,000. This ranks Nigeria amongst the poorest oral health manpower in the world (Jeboda 1997; Aderinokun 2005; Shehu 2005). This has adversely created a loophole for malpractices in the health care sector with large proportion of oral health care delivery being held in the hands of quacks (Adams 1999; Adebola 2005; Aderinokun 2005). Firstly, professional quackery where dental auxiliaries open practices and offer services that they are not qualified or competent to offer. Secondly, non-professional quackery where people who have no training at all in oral health practice act as oral health care providers (Jeboda 1997; Adebola 2005; Shehu 2005). This unfortunately, is the range of oral health care services that are commonly available and accessible to the majority of the Nigerian population.

Excessive health inequalities and the need to provide better services, led to development of a National Oral health policy in 2000, which states that: "policy shall direct the establishment of a comprehensive Oral Health care system. It will be fully integrated with general health on primary health care basis that is promotive, preventive and accessible to all members of the population irrespective of their location in the country. The system shall also have facilities for curative and rehabilitative care in the available resources, so that all individuals and communities are assured of good quality of life" (FMOH 2005). The aim was to bring equity of access to health care to different communities (Adams 1999; Adebola 2005; Aderinokun 2005; Shehu 2005).

The Nigerian oral health profile varies today. Periodontal diseases affect practically all Nigerians but there is also increasing prevalence of other oral diseases. The main determinants of the state of oral health in the country are; severe malnutrition, compromised immune system, changes in dietary habits, increased use of tobacco and alcohol, unsafe cultural practices, widespread poverty and underdevelopment (Adams 1999; Aderinokun 2005; Shehu 2005). Several attempts have been made to successfully incorporate oral health into Nigeria's national health policy, though the story of the primary health care system in Nigeria is somewhat different.

4.2. The Primary Health Care System in Nigeria

The military head of state, President Ibrahim Babangida in 1987 launched the Primary Health Care plan (PHC)(Congress 1999) as part of the federal government health policy, which is set to be a major landmark in health care delivery in Nigeria then (FMOH 2005; FMOI&NO 2005). Planned to have an effect on the whole population, its foremost stated objectives included improved collection and monitoring of health data, accelerated health care personnel development; ensured availability of fundamental drugs nationwide; population nutritional improvement, realization of an Expanded Programme on Immunization (EPI); address national family health agenda; promotion of health responsiveness; and extensive promotion of oral re-hydration therapy (ORT) for management of diarrhoeas in neonatal childhood infectious disease (FMOH 2005; FMOI&NO 2005). The execution of these activities was projected to take place primarily through alliance between the local government councils and Federal Ministry of Health,

which would be directly funded by the federal government of Nigeria (USAID 1997; Congress 1999)

From the onset, the Expanded Programme on Immunisation (EPI) was the most realistic and probably made the greatest impact in the population out of all the set objectives. The immunization program focused on the most common childhood infections: tetanus, tuberculosis, diphtheria, pertussis, measles, and polio. The intention was to dramatically increase the fraction of immunized children less than two years of age from about 20 % to 50 % and ultimately to 90 % towards the end of 1990 (Edozien 1995; USAID 1997; Congress 1999).

By August of 1989, 300 out of the 449 Local Governments in the country have established the programs in the rural communities since its inception in March 1988 (FMOH 2005; FMOI&NO 2005). Even though the program was said to have made a great deal of progress its aim of reaching the target of 90% coverage was probably exceptionally over ambitious, most especially, the economic policy of structural adjustment programme (SAP) of the 1980s was tough on Nigerian economic growth and development (USAID 1997; Congress 1999).

Primary Health Care also incorporated partially the government's population control program. This led in turn to a very strong official policy of advocating for women of child bearing age not to have more than four children, in their productive years (FMOH 2005; FMOI&NO 2005). This policy was in place by late 1980s and this would bring

about a significant decrease from the projected fertility rate of nearly seven children per woman by the end of 1987 (Edozien 1995; USAID 1997; Congress 1999). There were surplus contraceptive supplies and birth control information in most of all health facilities situated all over the country, even though, no official sanction were attached to the government's population control programme most especially considering the countries multi-religious beliefs concerning child bearing (USAID 1997; Congress 1999)

In the oral health care sector, several experts in the field of Oral diseases, in the country have incessantly proposed to the government, on the need of developing and implementing, a Primary Oral Health Care Programme (POHC) for the country. It may be possible to integrate it into the existing National Primary Health Care (PHC) programme. In view of this a seven-man committee was set up by the Federal Ministry of Health in 1995 to present guidelines for possible adoption of a National Oral Health policy (Jeboda 1997; Adebola 2005; Aderinokun 2005; FMOI&NO 2005; Shehu 2005). The following objectives were the key areas for immediate attention with respect to Primary Oral Health care;

