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Challenges affecting the World Health Organisation's Contributions to Sustainable Development in Nigeria

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ABSTRACT

This article examines the relationship between health and sustainable development through the lens of cooperation between Nigeria and the World Health Organisation (WHO). While the relationship has yielded some benefits, Nigeria has not fully realized the potential of this cooperation due to various challenges. Drawing on the collective and public good theory, this article investigates the gaps in the WHO's efforts to address policy issues, facilitate collaboration, and manage public health goods. It identifies challenges stemming from three thematic areas: the global health environment, internal issues within the WHO, and the Nigerian context. To fully benefit from the relationship, Nigeria needs to improve coordination within the health sector and ensure the sustainability of WHO programmes. The credibility and technical expertise of the WHO remain valuable for Nigeria's development.

1. INTRODUCTION

The establishment of the World Health Organisation (WHO) in 1948 created a new avenue for the organization to contribute to the highest possible level of health. It is no overstatement, therefore, to say that the primary authority in global health still resides with the WHO. This is determined by the WHO's inclusive nature, normative functions, and ability to adopt binding instruments. The WHO has contributed to global health and, by extension, to development through various global initiatives, conventions, agreements, and recommendations including the Alma Ata Declaration 1978, International Code of Marketing of Breastmilk Substitutes 1981, Bamako Initiative 1987, International Health Regulations 2005, and Framework Convention on Tobacco Control 2005, among others.

The attainment of independence by Nigeria in 1960 marked a new era in Nigeria's relationship with the WHO. Nigeria's transition from associate to full membership in the WHO provided another opportunity for the organization to contribute to Nigeria's development. Since 1960, membership in the organization has fostered greater cooperation and collaboration between Nigeria and the WHO on health issues. The WHO has been instrumental in the health development of Nigeria and has often acted beyond its original mandate in doing so. The WHO has influenced public policy, especially health policies in Nigeria, through its legal instruments, notably conventions, regulations, and recommendations. It has shaped policies in Nigeria through 'diplomacy by conference', such as the Alma Ata conference of 1978. Following this declaration, Nigeria has made numerous efforts to reform its health system in accordance with the principles of primary health care (PHC), leading to the introduction of the first Nigerian National Health policy in 1988 [1]. This period also saw the establishment of several WHO collaborating centers in Nigeria.

In addition, the Organisation has benefited significantly from prominent professionals who represented Nigeria at such forums as the World Health Assemblies, Executive Board sessions, and meetings of Expert and Regional Committees. Nigerian health professionals, who are beneficiaries of WHO's capacity-building efforts, have also provided expert advice to other member states within the WHO's African region and beyond. Nigeria has contributed to the sustenance of WHO initiatives through financial contributions. For instance, between 1961 and 2007, Nigeria contributed a total sum of $14,248,242.72 to the WHO's Regular Budget Fund (BRF). Apart from the BRF, Nigeria has also made extra-budgetary contributions to the WHO on several occasions. In 1974, the Federal Government approved a Nigerian contribution of N20,000 towards the WHO Appeal Fund for combating health problems in the drought-stricken Sahelian zone of Sudan. Furthermore, in 1975, 1976, and 1977, Nigeria supported the following extra-budgetary contributions: Special Regional Accounts of the Bio Medical Research Centre in Ndola, Zambia, and the Malaria Eradication Special Account of the WHO African Region. Also, in 1990, Nigeria made a 2 million naira donation to the 24 million naira Special Fund for Health in Africa. The fund was used in financing community health priorities, especially child survival, safe motherhood, adolescent health, better nutrition, water supply, and health education. Other areas include selective disease control, workers' health, and social welfare. Nigerians have also been prominently featured in top appointments within the WHO.

This article posits that despite the relationship, Nigeria has not reaped the maximum benefits from collaborating with the WHO due to several challenges. It seeks to investigate the constraints for deriving optimal advantages from the relationship and suggests solutions for improving efficiency. This article explores these challenges affecting the relations between Nigeria and the WHO from three major thematic perspectives: the global health environment, the impediments that emanate from the WHO, and those from the Nigerian environment.

