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Bailing Out Collapsing Social Infrastructure in Developing Countries Through Sports: How Football is Contributing to Healthcare Improvement in Urban Nigeria

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Although the role of sports in shaping/changing urban and regional landscapes through megalomaniac building of stadia, golf courses, among other spectacular artifacts have recently attracted tremendous academic research interests, sports' role in improving collapsing health-care infrastructure in developing countries is poorly documented. Here, we show the potentials of football in multi-stakeholder mobilization for financing/ improving/ in urban health-care Nigeria using contributions towards heart diseases treatment by Kanu Heart Foundation and campaigns by Nigeria's international footballers. Geo-demographic analysis of secondary data is applied to highlight inadequacy of healthcare in urban Cross River State, like of urban (like rural) Nigeria. How various diplomacy concepts could be employed by urban managements to mobilize sports-heroes, stakeholders (professionals: players, managers, clubs; civil society, etc) for fund-raising towards improving healthcare in Nigeria is described. The policy implication of this paper includes employing multi-dimensional diplomacy for managing multi-stakeholder urban sports and health development programmes as a means of surmounting the problem of inadequate funding for urban health

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development in Cross River State, Nigeria. Although this article focuses on Nigeria, its description of health-care deficits and findings speak for much of sub-Saharan Africa and developing countries.

Keywords: football, urban health, improvement, diplomacy, governance, stakeholders

Introduction

Within the past 50 years, developing countries (DCs) including those in sub-Saharan Africa, most of which emerged from traumatic colonial rule have increasingly experienced rapid urbanization coupled with expansion of sports infrastructure (such as stadia, hosting of sports events that frequently attract several thousands to millions of visitors to particular cities. More recently, within the past two decades, incomes earned by sports people (athletes, footballers and so forth) and hosts of sports events have increased substantially. In developing countries, these processes of rapid urbanization and expansion of sports infrastructure, frequency of sports events (festivals, and so forth) have occurred within a urban systems that present poor health infrastructure and services. Although the understanding of these issues involving paradoxical occurrence of failure in urban health management systems in developing countries under the context of increasing fortunes or expansion of sports infrastructure and earnings by sports people (competitors, businesses and their operators, and so forth) is crucial for achieving sustainable urban development in DCs, knowledge of their nature, magnitude and characteristics has lagged behind their seeming frequency and conspicuousness in DCs. While the contribution of sports to multiple sectors (socio-cultural, economic, political, physical environmental among other aspects) of the city is being increasingly acknowledged as constituting issues that warrant interdisciplinary and trans-disciplinary academic research in the global North, academic research on the inter-relationships between sports events and the development of urban services (e.g. health systems) in DCs remains underrepresented and scanty.

The academic literature describes the way organization of sports since the end of the Second World War has undergone tremendous commodification, mediatisation, and transnationalisation such that the sports started reflecting features of a central component of popular culture on a global scale. Some Sociologists are increasingly advocating for: analyses of the global society to revolve around sports and also the use of sports as an instrument for universalizing (i.e. spreading) norms of social justice and democratization globally. The latter

suggests that recent intellectual exploration of the role of sports in popular global culture within sociology should be extended or exceeded. The various (political, economic and environmental) aspects of sports are also being explored in addition to the sociological.

Connected to the foregoing logic, scholars have through active publication placed one of the sports (football) in the academic mainstream and demonstrated how this game is promoting the norms of democratization and social justice and (i.e. globalization) as well as provide an instrument for analyzing and understanding the global society and its culture. One of the features of the spectacular and rapid expansion of football at the level of nation-states is the employment of neo-mercantilism (policies of self-protection and self-aggrandisement created and applied by nation-states since the end of the Second World War to the present) for operating national football associations and national league systems and frequently complemented by other policies of nation-states.

Academic research and publications on other sports other than football is also expanding. Reports on impacts of Sports Mega-Events (describing sports shows and festivals that attract several millions of participants: sports people, sports administrators, business people, spectators, journalists and other people who usually throng and congest host cities of big global sports events such as the Olympic Games, Football World Cup, Commonwealth Games and similar events) in the global North have been documented. Although some of these argue that the elite (a minority of shrewd business men who also influence public opinion) placed themselves strategically to (and did) appropriate most of the profit that accrued from the sports mega-events (Montreal Olympics in Canada and the two others: Japanese component of the 2003 Football World Cup that was co-hosted with South Korea and the Winter Olympics, Japan), Whitson and Horne acknowledge that immense benefits accruing from them have also benefited host cities of these mega events in terms of economic, socio-cultural, political and physical built environmental among other sectors. Some contributors to this debate reported that the poorer strata of the residents of those host cities were compelled to bear financial burdens of the events afterwards (Whitson, and Horne, 2006; Spaaij, 2000, 703-5; Giulianotti, and Robertson, 2009).

However, the issue of appropriation of city resources generally (including profit arising from sports mega-events) by the urban elite is not new to urban development studies including their geographic, sociological, economic and political aspects. Urban geographers and sociologists have explored the nature of social justice in the city long concluded that the city of the industrial capitalism era is the product of capitalist. Consequently, urban processes (including sports

events among others) have almost always been organized and managed in ways that profit the elite and bear no or little benefits to the majority of the residents of the city. It was suggested that revolutionary practice was required to change that variety of urbanisation that benefits only the elite to one that humanizes the city by creating benefits for all residents (Harvey, 1973, 314). Recent agreement with Harvey's analysis occurs in the suggestion that the near simultaneity and temporal coincidence in the origin of modern global sports events (i.e. renewal of the Olympics in 1894 and holding of the first Football World Cup in 1930) with the emergence of modern capitalism perhaps made sports mega-events to be controlled by capitalists (Horne, and Manzenreiter, 2006, 5). The expression of enormous passion in sports events and the way it drives urban managers into irrationally invest huge sums of public money into development of sports and related infrastructure required for hosting the sports mega-events has been documented. It has been observed that the stakes in this regard have been increasing due to competition among contenders for winning hosting rights for such global events especially in the United States of America, whose numerous cities have been (and have almost always been) contesting to host the Olympics (Schimmel, 2006). Wolfran Manzenreiter further described the passion exhibited by the Japanese during the 2003 Japan-Korea FIFA Football World Cup. The Japanese showed their passion by wearing uniforms, painting the face of people, using gadgets, and taking advantage of the anonymity of operating in the large crowds of spectators to voice opinions that were usually restricted and not spoken as a means of enjoying liberty from usual politico-legal restrictions (Manzenreiter, 2006).