- To provide promotive and preventive oral health care services integrated into the primary health system of the Nation.
- To provide oral health education to the community in order to promote dental health awareness and community participation
- To promote and accentuate already existing, socially and culturally acceptable methods oral hygiene maintenance
- To provide screening and referral of oral health services to deprived target groups

- To properly identify target groups easily available for oral health education for example, school children, pregnant women and nursing mothers
- To adequately provide emergency oral services at the community level
- To train appropriate personnel on ground for the provision of primary oral health care
- To develop and re-examine alternate models for the delivery of primary oral health status of the community sporadically (Adebola; 2005: 16)

Unfortunately, in 2004 the primary oral health care programme had not been integrated into the national primary health care policy in Nigeria (Aderinokun 2005; Shehu 2005). Instead, the federal government expended huge resources in the pharmaceutical sector, which depleted the national economic reserve in the pursuit of international trade on hospital consumed drugs, with the sole aim of improving the availability of pharmaceutical drugs nationwide (Aderinokun 2005; Shehu 2005). Foreign exchange had to be released for essential drug imports, so the government endeavoured to developed local drug manufacture. Raw materials for local drug manufacture had to be imported a consequence of this was that costs were only partially reduced (Aderinokun 2005; Shehu 2005).

For Nigeria to mutually maximise its foreign exchange expenditures and simultaneously to implement substantial expansion in primary health care, foreign aid would almost certainly be required (FMOH 2005; FMOI&NO 2005). Despite the progress made against many infectious diseases, Nigeria's population continued through the 1980s to be subject

to several major diseases, a number of which transpired in acute outbreaks leading to deaths in hundreds or thousands (USAID 1997; Congress 1999). Other diseases recurred chronically, causing significant infection and debilitation in general. Among the former were Cerebrospinal Meningitis (CSM), Lassa fever, typhoid fever, yellow fever and, lately, HIV/AIDS; the latter included onchocerciasis popularly referred to as river blindness, guinea worm, malaria and schistosomiasis also known as bilharzia (USAID 1997; Congress 1999).

Despite Nigeria's economic and agricultural advances, malnutrition and its attendant diseases also continued to be an intractable crisis among children and infants in various communities. Cerebrospinal meningitis was very significant among the worst acute conditions; it is a potentially fatal inflammation of the membranes of the brain and spinal cord that may recur in sporadic epidemic outbreaks (USAID 1997; Congress 1999).

In Africa the meningitis belt stretches from Senegal to Sudan, and Northern Nigeria is one of the most heavily populated regions in this belt with all the areas having a long dry season and low humidity annually between December and April (FMOH 2005; FMOI&NO 2005). In 1986 and 1989 the disease plagued the northern and middle belt areas, usually emerging during the cool, dry harmattan season when most people are indoors most of the time, consequently, promoting contagious spread. In forty-eight hours of first symptoms, paralysis, and frequently death do occur (USAID 1997; Congress 1999).

The federal and state governments in 1989, in response to the outbreaks, attempted mass immunization in the affected provinces (FMOH 2005; FMOI&NO 2005). It was unachievable, due to, bad inaccessible roads, inadequate medical facilities and difficulty of storing vaccines in the harsh conditions of the northern areas where these outbreaks are frequent. There was a large outbreak of yellow fever which occurred in scattered areas, early in November of 1986 and continued for several months thereafter (USAID 1997; Congress 1999). The most heavily affected states in the northern part of Nigeria were Kaduna and Sokoto, Anambra, Cross river and Imo in the south, while Benue and Niger states are in the middle belt (FMOH 2005; FMOI&NO 2005). The death tolls were in thousands. Fourteen million doses of vaccine were dispersed with international support before the outbreak was eventually brought under control (USAID 1997; Congress 1999).

In the 1980s, periodically, Lassa fever which is a highly contagious and virulent viral disease also appeared in various localities. This disease was first identified in 1969 in Lassa town in northeast Nigeria (USAID 1997; Congress 1999; FMOH 2005; FMOI&NO 2005). It is believed that rats and other rodents are reservoirs of the infective virus, and that transmission to humans by these vectors, occur through compost or food contamination of houses and in the immediate environs. This condition has no known treatment and mortality rates are quite high.

HIV/AIDS was officially confirmed in 1987 in Nigeria, considerably later than its emergence and extensive dispersion in much of Central and East Africa (USAID 1997; Congress 1999; FMOH 2005; FMOI&NO 2005). Nigeria's federal ministry of health, in

March 1987, proclaimed that tests of a pool of blood samples collected from high risk groups had turned up two laboratory confirmed cases of HIV/AIDS; both are of HIV Type-1 strains (FMOH 2005; FMOI&NO 2005). Subsequently, HIV Type-2 strains, a rather less virulent strain found primarily in West Africa was also established. The infection rate for either of the viruses in Nigeria was thought to be below 1% of the population in 1990 (USAID 1997; Congress 1999).