2. LITERATURE REVIEW

The literature highlights the link between health and development. In particular, the WHO has long recognized this connection between health and sustainable development. The Organisation has observed that any program for social and economic development is largely dependent on the potential and availability of the human capital required for various sectors of a nation's economy. It asserts that the process of development is influenced by factors such as ill health, malnutrition, and unfavorable environmental conditions [2, 3].

Several scholars have also argued that a complex relationship exists between health and development. According to Robert Rogel, the early industrial growth of Britain was a result of the country's ability to control high mortality and morbidity rates due to improved nutritional conditions and the elimination of numerous infectious diseases starting in the late 18th century [4]. David Landes, on the other hand, provides ample evidence that improvements in population health have sparked economic growth, and that cultures with poor baseline health tend to lag behind [5]. Indeed, historians have thoroughly demonstrated the benefits of improving population health on economic success and governance [6-9].

Conversely, economic growth can facilitate the financing of public health initiatives including education, immunization, screening, health education, environmental cleanliness, and basic hygiene [10]. Furthermore, social progress, particularly in the area of education, has been linked to improved health outcomes through better nutrition and reproductive health. However, macroeconomic reforms may not necessarily benefit the entire population. Scholars have demonstrated that some well-intentioned economic policies, particularly structural adjustment policies, have had devastating human repercussions by exacerbating poverty and promoting resource mismanagement [10-12].

A few scholars have portrayed African participation in international organizations as detrimental to their development [13, 14]. According to these scholars, international organizations often serve as instruments of capitalist classes and states, perpetuating systems of dominance that sustain underdevelopment. They argue that the World Health Organization and other international organizations strongly support a number of international health measures, including family planning and population control. More significantly, they note that the implementation of population control measures has become a crucial prerequisite for the awarding of Structural Adjustment Loans (SAL) [15]. They further contend that supporting population control programs in Africa, a continent with high mortality rates due to conflict, famine, disease, epidemics, and particularly the AIDS pandemic, is unjustified. According to Mueniwa Muiu and Guy Martin, this

situation could more accurately be described as genocide or indirect triage [16]. They assert that the developed countries dominating these organizations are merely paying lip service to the wellbeing of the developing countries. However, it is more constructive to view Nigeria's membership in the WHO as a catalyst for national development.

Recent studies have demonstrated how the WHO has facilitated health and development in Nigeria [3, 17, 18]. These studies have explored the relationship between diplomacy and social, political, and economic development by examining the relationship between health diplomacy and the development of public policy in Nigeria. They affirm that medical and public health knowledge and technology can enhance prospects for health development. Accordingly, they have examined the outcomes of the multilateral negotiations that took place within the World Health Organization (WHO), particularly the International Code of Marketing of Breast Milk Substitutes, which was developed to counteract the negative impacts of infant formula. Similarly, other studies highlight the WHO's technical and financial support for comprehensive health sector reform to promote equity and access to health services in Nigeria.

Challenges within the WHO-Nigeria relationship have also been extensively discussed in the literature [19, 20]. It has been discovered that governance issues pose a significant barrier to improved health outcomes in Africa, especially in Nigeria. The externalization of health responsibilities and the proliferation of actors working in the field of health across the continent have been caused by state inability to provide social services. This diversity of actors demonstrates the WHO's struggle to coordinate actions effectively, ensure efficient use of resources, prevent significant program overlap, and address local needs. Historically, the World Health Organization directed and coordinated international responses to health concerns independently. From the 1950s to the 1980s, global health was typically hierarchical, with the WHO recognized as the authoritative body.

Bureaucratic rationalization, informed by strict adherence to the WHO constitution, has also impacted the Organization's partnership with Nigeria. This was evident during the Nigerian Civil War (1967–1970), when the WHO was criticized for failing to provide emergency aid in the conflict-affected areas.