Maurice Roche highlights crucial impacts of sports mega-events on the city in terms of economic, demographic, and cultural and architectural aspects. Owing to spectacular advancement of information and communication technologies, it has become possible to broadcast activities in such events in real time to the global audiences thereby increasing their commercial, economic, political and cultural interests (Roche, 2006). Other academic research is showing that sustainable urban development could be achieved through the institution of football clubs and/or teams. It is argued by these researchers that apart from simply being a sporting organization, football clubs and teams drive the economy and the society and promote local development. In this connection, Vlad Roşca recently proposed strategies have been proposed on how to promote investments in football clubs could be undertaken as a means of achieving sustainable development in terms of the economic, social and environmental sectors of the local city region (Roşca, 2010). Despite the way the foregoing analysis provides a useful background for understanding the way sports generally and sports mega events affect social (in)justice in Third World city, the analysis has not yet received the attention it deserves. However, scholars have provided

some insights into the issues in Third World urban centres. For example, the prevalence of "criminalization" of the economic activities of the poorer people residing in or sectors of human settlements and the way public policy controlled by the elite cause city sectors inhabited by the poor in developing countries to be fundamentally deficient by being compelled to find unsuitable spaces such as areas of steep elevation, and deprivation of basic housing and urban infrastructure (paved and surfaced roads) and services (health facilities, safe or improved water and sanitation, modern electricity, and so forth) have been documented. It has been shown that the criminalization of such city sectors by the elite has taken the form of declaration of operational spaces of the urban poor as "illegal" or outside the tolerable levels of the laws of the city thereby making them to "qualify" for constant and regular harassment by state agencies and which apply their instruments of violence to massively and viciously demolish such structures (Sen, 2007, 51-68; Sen, 1984, 51-68; Hardoy, and Satherthwaite, 1989). The fundamental defects in most city sectors occupied by the poor makes them most vulnerable to environmental degradation, opening them up to hazards and disasters such as flooding and the spread of virulent diseases associated with improper disposal of human wastes. Cities such as Lagos mega city in Nigeria, and its counterparts elsewhere in sub-Saharan Africa: Accra (Ghana) and South African cities have been cited as examples of this phenomenon (Bull-Kamanga et al. 2003).

The Problem

Football has been and is increasingly becoming a game that is followed passionately by billions of people around the world. Stadia and activities that associated with football have become ubiquitous features of the urban areas and this rapidly urbanizing age. Football is a money-spinning phenomenon of repute: with the sign-up fees of some individual professional footballers dwarfing annual budgets of urban managements in developing countries. Despite the expansion of national football systems through neo-mercantilism the potential of the game, its professionals, processes and institutions to contribute to the development of other social institutions (such as the healthcare systems at national and/or local-regional levels) is under-researched and poorly understood. Specifically, the way individual professional footballers of sub-Saharan African extraction have perceived and responded to the failure of public healthcare systems is under-researched and poorly understood. The revenue-generation potential of football and footballers is yet to be appreciated by managements of beleaguered urban centres in Sub-Saharan Africa (SSA), where socio-economic and environmental conditions are poorer than elsewhere in the world. Some associated problems include the fact that funds generated from football have been restrictively been applied to the development of stadia and related physical infrastructure but left

out urban health infrastructure and services in developing countries-where these have historically been grossly inadequate. Moreover, urban managements in Africa have tended to remain restricted to conventional and traditional models of revenue generation such as financial hands-out from central governments and rather weak internally (locally) generated revenue e.g. taxes on property, services and so forth. Additionally, urban sub-Saharan Africa, characteristically afflicted with urbanization of poverty, has failed to harness the money-spinning influence of footballers (and football) to transform and improve weak health infrastructure and systems in the region. What models exist that are capable of enlightening urban managements on how to harness the revenue-generating potentials of footballers and football? What models and concepts exist that could be adapted to accomplish the use of footballers and football as a source of funding of urban health improvement programmes?

Focus and organization of this paper. This article strives to address some of the foregoing issues that are as less revolutionary as proposed by David Harvey. This is not because the proposed revolutionary practice is not important but due to the need to undertake such work separately from the present article. Although the basic arguments of the paper could be applied to most sports, we focus on football because of the increasing involvement of footballers in founding and management of charities. Specifically, we case study the Kanu Heart Foundation resulting from the increasing popularity of, and benefits arising from, football in Nigeria.

The rest of the paper is organized into sections. We show a background on the poor health indicators in Nigeria, present the concept of diplomacy and its versatile applications in disaster management and other purposes and how it promises capability of enlightening the discussion of the use of football's passion and revenue generation for urban health improvement. Later we analyse the contribution to urban-related health improvement in Nigeria by one of Africa's most decorated and successful footballers: Nwankwo Kanu. Then we present and discuss findings of a case study of poor urban health in Calabar, capital of Cross River State, Nigeria, conclude the paper and make recommendations for health-care improvement in urban Nigeria.