Less remarkable than the acute infectious diseases but frequently similarly destructive were a host of chronic diseases that were severe and prevalent but only seldom result in death. Malaria is the common of all these conditions, especially cerebral malaria, which is very fatal. Another endemic disease in most rural areas is caused by the guinea worm parasite, which is spread through ingestion of contaminated water, which leads to recurring illness and infrequently permanently crippling its victims (FMOH 2005; FMOI&NO 2005).

The World Health Organization (WHO) in 1987 estimated that, there were 3 million cases of guinea worm in Nigeria which is about 2% of the world total of 140 million cases seen (WHO 1987). Nigeria is ranked number one, in the world with the highest number of guinea worm cases reported. Work and school malingering is usually due to guinea worm and related complications (WHO 1987). Practical campaigns were put in place to eradicate the disease in all the affected states and local government areas, through education, provision of safe drinking water supplies to rural communities. The Nigerian government set out a very ambitious target of complete eradication by the end

of 1995, with enormous support from the Japan International Co-operation Agency (JICA), Global 2000, and several other international donor agencies (USAID 1997; Congress 1999).

Other water borne parasitic diseases schistosomiasis and onchocerciasis, were also found in different parts of Nigeria. Schistosomiasis arises from blood flukes, which employs freshwater snails as an intermediate host. The parasites invade humans when the larvae infiltrate the skin of individuals wading through a stream, lake or pond, in which the snails live. Often times, schistosomiasis results in chronic debilitating illness on rather than acute phase.

Onchocerciasis which is an infectious disease is caused by filarial worms, readily transmitted by small black flies, which characteristically live and breed near rapidly flowing water (USAID 1997; Congress 1999). The worms cause river blindness by damaging the eyes and optic nerve in young adulthood or later in life. The disease is endemic in some rural communities near the Volta River tributaries with about 20% of adults (30years and above) are blind as a result of the disease (FMOI&NO 2005). Most interventions have focused on a dual strategy of trying to eliminate the flies with insecticide sprays and treating infected patients. The middle belt of Nigeria which is a lowland savannah areas forms a safe haven to the flies, consequently the disease is most common in these parts of the country (USAID 1997; Congress 1999).

Applying the principles of Primary Health Care Approach of the Alma-Ata Declaration (WHO 1978) Nigeria has failed in the area of equitable distribution of health care, especially oral health and lack of use of appropriate technology in addressing its health care needs (Aderinokun 1999; Aderinokun 2005; Shehu 2005). Widespread corruption and human right abuses, insecurity, siphoning of public funds by the elected government officials has lead to negative influence on oral health especially in the provision of basic health care infrastructure. This is further worsened by incessant strike actions, by the oral health care personnel in the public sector. In most cases these strike actions are due to low salary and wages, with consequent crippling of the economy and dilapidation of the existing poor oral health facilities (Adams 1999; Aderinokun 1999; Aderinokun 2005; Shehu 2005). Another compounding factor is Nigeria's dependency on foreign consumables and non-consumables materials for the delivery of the oral health needs of the population (Aderinokun 1999; Aderinokun 2005; Shehu 2005). In the area of education and research in oral health, Nigeria has a poor oral health information system that does favour proper and adequate data collection for developmental purposes.

4.3. Basic Data on Oral Health

It is virtually impossible to make precise appraisal of the oral health status of Nigerians. This is largely due to un-coordinated system of collecting basic oral health data in the whole country (Adebola 2005; Aderinokun 2005; Shehu 2005). The best existing estimates were obtained from a few health care centres where such data were collected from institutional records, sample surveys and special studies. These limited Oral health

statistics show that in general the oral health status of the population is poor. As stated earlier the Nigerian oral health profile varies markedly with underlying factors being the key determinants of the present status. These include altered nutritional habits, child malnutrition or under nutrition with corresponding reduced immunity, generalised poverty and underdevelopment, alcohol consumption, increased cigarette smoking and use of tobacco products (Adams 1999; Adebola 2005; Aderinokun 2005). Cultural practices are mostly injurious to oral health and rarely affect oral health positively (Adebola 2005; Shehu 2005).

In a communiqué issued at the end of a meeting of key officers which took place in Jos, Plateau State, Nigeria on the 20th February, 2003 at the Regional centre for Oral Health Research and Training Initiative (RCORTI) for Africa. It was decided that the following oral diseases should be listed in the order of precedence for Nigeria, probably, due to their high prevalence or because of the severity of the destruction to normal tissues (morbidity), death as a result of the condition (mortality) (Adams 1999; Adebola 2005; Aderinokun 2005; FMOH 2005; FMOI&NO 2005). They are;

- Cancrum Oris (NOMA)
- Oral Manifestations of HIV/AIDS
- Oral Cancers
- Maxillofacial Trauma
- Dental Caries
- Periodontal diseases
- Fluorosis

Different studies at different times in various sections of the country were conducted, but the data presented are not reflective of the entire population rather it serves as an insight to what may be expected in a properly organised national survey.