Perhaps the most significant reason for Nigeria's membership in the World Health Organization was the aspiration to achieve national development [21]. When African nations achieved independence, their leaders prioritized development over mere independence [2]. They argued that since independence had been attained, development was the most crucial goal; without it, political independence could not be solidified and the humiliation of colonialism could not be fully eradicated. Nigeria was particularly interested in the Organization as a means to address the endemic health problems of its population, given the critical role of the health sector in the country's social and economic development.

3. THEORETICAL UNDERPINNING

This article is anchored on the collective and public good theory. The theory states that public goods are non-excludable and non-rivalrous resources available to a common pool of people. Garrett Hardin tells the tale of a group of herders who share a grazing pasture in "The Tragedy of the Commons"

[22]. He contends that when each person tries to maximize their own gain in a rational manner, the collective suffers, and eventually, everyone suffers. According to Hardin, the common grazing area is a communal good that all group members can use independent of personal contribution. 'Natural commons' like the oceans, atmosphere, ozone layer, and polar areas are examples of tangible collective or public benefit. 'Human-made commons' include things like the internet, universal rules, principles, and knowledge [23]. "Global conditions," such as peace, health, and financial stability, as well as free commerce, environmental sustainability, and poverty eradication, are examples of intangible public goods.

The use of collective and public goods involves interdependent activities and choices. States can undergo unforeseen negative outcomes because of the decisions and activities of others. A fundamental question in collective or public good theory borders on who provides the public good. There is a tendency that such goods will not be adequately delivered in the absence of a collective action mechanism. However, all can benefit, if the goods exist and are adequately provided. Olson [24] has opined that collective goods are more conveniently delivered in small groups than in large groups. According to him, a larger group will fall short of producing an ideal quantity of collective goods. Smaller groups have the advantage of being able to checkmate one another and ensure compliance because mistakes are more immediately seen. Small groups can also generate sufficient group pressure and gather crucial information for efficient allocation. However, voting procedures and delegation can make it easier for larger organizations to work together [25]. It can also achieve it by forcing nations to establish organisations with effective rule enforcement powers that compel states to act in a mutually beneficial manner. Public goods theory also suggests rewards and punishments as powerful instruments that can be used to restructure actors' preferences for those confronted with a collective action problem.

The collective and public goods theory, particularly in the health field, has been criticised by Gavin Mooney and Janet Dzator [26]. They argued that the base of the approach remains welfarist and does not adequately address the problems of values, especially those relating to care and compassion. They maintained that caring globalisation is needed, which puts human freedom and development above economic forces in any ideological competition. In their view, the collective and public good theory has failed to address these aspects. Indeed, the theory seems to ignore and act as negative influences and disincentives in developing a more caring world.

Notwithstanding, collective and public goods theory explains the World Health Organisation's role in producing global public goods. It is widely acknowledged within the global community that promoting global health is a positive form of engagement due to health's status as a 'global public good', a universal right for all. For example, prevention and spread of infectious diseases, and improving food security among others are all global public health goods. This theory also explains the gaps in the WHO efforts to deal with policy issues and facilitate cooperation, and manage public health goods. They believe that the United Nations and its agencies have helped to check power politics by creating some degree of shared interests in place of national interests, and have provided a forum for international cooperation and promotion of human progress and development.

4. METHODOLOGY

The study adopts the distinctive historical method. It relies heavily on primary and secondary materials. The article draws upon materials from the WHO archives in Geneva and the National Archives Ibadan, Nigeria. With particular reference to primary materials, interviews were conducted with 10 individuals including WHO representatives in Nigeria and in Geneva, Switzerland. Government officials at the Federal Ministry of Health and Foreign Affairs, Nigerian Institute of International Affairs, National planning Commission, and other government agencies were interviewed. The interviews were semi-structured and took the form of oral history and were focused on the individual's experiences and views on how the WHO had influenced development in Nigeria. The study further draws from archival materials especially the National Archives, Ibadan, and the World Health Organisation Archives, Geneva, Switzerland. Although very little of the interview material is formally presented here, it was used to fill the gap in the documentary record.