Methods and Data

We used the method of case study and survey. Secondary data were used in describing the use of football talent and passion for health improvement in Nigeria by the Kanu Heart Foundation, and to describe the level of development of football in Calabar, the capital city of Cross River State, southeastern Nigeria. While geodemographic analysis of secondary data was undertaken to analyse

the health-care scenario in Cross River State, including Calabar-where the U.J. Esuene Stadium has hosted football activities since the 1970s. Specifically, the secondary data used here were obtained from reliable sources (popular literature and official records of government agencies. To accomplish the geodemographic analysis of health-care in Calabar city and Cross River State, we extracted and used data from the 2007 Federal Republic of Nigeria's Directory of Health Establishments in Nigeria, published by the Abuja-based National Bureau of Statistics (NBS). To describe other aspects of Cross River State, we obtained data from the Cross River State Government-managed Economic Empowerment and Development Strategy, popularly described by the acronym: CR-SEEDS (I) 2005-2007 and CR-SEED (II) 2009-2012 [State Planning Commission (SPC) 2005, SPC 2008, Government of Cross River State's CR-SEEDS-2, 2009, Schimmel, 2006]. The application of geo-demographic analysis techniques involves geo-computing of geo-spatial distribution of phenomena and features over space and their constituent human population sizes and/or (population) characteristics including its founding (basic principles of Euclidean space and multi-dimensional representation of the phenomena and features have been amply described in the scientific literature (Ingwe, Otu, Agi, Eja, and Ukwayi, 2008) and does not bear repetition here. It suffices to state that the application of geodemography in this study involved geo-computation of per capita shares of healthcare infrastructure/professionals for the populations of the study area (Calabar Municipality and South Local Government Areas), two the 18 Local Government Areas forming Cross River State. This method is being increasing applied in various studies.

Relating Diplomacy to Resource Management and Resolution of Development Problems

The term diplomacy has traditionally been restrictively used to denote peaceful deployment of relations as one of the most important means of foreign policy for determining, and strengthening peaceful international relations among political entities, mainly sovereign states. It is regarded as a veritable instrument for maintaining peaceful relations among various countries: therefore, wars result when it is inadequately conducted and provides a last resort after the hostilities of war and conflict. It has been suggested that the level of political development determines the kind of diplomacy that emerges in the particular country. Effective diplomacy (sometimes culminating in war between states) refers to one that achieves the desired objectives through the application of a minimum of resources and commitments. On the contrary, inefficient diplomacy describes the failure to accomplish objectives after expending more resources and commitments. The origin of diplomacy has been traced to the 1648 Treaty of Westphalia by European states, whose membership and adopters

later increased to involve other states and evolution and refinement of the principles, procedure and practice of the strategy. A major aspect of this strategy is the appointment and designation of diplomats (ambassadors), constitution of embassies and consulates including diplomatic staff and plenipotentiaries. Some key aspects that are considered to be essential for effective diplomatic operations usually involves measures aimed at creating conducive environment (an attempt to recreate the diplomats' home scenario in the foreign country) for healthy work and living of foreign diplomats by the host-country. These include the granting by the host-country of some far-reaching legal and political privileges that are enforced by security agents (e.g. exemptions from (or immunity to) the scrutiny, harassment, and conformity to ceremonial protocols). Some of the numerous objectives, central points and instruments for conducting diplomacy are: economy, culture, science and technology, sports, among others.

Diplomacy and its multidimensional applications. Various forms of diplomacy have been defined and classified to include those that could be employed to various degrees of directness and immediacy, with adaptations, to different socio-economic, environmental development situations. To adapt diplomacy for harnessing potentials in football specifically and sports in general, it is necessary to examine its various kinds or systems immediately. Several kinds of diplomacy have been distinguished as follows: ping pong, shuttle, gun-boat, preventive, dollar, conference, secret, summit, parliamentary. Ping pong diplomacy (so named in Chinese language after the game of table tennis). This refers to the conduct of diplomacy in ways that resemble the game of table tennis. This was characteristic of the early stages of diplomacy the Sino-American rapprochement in the 1970s.

Shuttle diplomacy refers to one that is characterized by frequent travel by one country's diplomat(s) to execute peaceful relations with countries with which it has particular interests (i.e. within the above list of objectives or central points). While it is possible that it could be applicable to the wide range of objectives listed, it has been used specifically to denote the pursuit of peaceful settlement of dispute between nation states. The example of shuttles undertaken by the former Secretary of State of the United State of America: Henry Kissinger (b. 1923) aimed at resolving the Arab-Israeli question under the regime of President Richard Nixon (1913-1994) is believed to have raised this form of diplomacy to world attention. Gun-boat diplomacy refers to the resort to military might and operation(s) as a strategy of compelling (through intimidation by showing off potentials of military superiority either as threats and/or actual application of unilateral force) a weaker country to acquiesce in a dispute between two or more nations involved in disagreement. Preventive diplomacy describes one that (is similar to gun-boat) by involving harmful application of unilateral military

force as a means of causing another country in conflict with its user to end its "aggressive" stance. The aim of resorting to it is usually to cause fear in the victim state by exhibiting harbingers of further debilitating military action thereby preventing further attempts and plans by the victimized state to pursue military campaign.

Dollar diplomacy refers to the type that has been associated with the USA's use of financial and material resources to subdue less prosperous and affluent countries thereby purchasing their political support and allegiance and furthering the USA's foreign policy or achieve its immediate political outcomes. Conference diplomacy describes the common practice in the 20th century of assembling protagonists of international conflict at conference(s) that are facilitated by mediators or intermediaries, as a strategy of ending hostilities. Secret diplomacy describes the employment (or execution) of malevolent and hidden agenda that are not favourable to third parties. Summit diplomacy refers to assemblage of heads of state and governments to discuss issues of interest to their respective governments or countries. Parliamentary diplomacy describes the use of parliamentary methods and principles (e.g. voting in a conference-type environment and so forth) to contrive desired results by manipulative organization of event(s) (Igwe, 2005).