Table 2: DMFT School children Edo state

Number of Students	Age in years	DMFT
87	**12**	**0.51**
63	**13**	**0.65**
80	**14**	**0.65**
128	**15**	**0.66**

Source: Oral Health and Preventive Dentistry **2**: 27 (Okeigbemen 2004)

In 2002 a study of DMFT was carried out on school children at Egor District in Edo state (Okeigbemen 2004) of 358 students from 8 different schools, 87 were 12year old, 63 were 13 year old, 80 were 14 year old and 128 were 15year old and the results are: 12year-0.51, 15 year- 0.66 while 12-15year -0.65(35% affected)

Table 3: DMFT/dmft Lagos and Ibadan 1990 – 91

Age in years	DMFT/dmft (% affected)
6	**0.1 (4.4)**
9	**0.4 (18.3)**
12	**0.7 (30.0)**
15	**1.3 (42.5)**

Source: Int. Dental J. **45**: 36 (Adegbembo 1995)

Table 4: DMFT Lagos and Ibadan 1990 – 91

Age in years	DMFT (% affected)
15 – 19	**1.5 (46.2)**
35 – 44	**2.5 (44.1)**
55 – 64	**3.6 (36.0)**
65 +	**8.8 (43.4)**

Source: Int. Dental J. **45**: 36 (Adegbembo 1995)

In 1990-91 the results were a bit different, 6year-0.1(4.4% affected),9year-0.4(18.3%), 12year-0.7(30%), 15year-1.3(42.5%), 15-19year-1.5(46.2%), 35-44year-2.5(44.1%), 55-64year-3.6(36%), 65+year-8.8(43.4%)(Adegbembo 1995) In the second study there is an obvious rise of DMFT with increasing age, these two studies are not conclusive for the country as there are no wide geographical spread.

Though smoking of been associated with oral health, it is a growing habit amongst the youth and in Nigeria a huge amount of money is spent on tobacco. A total of $12.3million in 1990(0.1% of all imports costs) spent on un-manufactured tobacco which was six times the amount in 1985" (CDC-TIPS 1990). Figures are expected to be higher with additional products smuggled in across the nation's boarder.

Table 5: Smoking pattern in Nigeria

Years	Annual averages (15 yr +)
1970 – 72	**290/year**
1980 – 82	**350/year**
1990 – 92	**370/year**

Source: www.who.int/countries/nga/en/

Table 6: Smoking prevalence in Nigeria

Age range (years)	Prevalence (%)
20 – 29	**7.7**
30 – 39	**3.9**
40 – 49	**13.1**
50+	**12.3**

Source: www.who.int/countries/nga/en/

WHO reported that "the annual averages per adult (15year+) of smoking are 1970-72: 290/year; 1980-82: 350/year; 1990-92: 370/year"also "Age patterns, the 1990 survey reported prevalence of smoking at least one pack of cigarettes/day as follows; age 20-29: 7.7% ; age 30-39: 13.9% ; age 40-49: 13.1% and age 50 and above: 12.3% (WHO 2006).

Oral cancers (Odontogenic tumours) in Nigeria using the WHO classification were reported from only 2 different teaching hospitals in Lagos (1971-1991) with a total of 257 tumours (Odukoya 1995) and Ibadan in Oyo State (1980-1994) of a total 125 tumuors (Arotiba 1997).

Table 7: Oral cancers Lagos & Ibadan (Nigeria)

Oral cancer	Number (%) Lagos	Number (%) Ibadan
Ameloblastoma:	**169(65.8%)**	**76(60.8%)**
Adenomatoid Odontogenic Tumuor	**18(7.0%)**	**16(12.8%)**
Calcifying epithelial odontogenic tumuor	**1(0.4%)**	**2(1.6%)**
Calcifying odontogenic cyst	**7(2.7%)**	**3(2.4%)**
Odontogenic Fibroma	**13(5.1%)**	**2(1.6%)**
Myxoma and Fibromyxoma	**34(13.2%)**	**21(16.8%)**
Ameloblastic odontoma	**2(0.8%)**	**1(0.8%)**
Odontogenic fibroma	**13(5.1%)**	**4(3.2%)**
Total	**257**	**125**

Source: Oral cancers Lagos & Ibadan (Nigeria) (Arotiba 1997; WHO 2006)

The teaching hospitals were the data were collated were the main referral centres for oral cancers in Nigeria. Figures in future may have a greater national representation with the recent establishment of more referral hospitals across the 6 geo-political zones of the country (Arotiba 1997). Currently there are 77 Universities and degree awarding institutions in Nigeria. Only four universities out of these 77 train dental professionals (JAMB 2006).