Secondary materials include government publications, the official records of the WHO and the UN General Assembly meetings, news media, articles in Nigeria public health journals, identified though searches in the WHO Library in Geneva, Redeemer's University library, University of Lagos Library, The Nigerian Institute of International Affairs Library, Google scholar, website of the Federal Ministry of Health, Nigerian Parliament legislative records. Search terms were related to international health, international development, global health, the WHO, and Nigeria health policies. Both the interview materials and documentary record were analysed using the historical methodology for a clear understanding of the challenges confronting the WHO-Nigeria cooperation.

5. RESULTS AND DISCUSSIONS

5.1 Challenges from the global health environment

One major challenge of the cooperation between Nigeria and the World Health Organisation is the proliferation of global health actors. The funding for global health programs in underdeveloped nations has expanded as a result of this scenario. A total of 90 active global health initiatives, roughly 40 bilateral donors, 26 UN agencies, and 20 global and regional funds comprise today's global health actors [27]. Significant resources accompanied these initiatives. According to available data, funding for health care worldwide grew dramatically from $6 billion in 2000 to roughly $14 billion in 2005 [28] and $21.8 billion in 2007 [29]. It is also estimated that $54.8 billion in development assistance for health was disbursed globally in 2020 [30]. It demonstrates that when more organizations became involved, net resources for global health increased quickly. Indeed, tackling diseases in developing countries' diseases has become an aspect of many states' foreign policies since 2000. Several reasons accounted for this development. Some gave a moral justification to the need to control the spread of major diseases. It is also a clear manifestation of public diplomacy. Others see it as an investment in self-protection from contagious diseases from other countries [31].

At the national level, this expansion has led to a proliferation of actors and governance mechanisms, which has had an impact on national systems and management capability. One example is the health environment in Nigeria. Six of the 17 UN organizations, including the World Bank, United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA), United Nations Children Fund (UNICEF), United Nations Office of Drug and Crime Control (UNODCCP), and the World Health Organization, according to the WHO, have supported Nigeria's health sector [32].

In addition, the World Bank has been working on a cross-sectoral HIV/AIDS Project and the Health Systems Developments Project II, two sizable loans for health-related projects. UNDP conducts United Nations operational efforts in the nation with an emphasis on reducing poverty. The priorities of UNICEF were children's rights and matters pertaining to their health. The UNODCCP concentrates on preventing drug misuse and associated problems. For its part, UNFPA focused on population-related issues. Other organizations include the Food and Agriculture Organization (FAO), which promotes food security, the United Nations High Commissioner for Refugees (UNHCR), which is concerned with the protection of refugees, and the United Nations Fund for Women (UNIFEM), which supports gender mainstreaming. The United Nations AIDS Programme (UNAIDS) collaborates with other members of the United Nations (UN) theme group on HIV/AIDS to expand joint activities. Additionally growing their interest in Nigeria are the African Development Bank (ADB) and the European Union (EU). In order to eradicate polio, the EU and the Federal government agreed to revitalize the PHC system with a focus on immunization programs. The European Union contributed 333.3 million pounds, or $41.4 million, in support of water and sanitation projects in Nigeria that were supported by UNICEF. This was the largest contribution made by the Union to a development organization anywhere in the world. The Department for International Development (DFID), the United States Agency for International Development (USAID), the Canadian International Development Agency (CIDA), and the Japanese International Cooperation Agency (JICA) are just a few of the bilateral organizations that are active in Nigeria's health sector.

The bilateral organizations fund the government directly and also transfer money for health-related projects through the WHO and other UN bodies. The Nigerian health industry is also home to numerous local and international non-governmental organizations. Through non-governmental organizations, the country received foreign aid in the 1990s. This pattern altered to focus on providing the government with bilateral and multilateral aid. The health sector received aid from the corporate sector as well.