Diplomacy in Disaster Management. The works of Ilan Kelman and J.C. Gaillard have shown how diplomacy has been (could be) applied in managing environmental disaster by national governments and their agencies, ministries and departments (Kelman, 2007; Kelman, 2008, 40-6; Kelman, 2008, 1-2; Kelman & Gaillard, 2008). Very specifically, Kelman advocates for the use of diplomacy for improving the current dismal state of the art of disaster management by providing opportunities in form of legal and political frameworks designed for national disaster management to anticipate, solicit, receive, and use donations from foreign nations to assist existing national disaster management systems during disasters. While disaster diplomacy presents huge potentials for improving disaster management, Kelman argues that it has remained largely under-utilised. He cites the example of the failure of the US Government under president George W. Bush to harness the opportunity for leveraging the US' response to the recent disaster: Hurricane Katrina, which devastated several states of the USA especially the State of New Orleans (Kelman, 2008, 40-6; Kelman, 2008a, 1-2; Kelman, 2008, 2008b, 1-2).

The conceptualization of diplomacy in disaster management is significant by demonstrating its versatility and amenability to transcend sectoral boundaries such as from those presented here (Igwe, 2005) including sports to the specialized sector of disaster management, which is his major concern. By pioneering this

versatile adaptation of diplomacy, Kelman confirms our current undertaking to also adapt diplomacy for application in football: a component of sports associated with hazards and disasters, which is included in the list provided (Igwe, 2005). It is important to accomplish our desired objectives by adapting principles and methods of diplomacy to make it capable of transforming specific institutions, structures, processes, and attitudes (Todaro and Smith, 2005) of the sectors concerned: football, sports and health in the case of this article, under the context of the urban region. The foregoing elaboration of diplomacy has been restricted to its application at the level of national systems i.e. nation states or countries thus making such use of the concept to take the character of Fordism. The focus of this article on sub-national politico-economic setting (i.e. urban centres, be they municipalities, towns, mega-city, or community etc) beckons for the adaptation of diplomacy to fit the commensurate sub-national setting in order to make it useful and relevant. This need beckons for the deployment and elaboration of a corresponding concept to serve the purpose of conjunction or linkage. Therefore, we resort to the concept of Post-Fordism in order to accomplish this task.

Post-Fordism as a means of linking Diplomacy to management of urban centres. Although the transformation of diplomacy from its strictly Fordist sense for fostering relationship among sovereign states (countries) is yet to be stressed, the increasing employment of diplomacy in Post-Fordist context (i.e. among sub-national socio-economic and political entities (e.g. provinces, states, local councils, municipalities and so forth) is yet to be adequately stressed in the development literature, evidence of employment of diplomacy by sub-national entities seems to be profuse. Several scholars have contributed to the literature on Fordism and Post-Fordism. The appreciation of Post-Fordism requires an understanding of Fordism, the preceding economic system. Peter Burnham traced the formal academic use of the term (Fordism) to the work of Antonio Gramsci, a Sardinian Marxist who was raised the term to high visibility in the 1930s. Gramsci used the term to conceptualise the evolution of a distinct stage of capitalism through the adoption of mobile assembly lines and product standardization techniques that characterized industrial manufacturing systems and the associated social relations of production in the USA under the leadership and influence of Henry Ford. These techniques have also been described as Taylorism (to denote and remember the work of their leading American exponent in the early 20th Century. In the 1980s, Fordism was used to refer to a regime of accumulation which was perceived to have characterized western Europe to different levels in from 1945 to 1973. some features of this era include the linking of mass production to mass consumption, involvement of trade unions in a tripartite negotiation system with capital and the state, the strengthening and promotion of a welfare state through social and political

agreements, the creation of government that is dedicated to full employment, leading to policies focused on Keynesian demand management, and the Bretton Woods agreements, which are regulated by international economic relations. Post-Fordism which emerged in the 1980s (as a successor to Fordism) is a production system that is characterized by management strategies designed to match the transient situations that are dynamic, the appeal of monetarist philosophies to governments, flexible specialization, manufacturing in smaller batches contrasted to previous production of large quantities, matched by niche consumption by special segmented population strata (Burnham in: McLean & McMillan, 2003).

Poor Health Indicators in Nigeria: Justifying the Search for Alternative (Non-Government) Funding of Health-Care in Nigeria

Developing countries have been frequently described as places where Hobbessian life is "shortest, nastiest, and most brutish'. Diseases frequently contribute directly towards making human lives shorter and brutish. While brutishness also contributes to ill-health, it mostly results from the sheer bestiality of human beings on their own kind in a manner that places animals considered to be at a lower level of existence than Man at a higher pedestal of civilization. The high incidence of diseases and health problems in developing nations has been profusely documented in several sources including the Human Development Index (HDI) published by the United Nations Development Programme (UNDP) among others. The belief that urban centres contribute to economic development has also been profusely documented (Mabogunje, 1973; World Bank [WB], 2009). Sadly ever since it was discovered that urbanization in the developing world has been much more associated and accompanied by poverty in what has become derisively known as the urbanization of poverty, the effort to formulate and invent social and technological solutions in ways that would facilitate the reversal of urbanization nature in developing world from promoting pauperization to creation of prosperity has been generally poor.

Specifically, while it has been well known that health creates more productive people, and by extension that a healthy urban population is bound to be more productive than an unhealthy one that is hampered by diseases, innovations designed to promote urban health have remained rudimentary in developing nations. A large proportion of the residents of urban Nigeria (about 57.3 million people) have been consigned to life in slums or "illegal" settlements in Nigeria. These are people who are likely to be directly or indirectly involved in the informal economy, which are not covered by public spending on healthcare. The urban problems described above are almost ubiquitously distributed to the nation's primate mega city (Lagos) and thousands of urban areas in the country.

Some of the environmental problems such as flooding and related hazards and disasters are most intense in urban centres located around the nation's vast coastal areas that are known for attracting huge population through natural increase and migration.