Table 8: Oral Health Professionals in Nigeria

Profession	Training institutions(No)	Registered practitioners
Dentist	**4**	**2,482**
Dental nurse (DSA)	**2**	**1,540**
Dental Therapist	**2**	**1,100**
Dental Technologist	**1**	**850**
Hygienist	**2**	**450**

Source: 2004 Oral Health Professionals in Nigeria

WHO country profile on Nigeria, shows that in 2004, 260 dentists (6 years training) graduated from 4 different universities located in the south-west of the country, others are; 2 schools for Therapists, 2 schools for Dental Nurses also called Dental Surgery Assistants (DSAs) and only 1 school for Dental Laboratory Technicians. This puts the total Dentists as 2,482 which come to 1: 45,183 that is the Number of Dentists/100,000. The next highest figure is the Chair side Assistants (Dental Surgery Assistants or DSAs) 1,540, Dental Therapist at 1,100, Denturists/Dental Technologists 850 and finally Hygienist 450.

Table 9: Dentist employment statistics (Nigeria)

Place of employment	Dentist number
Government/Public service	**1,900**
Private Practice	**950**
Military	**176**
Academia (University)	**100**

Source: Nigeria dentist employment statistics 2006

Total dentist distribution by sex, Male = 53%, Female = 47%

Majority of dentist are in the government services (1,900), with 950 in private practice, the lowest number are in the university that is 100 while the military has 176 practitioners. It is a male dominated profession; male 53% while female is 47% of the total dentist population (NDA 2005; WHO 2006).

In the contexts of early medical education in Nigeria, medicine has dominated dentistry from the onset, with contributory factors include, socio-political move, the felt needs of the country for fundamental health services during colonial rule, the predominance of medical schools, over only four accredited dental institutions in Nigeria and the overwhelming number of medical professionals over dental practitioners (Adams 1999; Aderinokun 1999; Akande 2000; Akande 2004). This in effect has contributed to the present poor oral state of the populace.

Medical doctors were among the privileged citizens of cities and town in different parts of the country and they participated in politics at all levels; the federal, state and local government. For example, Dr. Adekoyejo Majekodunmi, a medical practitioner, was appointed the first Administrator of Western Nigeria. He influenced and boosted the status of medical practice in Nigeria as against dentistry, right from the time he resumed work in Ibadan on May 31, 1962 (Adams 1999; Aderinokun 1999; Akande 2000; Akande 2004).

Table 10: Medical and Dental practitioners registered for the year 2000

Profession	Provisional registration	Full registration
Dental	**185**	**868**
Medical	**3040**	**12,868**

Source: Nigerian Medical & Dental Council Registration Board (NMDC; 2000: 97)

Table 11: Medical & Dental Practitioners with Provisional registration 1995 – 1999

Year	Medical	Dental
1995	**143**	**5**
1996	**110**	**2**
1997	**371**	**11**
1998	**887**	**44**
1999	**1103**	**89**

Source: Nigerian Medical & Dental Council Registration Board (NMDC; 2000: 97)

Table 12: Medical and Dental Practitioners with Full registration 1995 – 1999

Year	Medical	Dental
1995	**1,178**	**77**
1996	**484**	**24**
1997	**895**	**76**
1998	**701**	**46**
1999	**89**	**5**

Source: Nigerian Medical & Dental Council Registration Board (NMDC; 2000: 98)

Table 13: Expatriate registration for the period 1996 – 2000

	Medical	Medical	Dental	Dental
Year	**Provisional**	**Full**	**Provisional**	**Full**
1996	**8**	**-**	**1**	**-**
1997	**35**	**-**	**2**	**-**
1998	**30**	**-**	**-**	**-**
1999	**35**	**-**	**2**	**-**
2000	**-**	**112**	**-**	**6**

Source: Nigerian Medical & Dental Council Registration Board (NMDC; 2000: 98)

The comparative analysis of the registered medical and dental practitioners, Tables 10, 11, 12 and 13 shows that medical doctors outnumber dentists in Nigeria. This wide margin has a socio-political connotation, especially in formulation of health policies and

in terms of doctor-patient ratio in all the regions of the country. The Nigerian Medical and Dental Council (NMDC) register, 2000 edition (Table 10) illustrates the total number of registered medical and dental practitioners licensed to practice in Nigeria. However, a five year analysis (1995 – 1999) of the register, shown in Tables 11 and 12 illustrates the comparative figures of medical doctors and dentists who registered for the period under review. The expatriate quota for temporary registration for 5 year period (1996-2000) is shown in Table 13 (NMDC 2000).

Another point of note is that, dental clinics or hospitals are sparsely distributed in the country. The tendency is for auxiliary personnel to run ill equipped dental outfits in the local government areas, providing the bulk of all dental treatment. These auxiliary personnel are trained at the appropriate institutions and regulated by each professional board as concerns licensing and job specification. Their control in practice is often difficult as they operate outside their scope of training especially with the acute shortage of dentists in the country (Adams 1999; Aderinokun 1999; Akande 2004; Adebola 2005).