The traditional relationship architecture in the global health sector has changed as a result of trends toward more resources and more participants. It spreads authority as well. The structure of global health governance has remained mostly unchanged since the middle of the 20th century. When the WHO was founded by the UN in 1948 to coordinate global health initiatives, the architecture became formalized. From the 1950s until the 1980s, global health was largely hierarchical with the WHO as the recognized authority. This architecture included the international organisations that made up the United Nations system with relatively clear lines of authority down to the regional players and the developing countries being served. The 1990s, however, saw a complete disruption of the architecture. This resulted from the arrival of numerous new actors into the global health arena as well as other global influences that had an impact on how human civilization was being remade. The emergence of the internet and globalization are two examples of these factors. They established horizontal connections all over the world, enabling people and organizations to communicate and receive information in ways never before possible. As a result of the emerging international health hazards, the phenomenon of globalization altered how states safeguarded and promoted health. Like other sectors, global health felt these forces and adjusted to them [33]. Thus, as the influence of the WHO waned, the official role of developing countries, including Nigeria, also declined [34].

As a result, relationships and authority were dispersed across UN health agencies, the World Bank, philanthropies, corporate organizations, and the country being served, resulting in a fragmented global health architecture. What effects did the new global health architecture have on Nigeria's cooperation with the World Health Organization? This new change has an obvious consequence that many players are not bound by the previous regulations. This change was confusing for a sector that had become accustomed to traditional duties and procedures.

Instead of working hierarchically through established regional players and the WHO, the new actors developed their own procedures, built ties with other organizations, and sent communications to other participants. The UN is becoming less and less significant, as Seth Berkley correctly noted, "when an NGO and its leaders can directly collaborate with the Head of State." Undoubtedly, both good and harmful changes are taking place in the power dynamic.

It is no longer obvious who should make decisions on overarching strategy and governance given the weakening of the WHO's authority and the increasingly fractious relationships among major global health actors. While this diversity of activity and partnership has elevated health status on the policy agenda and altered the power dynamic, Walt has argued that it has also given rise to worries about conflicting mandates, competition and duplication of health activities, inadequate coordination, and, more recently, governance-related issues [34].

Because of this, policy is currently being decided on ad hoc by multiple organizations in the absence of apparent authority. For instance, the World Economic Forum has greatly shaped the agenda for health since the late 1990s. Numerous new programs have been introduced, including the Product Development Partnership Initiative [35]. The result is that it has complicated Nigerian national policymaking. The effect is that it has compounded national policy making in Nigeria.

The failure to achieve favourable results following the Paris and Accra Declarations on AIDS effectiveness, which established principles for better assistance delivery and greater money for health, is concerning [19]. Policy juggling in the domain of aid coordination is still a feature of the modern healthcare system. It is exclusive and heavily influenced by the requirements and priorities of donors. There are still certain programs that function in the country without adequate accountability, transparency, and evaluation systems. Due to the majority of programs' attention being drawn to immediate results, the issue of sustainability has been relegated to the margins. Many funders are unaware that it would take at least a decade to significantly improve public health. Furthermore, rather than focusing on individual disorders, efforts should be

directed at broad changes that affect communities' overall wellness. One issue is that not all of the funds allocated in the budget are used properly.

According to reports, a significant portion of funds intended for health assistance in sub-Saharan Africa never made it to the people who needed it most [36]. Examples of financial misappropriation include paying ghost workers, padding storage costs, diverting drugs to the black market, and selling dangerously counterfeit medications.

By creating an International Clinical Trials Registry Platform (ICTRP), the WHO has significantly improved worldwide clinical trial transparency and access. Throughout public health crises like the current COVID-19 epidemic, the Ebola outbreak in 2015, and the SARS outbreak in 2003, the organization has demonstrated strong leadership. The International Health Regulations and the Framework Convention on Tobacco Control have both been successful global health governance mechanisms thanks in large part to the WHO. The group was instrumental in organizing the International Health Partnership and related projects. The WHO even went so far as to create a precise institutional policy on public-private relations to instruct officials on roughly how to manage these encounters [37]. All of the stakeholders in health made up the expanded Interagency Committee on Health (ICC), which was established by the WHO. The committee's chairperson is the minister of health. Additionally, ICC met with state governors. For NPI, TB, RBM, APOC, and HIV/AIDS, the WHO, UNICEF, and other partners have created an operational coordination model.