Nigeria's population rose from over 140 million in 2006 to 161 million in 2011 (National Population Commission 1991, BussinessDay, 2011, Vanguard 2011). Based on surveys undertaken in the late 1990s, about 70% to 90.8 percent of Nigeria's population was classified as poor-unable to earn and spend US$1 per day and US$2 per day. Healthcare expenditure per capita (in international US Dollars) in two dimensions (total spending and government spending) for Nigeria and the rest of Sub-Saharan Africa. Although Nigeria possessed the second largest total gross domestic product in Sub-Saharan Africa in 2002, the country was one of those with the least (37th position overall) per capita government spending on health care in the rather poor region. While South Africa's government per capita spending of US $270 on health care was the largest (i.e. corresponding to her first position on the size of her total and per capita GDPs, Nigeria's performance on this human capital building activity was surpassed by Botswana and about 35 other Sub-Saharan African nations. The consequences of these low spending on health care was betrayed by the poor health indicators of Nigerians. The "life expectancy at birth" was: 48.1 and 51.5 years for the five-year periods between 1980-1985 and 2000-2005 (World Resources Institute (WRI), United Nations Development Programme (UNDP), United Nations Environment Programme (UNEP), and World Bank,. 2005). The number of physicians per 100,000 of the population in Nigeria between 1995 and 2003 was only 27 (compared to a regional average of 516 and 348 physicians per 100,000 people respectively in North America and Europe. The percent of the population using improved water source in 2002 were 49 percent for rural areas and 72 percent for urban areas. The percent of the population using improved sanitation in 2002 were: 30 percent for rural areas and 48 percent for urban areas. The percentage of adults aged 15-49 years living with HIV or AIDS in 2003 was 5.4 (%) representing a change since 2001 of 6.5. The percentage rate of use of anti-retroviral therapy (ART) between 2002-2003 was: (1.5) while the incidence rate of Tuberculosis per 100,000 population in 2002 was: 305 (WRI, UNDP, UNEP, and World Bank, 2003; WRI, UNDP, UNEP, and World Bank, 2005). Considering the rather poor health care indicators presented above, it is necessary to seek alternative sources of funding to improve the situation in Nigeria.

Inadequacy of health facilities in Nigeria. Despite being Africa's most populous nation with over 151.3 million people in 2009 (WB, 2009), about 70-90 percent of poor Nigerians resort to rely on and contest for the use inadequate number

of available health facilities. Although Nigeria earns large revenue annually from exporting crude oil and gas since the 1960s to the present, human capital development including health care remains underdeveloped due to corrupt embezzlement and stealing of about 80 per cent of the nation's earnings by the elite (Ribadu, 2009; Omojola, 2007). In 2004, the entire country had a total number of 13,951 publicly owned (health facilities). Out of this total, the various types were: 13,703 primary health centres (PHC), 845 secondary, 59 tertiary. In the same year (2004), Nigeria had a total of 9,029 privately owned health facilities of the following types: 6,575 PHCs, 2458 secondary and one tertiary type. The specialization of health facilities in Nigeria in various fields of medicine and health care were as follows: 571 general, one pediatrician, 3356 maternities, 47 infectious diseases, four orthopaedic, 16 neoro-psychiatric, 11 tuberculosis, and 10 ophthalmic (Nigeria, Federal Republic of. 2006, 90-91). The high level of unemployment in urban Nigeria has reportedly been prolonged: have been ignored since Nigeria's independence in 1960 i.e. nearly half a century ago. The literature shows that the problem was observed in the late 1960s when management problems of rapid urbanisation in Nigeria attracted the attention of policy makers (Adedeji & Rowlands, 1973). Unemployment and underemployment have increased since then up to the present (Ingwe, 2009). This indicates that this (and related) problems revolve around the failure of public economic planners to harness the country's greatest assets for development, which is human power arising from its large youthful population (Ayida & Onitiri, 1971). More recent reports indicate that increasing unemployment of the youth in urban Nigeria has resulted in the victims resort to crime, violence and social vices (prostitution). The problem has been described as increasing and uncontrolled by the public and private sectors of the economy. The intensification of unemployment is attributed to the obsolescence of Nigeria's private sector while the informal sector has become the resort of the embattled youth (Da Borges, Adubra, Medupin, & Okunola, 2003). Yet the informal sector has suffered due to the way public agencies declare it "illegal" and criminalize those involved in it.

Figure 1: Nigeria (shaded portion) embedded in Africa

The passion, fashion and compassion: Global Football craze and poor health in Nigerian cities. Football has become one of the most passionately and massively followed sports by majority of people in modern times around the world. This has been facilitated by urban managements which seem to be driven by passion for football to adopt the fashion of funding the development of stadia, and making them to attain the standard approved to host fiestas and tournaments by organizations responsible for managing football at national and international levels (e.g. national football federations and the international federation of football associations (FIFA). Football management in collaboration with urban managements around the world striving for standards involve serious efforts to improve urban health institutions, processes, structures and attitudes for approval by similar national and international health organizations e.g. World Health Organisation (WHO) and national health ministries. Football has become well known for its money spinning power represented recently by the record-breaking sign-up fees of 80 million Pounds Sterling for the sale of the

Portuguese international and professional club footballer (Christiano Ronaldo) by the English (Football) Club (Manchester United) to Real Madrid football club in Spain in 2009.

Academic interest in the impact of transfer fees in sports concentrating on the high fees in football [Feess and Muehlheusser 2003, Soccer Lens/ Transfer Fees Records. 2010]. It is yet to be shown how this impacts on urban development. So far, the huge pay, standard health and other facilities have served only the interests of footballers and their managers. The provision of these good things for footballers and their associates seems to be without compassion for their teeming population of followers. Excluded are the rest of urban residents who have to eke out livelihoods and healthcare elsewhere: conventional avenues. This equation may not pose serious problems in the North, where healthcare has been developed considerably. The weak health care systems prevailing in sub-Saharan Africa makes a case that the wealth deriving from football and investment of funds to develop the sub-sector should be taken seriously and without the ongoing discrimination. The clothing and social organizational fashion of a large proportion of Nigerians, especially the youth, recently became inclusive of massive use of some items (T-shirts, bangles, fez-caps and so forth) of the Premiership football clubs of various European countries and their supporters' clubs into which they organized themselves.