Auxiliary personnel get additional incentives from local government authorities and are therefore encouraged to serve in rural areas. The dental treatment needs of communities rest on auxiliary personnel, especially that few dentists have either gone the cities or left the shores of the country in search of greener pasture (Aderinokun 1999; Adebola 2005). The training of auxiliary personnel has been viewed as a means to an end in the present circumstance. This has been a very strong approach to oral health prevention in Nigeria as they form the bulk of care in rural communities. Training is targeted towards

prevention rather than curative treatment (Jeboda 1997; Adams 1999; Aderinokun 1999; Akande 2004; Adebola 2005; Aderinokun 2005).

Primarily, focusing on prevention, the training of dental auxiliary personnel is beneficial with a high graduate turn out in a short period. Community participation, the diversity of ethnic and cultural beliefs has made community involvement a problem of some sort, however, the involvement of indigenous personnel has markedly brought about an improvement on oral health perception and in its delivery (Jeboda 1997; Aderinokun 1999; Adebola 2005; Aderinokun 2005; Shehu 2005).

Long before the advent of modern medicine in Nigeria, 'Traditional Healers' have been offering both medical and dental services. They claim spiritual powers strong enough to cure any ailments, but recently, their existence has been relegated to remote areas (Jeboda 1997; Aderinokun 1999; Adebola 2005; Aderinokun 2005). The national health policy is advocating for a possible incorporation of traditional healers into the health care system after basic training and supervision, although this is still at an experimental stage (Jeboda 1997; Aderinokun 1999; Adebola 2005; Aderinokun 2005). There are problems of oral health in Nigeria, though a critical and well co-ordinated appraisal of the oral health system would reveal the lapses and possibly direct a positive course of action to improve the oral health system and the health sector as a whole. The praise singers for a better change have been non-governmental organisations that are gradually emerging in the health reform sector of Nigeria and other developing countries claiming to hold the key to the success of health in developing countries.

4.4. Oral Health and Non-Governmental Organisations

A Multi-sectoral Approach is one of the principles of Primary Health Care Approach of the Alma-Ata Declaration (WHO 1978). Its application to oral health in Nigeria is seriously threatened by the unstable political structure, multiple military interventions in the nations governing system and the introduction of martial laws. Overall a lack of respect for the constitution and a devaluation of the currency has been a serious deterrent to investment in oral health care, especially from the private sector (Aderinokun 1999; Shehu 2005). Lately, there is an increase support from Non-governmental Organisations (NGOs) in oral health activities with the aim of improving the oral health status of the populace. Sponsorship of programmes on curative as well as preventive dental diseases in Nigeria have been critically examined by these agencies and also to augment funding of oral health promotion by the federal government (Jeboda 1997; Aderinokun 1999; Shehu 2005).

Sustainable development in Nigeria is of interest for the developed world, especially the United States of America, because of the size and economic activity of its population and Nigeria's demonstrated and potential impact on the stability of the West African sub-region (Congress 1999). This is given additional burden by the political necessity of maintaining order in this foremost oil-producing country and commercial hub, whose wealth and population movements influence the whole region with a population growth rate of about 2.8% annually. This rate of increase threatens to undermine the economic

development and stability of the entire region. America also has major business interests in Nigeria (USAID 1997; Congress 1999).

Nigeria has been a military dictatorship for 30 of its 37 years, having momentarily experimented with democracy in 1979, 1983 and 1993 (USAID 1997; Congress 1999). For the first time in Nigeria's history, there would a change from one civilian government, to another civilian government on the 29th of May, 2007. The outgoing civilian government came into power in 1999 and was re-elected in 2003 for four year tenure, with the constitution making provision for a maximum of two terms of four year rule by a regime. The last military dictatorship attracted worldwide condemnation, for its disregard of the electoral will of its citizenry, as well as its record of human and civil rights abuses (USAID 1997; Congress 1999). The current regime has made little demonstrable progress to sustain the country's nascent democracy; security has been a paramount problem, with violent crisis engulfing the nation in the oil rich Niger Delta region and intermittent religious crisis occurring at different geo-political zones in the country.

Despite the instability in the polity, non-governmental organisations both local and international to function in the interest of giving better oral health (Akande 2000; Akande 2004; Shehu 2005). Medical and dental professionals branded themselves as disinterested scientists, who perform their duties not for self gain, but for the benefit of the public's health and well-being. Non-governmental organizations (NGO) like The Lords, Lions and Rotary International have granted financial aid to individuals and groups with chronic ailments like glaucoma, spinal cord injuries, sickle cell anaemia, tuberculosis, oral and maxillofacial cancers in support of their medical, dental or surgical

services. This prominence on dental, medical science and public service does a great deal to raise the medical and dental care profession's status in the eyes of the general public (Akande 2000; Akande 2004; Shehu 2005).