5.2 Impediments from the WHO environment

The WHO's status as the primary organization in charge of global health governance has been severely questioned. The WHO's operations and efficiency have been impacted by these challenges [38]. The WHO's reputation for being bureaucratic and ineffective, its submission to political pressure from more powerful member states, and the lack of defined priorities among various programs are a few contributing factors. Its failure to handle the difficulties of globalization and insufficient financial resources are additional contributing causes. While bureaucratic rationalization has positive potential for global health practice, it can be dangerous. Evidence from the Nigerian Civil War 1967 – 1970 demonstrates how the rigid bureaucratic structure of the WHO informed its widely criticized role during the Civil War. The WHO was visibly absent in providing emergency assistance in the war-affected areas, especially the eastern part of Nigeria. This is not to suggest that the WHO was not sympathetic to the plight of the people in the war-affected areas. Its constitution primarily constrained it. The WHO constitution did not empower it to take action on its own to assist populations of a country during emergencies. Article 2d of the WHO constitution requires the organization "to furnish appropriate technical assistance and, in emergencies, necessary aids upon request or acceptance of government" [39]. It has been argued that the Nigerian government may have used this constitutional provision to frustrate the WHO in providing emergency assistance in the war-affected areas to force them to surrender [20]. The government did not officially invite the WHO as enshrined in the constitution. Several entreaties by the WHO were also declined by the Nigerian government.

Unfortunately, recent developments do not inspire much hope for improvement because the WHO continue a long standing global health practice based on bureaucratic rationalisation making it an end in itself instead of a means for serving society. There is need for the WHO to always perform the leadership role in health emergencies. It is understandable, however, that member states are not willing to submit their autonomy and sovereignty to the multilateral system by granting the WHO a very broad jurisdiction to intervene in their domestic policies and measures. The WHO should not merely play a supportive and supplementary role in emergencies. Any health problem arising from such is not just a matter of domestic and interior issue. It is a matter that, if proper measures are not taken, would affect several countries, whether or not located in the immediate vicinity of initial occurrence. The sovereignty concept in this regard should give way to the coordinating efforts directed by the WHO as an international organisation. In this regard, international law granting sovereignty to states should be modified to the extent of permitting certain international interventions, at least with respect to allowing on the spot investigation and allowing international efforts to take charge of handling of public health emergencies.

Perhaps, the most critical factor affecting the WHO activities in Nigeria is inadequate funding. The WHO funding model cannot sustain the organisation's core function and mandates. The implication is that rather than assessed contributions from member nations, about 80% of its budget comes from outside donors. The smooth operation of the WHO and its purported impartiality and independence are not encouraged by this. As a result, other organizations like the World Bank, the Global Fund to fight AIDS, Tuberculosis and Malaria, and UNAIDS, to name a few, have taken up the WHO's key duties and funding. This state of affairs has resulted in unhealthy competition among various departments within the WHO, NGOs, and other organisations pursuing donor funding. It has also limited the ability of the WHO to articulately plan budget and implement its strategic aims.

Another challenge facing the WHO is what has been referred to as the "implementation gap" [40]. One of the aims of the WHO has been to assist countries in capacity building and manpower development. To achieve this, the constitution mandated the WHO to work through the national ministries of health. This arrangement has its benefits. It has facilitated the acceptance of the WHO in all member countries and has shielded the WHO from the charges of neo-colonial interventionism. However, the WHO's financial problems and the constitutional mandate to implement its programmes through the state ministries of health have created an implementation gap. It depends on the interest and efficacy of the state ministries of health.