Football, hazards, injuries and mass emergencies. Football has never been all fun. It has frequently been associated with injuries, occasionally mass emergencies, for both for footballers and spectators. The latter suffer mass emergencies especially in sub-Saharan African football. Mass deaths of football spectators, following stampedes, have been common in the region. The Guardian reports from London that in a football match played in March 2009, dozens of people were reportedly killed in a football stadium in Abidjan, the capital city of Ivory Coast. Despite the over-stretching of the stadium, irate and fanatical spectators' thought that they could not afford to miss watching the match stretched the stadium to cause that disaster. This shows how the passion for the game of football leads to their untimely death of many [http://www.guardian.co.uk/world/2009/mar/30/ivory-coast-stadium-football-stampede]. In the process of that misfortune, fans forgot the gross inadequacy of health facilities to take care of the emergency which could arise. Similar cases have frequently been reported across Sub-Saharan Africa. Moreover, with a large proportion of the urban populations of sub-Saharan Africa and Nigeria (73 percent regionally and 79 percent in Nigeria respectively in 2001) resided in pathogen-infested slums characterized poor sanitation, gross inadequacy of safe water, among other environmental problems, the high incidence of diseases and resulting high mortality have been reported (WRI UNDP, UNEP, & WB, 2005).

Dissenting feelings against the new wealth frontier: Stadia and professional footballers. Disappointments regarding unduly strong passion borne by most residents of urban centres nearly worldwide towards football have been expressed. During football matches played in Cairo and Sudan in the last quarter of 2009, citizens of two closely located north African countries (Algeria and Egypt) became too passionate about each of their countries' chances of qualification for the 2010 Football World Cup was described as "the mother of all (football) matches" culminated in violent attacks, and counter attacks, leading to injuries, more urban violence and diplomatic frictions. Fear of the impending violent clashes made the Police in Khartoum-the Sudanese capital city (venue of the match included the deployment of about 15,000 policemen i.e. a ratio of one police to two of the expected 35,000 crowd of spectators (The Telegraph, 2009). Such hostilities made a growing number of women to dislike football because of the way the passion of the game captures their men, absorbs the interest of the men and makes them forget themselves, forget their wives, and other things which are apart from football. Football is discredited for causing the death of about 40000 people who suffered extensive myocardial infarction during the recent 20 years of broadcasting of football matches (http://english.pravda.ru/society/family/20-06-2008/105551-football-0/).

It was recently that disappointed by the way football clubs and other sports enthusiasts spend disproportionately large sums of money to buy and reward talented footballers, the world-renowned African-American neurosurgeon, neurologist and Director of Pediatric Neurosurgery at Johns Hopkins Hospital in the USA (Dr. Ben Carson) was compelled to establish a foundation called the Carson Scholars Fund to encourage promising scholars in the disciplines of neurosurgery and neurology with financial support awarded to medical doctors who have achieved feats in the practices of intricate surgical operations. The rationale behind huge financial rewards to sports people when non-sports people labour for rewards that are less attractive in comparison is unacceptable to most people who are concerned about the fact that non-sports sectors (such as health-care, education and so forth) have been relegated to the background [The Carson Scholars' Fund (No year)]. Paradoxically, the irrationality of the differential rewards to the human undertakings in sports and other professions and vocations is not only a fact of life of the contemporary times, it is increasing in intensity. Since it is very difficult to reverse the trend, it seems to be reasonable to creatively harness the ongoing passion of football for the benefit of urban health infrastructure and services. This is especially crucial in Nigeria, whose huge population of over 161 million people (Bussiness Day, 2011)comprising a large proportion of young people have not only been exhibiting passionate support for the British premiership among myriad of other elite clubs and national football leagues (especially across Europe) but have reportedly been

increasingly been engaging in despicable violent fanaticism involving frequently physical attacks among supporters of various clubs. Yet these football fans and the larger population of Nigeria have been suffer under poor socio-economic conditions including abject poverty in general terms and especially in health care (Ingwe, Otu, Agi, Eja, & Ukwayi, 2008).

Are Football's High Earners Without Compassion?

It is indubitable that football has been a two-way money spinner: for its host cities, stadia and managers and for its professional players. It seems that in sub-Saharan Africa, these high earners from football are without compassion for their millions and billions of spectators and followers. The foregoing description of discriminatory benefits arising from football beckon for the use of innovative programme initiatives (including urban governance involving participation of stakeholders in the urban region) for improving urban centres and the stadia that they host. Civil society initiatives to improve urban living standards and catalyse local economic growth have been reported in the literature and provide bases for addressing the football sector.

Kanu Heart Foundation (KHF): A case of health-care improvement in Nigeria from a private Footballer's talent, passion and compassion. The Kanu Heart Foundation and its contributions to health improvement in Nigeria is being increasing documented due its commendable service to humanity and innovativeness. Paulinus Adjoghie recently reported on several aspects of the KHF. Owing to its peculiarity, being one of the few humanitarian institutions dedicated to health improvement and privately managed by an individual and his associates, in Sub-Saharan Africa, its history and management strategies deserve consideration immediately. The KHF's founding in 2000 is credited to the vision and mission to raise health-care in Nigeria by Nwankwo Kanu, a professional footballer who meritoriously serves Nigeria's (inter)national teams and several football clubs, currently regarded as Africa's and Nigeria's most decorated or laurelled footballer (having won one of the highest number of laurels both at the national and various football club levels). Apart from being captain of Nigeria's Olympic Gold-winning national football squad fondly called Dream Team 1996. Kanu had earlier won: the 1993 junior world (football) cup together with compatriots Wilson Oruma; the 1995 Federation Cup and the world cup for football clubs with The Netherlands' football club: Ajax Amsterdam (Daily Sun, 2009, 36).