The country's conventionally energetic non-governmental sector, spearheaded by private mass media and beleaguered pro-democracy organizations, is the single most dissenting civil voice of Nigerians. The United States Agency for International Development (USAID) is an example of an NGO with community based programmes. It is the America's government agency providing non-military foreign aid in form of economic and humanitarian assistance globally for more than 40 years (USAID 1997; Congress 1999). The USAID-Nigeria's exclusively nongovernmental programme supports essential health care delivery to the deprived Nigerians. It also helps in the corroboration of civil society's involvement in democratic processes and respect for civil rights (USAID 1997; Congress 1999).

The nation's economy has been in a downward spiral for more than two decades. The per capita gross domestic product (GDP) has declined, originally, as high as $1,000 in the middle of 1980 to as low as $285 in 1998 (Congress 1999). In January, 1993, the inflation rate spiralled upward from 22% annually to 87% by the end of 1998 (Congress 1999). The consumer price index, initially fixed at 100 in 1985 rose to about 2000 in just 3 years (Congress 1999). Consequently, the Nation's social and health sector services worsened in the midst of the country's political crisis most especially following the 1993 election annulment by the military government then. The plight of Nigeria's women and children has worsened since that period. Maternal and child mortality rates are ranked the

highest in the world; malnutrition is now commonplace and immunization coverage has declined far below 30% (USAID 1997; Congress 1999; Akande 2000).

The NGOs aided community programmes of civil education, human rights awareness, alternative social and medical service delivery. Genuine Nigerian nongovernmental organizations (NGOs) are endeavouring to build the competence and self-confidence of Nigerian society, as well as providing social, medical services and necessary avenues of expression. They have become Nigeria's champion for catalyzing solutions to the country's national dilemma. The all-private-sector USAID-Nigeria partnership programme, while continuing to sustain basic health and child survival services, is now developing on its wide-ranging NGO partnerships to completely engage in the reinforcement of Nigeria's civil society role in democratic involvement and respect for civil and human rights (USAID 1997; Congress 1999; FMOH 2005; FMOI&NO 2005).

This agency and the donor society have catalyzed and are making headway on the ascendancy of the NGOs working at the community level in different part of Nigeria. Unlike in democratic system, the past military regimes and its supporters' lack of political resolve, to meet fundamental basic social needs created an exceptional prospect for NGO development. In Nigeria, the United States is the major bilateral partner in health and other services. The United Kingdom, European Community (EU), Israel and Germany all have programmes running concurrently in the country (FMOH 2005; FMOI&NO 2005).

The International Monetary Fund (IMF), Carter Centre (Global 2000), the United Nations agencies (UNICEF, UNDP and UNFPA), The World Bank, African Development Bank

(ADB) and the Ford Foundation are other foremost donors to non-governmental activities in Nigeria (USAID 1997; Congress 1999; Akande 2000; FMOH 2005; FMOI&NO 2005). Many donors have worked sporadically in social, health, democracy and governance programmes, but there is now a stated pledge for advancement. In this effort, the British, Canadians and the Ford Foundation are the country's real accepted partners (USAID 1997; Congress 1999; FMOH 2005; FMOI&NO 2005).

Chapter Five

Summary, Conclusion and Recommendation

5.1. Summary

From the beginning of this study to the end a number of issues have been discussed, globalisation policies as it relates to developing countries with reference to Nigeria which directly and indirectly influences the country's economic and financial polices which ultimately affects the health system, oral health inclusive. The challenge is how to make globalisation work for oral health and to use health to promote better forms of globalisation.

The situation of Nigeria today in a globalised world is such that, it is difficult to get oral health into the Nigeria's policy agenda due to the influence of the global institutions. Presently the oral health is low in Nigeria's policy issues.

The presences of multinational corporations in Nigeria have made the implementation of policy for oral health difficult. For example, the case of pharmaceutical industries having a major impact on funding for health services and sucking the complete budget away, not only this but the complex web of policy in the IMF and the WTO impacts directly on the available funds for oral health in the country.

Globalisation has impacted on Nigeria and developing countries largely through the

importation of various technologies consequently impacting on the improper training of dentists for export and secondly the technologies that are said to be for oral health here the toothbrush and tooth floss are said to be good examples

There is a replacement of indigenous cultural practices which is an appalling cultural impact due to penetration of high technologies for oral health in Nigeria. This is more or less a form of colonisation of what is good oral health. For example, the American smile is a good example of this, but so has the introduction of sweet consumer products where the rich are already ignoring the traditional Nigerian foods in favour of the foreign imports. In this way sweet and damaging foods are being introduced as a form of cultural colonisation and this will ultimately be bad for oral health

The history of sugar production and consumption world wide has impacted on the health of Nigerians in the past through the slave trade and more recently through the inferior position of Nigeria as a commodity producing country in this respect oral health IS A GLOBAL PHENOMEMON in other words the poor oral health of more Developed Nations has been purchased at the expense of the freedom of those working in poor conditions in the developing countries, there is a web of dependencies behind patterns of oral health in the west that is rarely the subject of discussion in dental public health.