Kanu's numerous laurels and honours. For his contribution to Nigeria's competitive football, the country had rewarded him with prestigious national honours and awards including Member of the Order of the Niger and Order Of the Niger after some eminent football victories for Nigeria. Other decorations

have come from elsewhere outside the Nigerian society and borders. He has been serving an appointment as a Sports Ambassador for the United Nations Childrens' Fund (UNICEF) for several years and was at least twice Africa's Footballer of the Year between 1996 and 2007. It was while he was undergoing medical tests with the Italian football club: Inter(nationale) Milan, that he was suddenly diagnosed with a heart condition that would have abruptly ended his career as a footballer thereby compelling him to go under the surgical knifes of some of the world's best heart surgeons in the USA to restore his career. It was Kanu's appreciation of how close both his life and career came towards the brink of extinction that might have prompted Kanu to found and run the KHF shortly afterwards.

Only the strong passion for football could have compelled Kanu to return to football, a game and sport that is well known for its physicality, roughness and toughness. While most people expected Kanu to resign at that point of his heart surgery, the young man chose resilience that was based on his passion for the sport of his dream and a game that had given him so much fame and success within short times. Therefore, Kanu more generously decided to establish the KHF as a way of giving from his success and talent in football back to the grossly less privileged people in the Nigerian society: child sufferers of heart diseases, the disease which had threatened his ambition to make fame in football (Kanu Heart Foundation http://www.kanuheartfoundationng.com/).

Heart operations executed by the Kanu Heart Foundation. The KHF recently spent about US$4 Million accomplished an open heart surgery that cost £50,000 in London's Crown Hospital, and also managed 332 in Israel, India, UK and Nigeria among others. The beneficiaries of these surgical heart operations have been Nigerian children who otherwise would have died or suffered debilitating sickness for much longer than the KHF had alleviated their pains. The KHF has been as deft and creative in its approach towards resolving the problem of high incidence of heart problems as Kanu exhibits in his game of football. To reduce the exorbitant cost of treating heart ailments, the KHF rapidly accomplished as much as 13 heart surgeries within a short ten days at the University of Nigeria, Nsukka town of Anambra State by bringing in 20 heart surgeons and specialists led by Professor Novik from the USA in 2003. This strategy had a multiplier spread effect in terms of skills and experience transfer to Nigeria's medical community because of the opportunity it provided Nigerian medical doctors to learn from the specialists from the USA.

KHF's partnership to scale up heart surgery for Nigerian children. Owing to the increasing incidence of heart ailments in Nigeria and inability of patients and relatives to pay for the rather expensive corrective surgery which could cost

about £50,000 (several times higher than the average annual minimum of the Nigerian worker), the KHF has recently undertaken partnerships as a way of scaling up its humanitarian service as a way of reaching to heart patients who are most unable to fend for themselves and therefore commonly die when outside help does not come.

The KHF recently entered into partnership with an Italian non-government organization: Emergency Italy. The partnership which was recently realized through signing of a Memorandum of Understanding (MOU) by representatives of KFH and Emergency Italy (Kanu Nwankwo and Rosella Miccio respectively) in July 2009, is designed to facilitate implementation of 50 open surgical heart operations on patients presented by the KHF annually in Sudan. Other partnerships have been undertaken by KHF with Nigerian entities. KHF has been working with Lagos State University Teaching Hospital (LASUTH) to diagnose and treat heart patients.

Urban-based summits on heart diseases. The KHF has organized summits designed to address heart ailments and involving echo-cardiological tests (a kind of mapping and diagnosis of heart ailments) in several Nigerian urban centres (including Lagos, Enugu, Federal Capital Territory, Abuja, Imo state). The significance of these events include revelation of heart patients in the cities as follows: Enugu (42), Imo (54). This activity shows how the KHF has been employing summit diplomacy in its urban health improvement programme.

Other Recent involvement of Kanu in urban health improvement. The wife of Nigeria's President Alhaja Turai Musa Yar'Adua, recently appointed Kanu Nwankwo as the Ambassador of the Abuja city and the Abuja International Cancer Centre (AICC) in Nigeria's Federal Capital Territory, Abuja. This appointment is likely to have been prompted by the achievements of the KHF since its inception about nine years ago (Daily Sun, 28 July, 2009, 36; Kanu Heart Foundation http://www.kanuheartfoundationng.com/).

Extending Kanu Heart Foundation's achievements to the rest of urban Nigeria. The impressive achievements in form of treatments of heart diseases, among others recorded by the KHF, which is an individual's initiative has proved to be inspiring thereby leading to the adoption of the model by a national institution: the National Cancer Centre in Nigeria's federal capital territory (Abuja). However, the adoption of such an innovative strategy for fund-raising to improve urban health in Nigeria is lagging behind the rather tremendous problem of urban centres in Nigeria and Sub-Saharan Africa: regions that are noted for phenomenally high rates of urbanization of poverty, mortality and diseases incidence.

The case for intervention in the poor healthcare in Calabar city and Cross River State. The level of availability of urban healthcare in one of Nigeria's most enterprising cities deserves examination for several reasons. Calabar city has most recently been developed to become West Africa's and Nigeria's most preferred tourist destinations under the Cross River State's tourism sector development programme. The city region's population has increased rapidly to 450,787 people, comprising two of the following Local Government Areas and 2006 population sizes (Calabar Municipality: 179,392 and Calabar South: 271,395) (Nigeria 2007). The U.J. Esuene International Stadium (capacity: about 40,000), located in Calabar Municipality within the urban region has been a host of international, national, regional and local football among other sport events. This includes being one of the many venues that hosted the 1999 World Football Cup and also the 2009 World Football Cup in October to November.

Findings and Discussion of Poor Health Facilities in Calabar Urban Region and Cross River State

Following, we show results of a study of the rather poor health care in Calabar urban region and Cross River State region between 1999 to the mid-2000s. The poor health-care is shown in two dimensions: number of health facilities (institutions) available and their per capita shares (of health facilities for the populations) in the urban region, and number of health professional and workers available and also their per capita shares for the population. we report them at various levels or categories. There were: two federally owned and managed institutions (University of Calabar Teaching Hospital, CUTH, and Infectious Diseases Hospital, IDH; Calabar Municipality: 5.57 X 10 -06 and Calabar South: 5.22 X 10 -06); two state-owned institutions (Calabar Municipality: 5.57 X 10 -06, and Calabar South: 5.22 X 10 -06). Others are 18 plus 14 local health institutions (Calabar Municipality: 1.00 X 10 -04 and Calabar South: 7.31 X 10 -05); and six and 80 private health facilities (Calabar Municipality: 3.34 X 10 -05 and Calabar South: 4.17 X 10 -04).

Gross inadequacy of health professionals in the State. The region also had a weak health professionals base was discernible from aggregate data covering the entire Cross River State. The number of various health professionals and their per capita shares were as follows: 73 Medical doctors –general- (2.53 x 10 -05), only two dental surgeons (6.92 x 10 -07), 1,150 nurses (grade A) (3.98 x 10 -04), 203 nurses (of grade B) (7.03 x 10 -05), and ten pharmacists (3.46 x 10 -06). Others are: 19 Medical laboratory technologists (6.58 x 10 -06), four Dental technologists (1.38 x 10 -06), one Radiographer (3.46 x 10 -07), 78 CHEWS (Community health education workers) and no physiotherapist. Considering the foregoing description of the poor health facilities on offer in Calabar urban

region, it has been recommended that there is need to seek innovative solutions for providing improved healthcare in the city region (Ingwe, 2009).

Inadequacy of health facilities in Cross River State. Nationwide surveys have shown that the total number of health facilities in the state was only 544 (to cater for large population in the state in 2004) comprising 429 publicly owned health facilities and 115 privately owned health facilities. The various categories or levels of the publicly-owned health facilities in the state were: 406 primary health centres, 21 secondary health facilities and two tertiary health facilities. In the privately-owned health facilities category, there were: 72 primary health centres and 43 secondary health facilities. There was no tertiary health facility that was privately owned in the state. In 1999, the various categories of medical specialization of the health facilities that were available in the state were as follows: 28 general, 99 maternities, one infectious disease, one neoro-psychiatric, one tuberculosis, and none of the ophthalmic health facilities (Nigeria, 2006, 90-91).

Figure 2: Nigeria showing Cross River State (shaded part)

Weakness and strengths of professional football in Calabar and Nigeria. Although it is believed that institutions, processes, structures, and attitudes connected with professional football remains weak in Nigeria and most of Sub-Saharan Africa, the earlier presentation of football as a money-spinning sector applies. Moreover, the local leagues of the region have been experiencing steady progress.

This is especially true of South Africa, Nigeria, Cote d'Ivorie. In Calabar urban region, the professional football league recently hampered by the sacking of the city's football club (Calabar Rovers) from the national professional or premier league to the rank of amateurs in 2005. it only returned to the premier league most recently. However, the region does have some professional footballers holding contracts with professional clubs within Nigeria, elsewhere in Africa and other continents that are notable in football (e.g. Europe and Americas). Some foundations of urban Nigeria's football sub-sector which could be harnessed for contributing towards urban healthcare improvement in Nigeria include: the nation's several urban centres including 37 capitals of states, Federal Territory (Abuja), among others; a multiplicity of stadia; large and rapidly growing population comprising dominant youthful strata; and hundreds of footballers playing for football clubs around the world.

Conclusions

The KHF's contributions to healthcare improvement in Nigeria demonstrates the potentials for harnessing footballers' talents to develop healthcare in urban Nigeria and sub-Saharan Africa- regions characterized by phenomenal urbanization of poverty hampering urban healthcare. It presents a foundation on which further revolutionary practice in urban development can be built.

Policy implications and strategies for using football to improve urban health-care. For urban managements to gain from the actions and experience of the KHF, there is need to undertake some initiatives including the following: Urban managements in Nigeria and other sub-Saharan African countries could engage the expert services of civil society organizations that have emerged to promote urban governance generally and creatively mobilizing professional footballers within and outside Africa to promote urban health following the exemplary initiatives of the KHF. Urban areas in Nigeria and sub-Saharan Africa should take advantage of the civil society-led multi-stakeholder urban development initiative managed by the Centre for Research and Action on Developing Locales, Regions and the Environment (CRADLE). Briefly, the CRADLE initiative is anchored on creating urban management divisions that should be charged with developing relationships between the city and individual professional footballers, aiming to persuade the footballers to support urban health development; (i) Initiating innovative programmes for adopting diplomacy to integrate professional footballers with urban health infrastructure development; (ii) Ensuring that a proportion of funds earned from football within the city be dedicated to urban health infrastructural development; and (iii) Assisting urban managements to plan and manage urban healthcare improvements.

As shown above, civil society plays an important role in improving urban healthcare and governance in a city. The achievements of the Kanu Heart Foundation reviewed above give more credence to the profuse documentation of the distinctive contribution of global civil society in pursuing sustainable development generally (WRI, UNDP, UNEP, & WB, 2003) and urban governance in particular [Nallathiga, 2008, Datta, and Sen, 2008, Datta and Sen, 2008]. Owing to their vast experience, civil society could lead in identifying resources and programmes that could be mobilized from the football (and sports) industry for improving health-care in urban Nigeria. While the study focused on Nigeria, the findings and recommendations are easily applicable to the rest of sub-Saharan Africa. It is high time civil society experience was applied to mobilize governments to devise appropriate mechanisms (legislation, laws and implementation, etc) and mobilize stakeholders in football and other sports to improve the poor urban healthcare scenario in Nigeria.

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