5.2. Conclusion

This study has further fortified the understanding of globalisation as it relates to oral health issues, foreign and domestic influences on oral health in Nigeria, the citizens liking for so called modern delights with less regards to identity and culture. The globalisation and oral health challenge is not just about technology, neither is it just about supply and demand, getting markets right, although both will play a role. Oral health as highlighted is related to diet in many ways through nutritional influences on the peoples' well being. Attention has been drawn to soft drinks consumption, Coca Cola in particular and its encroachment to the overall oral health profile of Nigerians, its political and economic influences on the people's way of life.

Presently, the extent and nature of foreign policy attention devoted to health generally is historically outstanding. In globalisation, the problem of the obvious increased attention is whether this new political revolution reflects a transformation of oral health for the benefit of foreign policy or an alteration of foreign policy for the benefit of oral health. Although it can be said that globalisation could transform how we think of oral health and that oral health does not necessarily alter how we think about globalisation.

Inherent in the idea of making globalisation work is the debate that it is not working at the moment, though some may argue that this is not the case: the global economy is expanding, life expectancy continues to rise in the developed regions, and there are new discoveries and innovations in science which is proceeding apparently in an exponential rates thereby opening new frontiers to increased wealth, better oral health and happiness

in general. Nevertheless, as never before, there is increasing awareness of the consequences of our growing interaction in the 'Global village' and while a greater proportion of the globe reap the profits from globalisation; millions are yet to experience the positive story and are totally cut off from the process. Presumably, 90% of the world's population are barely benefiting from oral health research as less than 10% of health research is directed towards the major health problems that affect them.

Oral Health has a central role to play in meeting the challenge of making globalisation work especially in Nigeria which is a developing country. The danger is oral health would become a private good or commodity which is exclusive and rarely affordable as well as the preserve of only the rich, and as a matter only of Nigeria's national interest.

5.3. Recommendations

Nigeria and other developing countries probably have more to learn and gain from each other than they could benefit from the developed worlds that are long established. It is obvious that there is much trade policy capacity building to do in Nigeria especially with the low level of developments, inadequate political and administrative resources. The faults of globalisation in relationship to oral health in Nigeria must be addressed, not just for reasons of common humanity but for the basic reason that the negative aspects of economic globalisation may in time be a threat to the foundation of globalisation.

How Nigeria decides to approach globalisation must be determined by its most urgent goals, accelerating development and economic growth, addressing oral health issues with possible eradication of poverty, which is not only widespread but deep and severe in some parts of the country. Oral health and general health are paramount to Nigeria's economic and human development though poverty remains Nigeria's most pressing problem and economic growth is the bedrock of poverty reduction. Thus, Nigeria needs to attain, as quickly as possible, growth that is both rapid and sustainable.

Globalisation will not solve all of Nigeria's health and economic problems if anything it presents multiple threats. Absorption with the global economy is necessary but not a sufficient condition for growth though Nigeria could maximise the benefits of globalisation form integrating. Globalisation is not the magic potion! But sustainable growth, better oral health for all and poverty reduction depend on other factors as well, this include a responsible transparent government institutions, a reliable and trusted legal systems, accountability and macroeconomic stability a high investment to GDP ratio. The developments of the civil service, a sound banking system are all critical in this era of globalization.

Nigeria must also fix its growth prospects in the development of human capital, physical infrastructure, oral health and general health facilities, strong academic and research institutions. It must promote the growth of the private sector and the macroeconomic environment essential for the private sector to be workable. Nigeria must re-orientate its

policy to become competitive and capable of endeavouring into new areas in other to benefit from the global economy at large.

Given Nigeria's differences in education, infrastructure development, and macroeconomic stability in comparison to other African countries, the benefits of globalization are not likely to be the same for all. Nigeria can learn a lot from other country's development strategy, for example, by attaching importance to education, research, technology and an export oriented strategy. This would bring about decrease in the incidence of poverty and better oral health for all.

The importance of extending the appreciation of oral health issues amongst policy makers cannot be overemphasised. There should be initiatives in Nigeria to bring together diverse members of policy to discuss global challenges. Nevertheless, it is not just a matter for politicians, although they must of course play their part. This is basically a challenge to our ability to work together at all levels in the Nigerian communities as a whole that affect and are affected by these issues.

The places we live, political communities and nations, across different countries in the West African sub-region, Africa and the rest of the world in the establishment of global governance. By mobilising the key actors we can begin to fulfil the promises of oral health as bridge for human, global and peaceful interactions and then Nigeria can then reap the global benefits that this will bring.

Suggested further studies should include:

1. A study on the relationship between globalisation and critical health policies
2. Oral health and the emergence of aid policies
3. A comparative study on global oral health and Nigerian oral health policies
4. A critical study on the improvement of oral health in Nigeria in the 21st century the role of the WHO Global Oral Health Programme

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