As a result, the WHO is rendered powerless in Africa, including Nigeria. This is because many African states have failed to align its health programmes with the WHO policies. They have been unable to provide adequate health care and infrastructure for their citizens. As the WHO is faced with financial challenges in developing the infrastructure in Nigeria, the only alternative would be to circumvent national governments and directly implement its policies. In its current form, this is what the WHO cannot do.

On the other hand, it has been asserted that the WHO has no issues with implementation and that the presence of the WHO national representative demonstrates its local impact. These ambassadors are crucial to the UN system because they raise awareness of the WHO within the host nation's health

ministries. They are WHO staff members. They essentially act as a liaison between the WHO regional office and the health ministry.

They provide advice on health administration and policy to ministers of health. Additionally, they oversee compliance with the WHO plan and respond to requests for technical assistance and advice from local health professionals. This arrangement makes sense in theory. But in practice, it poses several difficulties. Although the concept of country representatives was well-intended, due to insufficient finance, country offices are constrained in what they might accomplish [41].

Besides, they are affected by the fact that their offices are domiciled in the capital city. The constant change and reshuffle in government has stymied their performance as they have to contend with the challenge of staff turnover in the ministries. The implication is an endless training of new appointees about the WHO's goals and programmes. The WHO representative had little impact on other determinants of health.

This is supported by the fact that the WHO representative works for the health ministry, which is often one of the least important ministries. Given these circumstances, each representative's zeal and aptitude will therefore be very important. Certain country representatives undoubtedly manage the work of the WHO and other foreign actors in the field of health. Individual differences can make it challenging for people to collaborate on projects based on personal style, knowledge, and self-interest, as Marx Rosenberg and others have emphasized. Collaboration is made more difficult by the varying levels of expertise on both the technical aspects of a health danger and challenges with leadership and management [35].

The WHO system of political appointments has constituted serious obstacles to effectiveness as it was not structured in such a way to source for the most qualified people. The selection process, in most cases, was seen as a way of rewarding their cronies. Member states, including Nigeria, nominate candidates for appointments by the WHO African region Director. The post is commonly used to compensate health professionals who have worked for their countries in various capacities. The implication is that the typical country representative is less interested in how to move the organization forward. Instead, they are looking forward to a comfortable retirement. The WHO system does not encourage its representatives to use their initiative. Representatives do not exert their political weight to remain in the good books of the regional director.

Administratively, their contracts are usually renewed, provided they remain in the good books of their regional directors. Hence, the threat of sanction, once out of favour, encourages conformity. It is reported that health workers in developing countries, including Nigeria, have observed that the WHO representatives cannot provide the needed technical assistance [42]. The Health Policy Unit's report demonstrates that bureaucratic and remote regional offices hampered WHO representatives. As a matter of fact the personnel process of the WHO should be reformed so that cronyism at the United Nation would not be part of the problem in future.

The expert and normative power of the WHO to discharge its legal obligations during health emergencies has been seriously challenged. Besides, there had been flagrant disregard for International Health Regulations agreement to follow the WHO advice on travel bans and trade restrictions during health emergencies such as the Ebola outbreak and the recent COVID-19 pandemic. Several countries acted unilaterally by closing borders and imposing travel bans despite the fact that the IHR is a legally binding treaty mechanism – a vivid example of health diplomacy based on its global reach and negotiating process [20, 43]. The IHR should be strengthened for it to be relevant and useful. This is because IHR, a legally binding treaty, lacks teeth.

5.3 Problems arising from the Nigerian environment

In addition to the challenges faced by the WHO, there are several problems arising from the Nigerian environment that have impeded collaboration. These include the cultural and social challenges inhibiting close collaboration between Nigeria and the World Health Organisation. The Nigerian health sector is characterised by three health care systems, the local traditional healers, the western orthodox medical care system and the faith healers, which rely solely on prayers. One of the key challenges to the WHO programs' implementation in Nigeria continues to be culture. It is commonly established that culture and health are related [44, 45]. Health is greatly influenced by customs, attitudes, norms, and habits. Nigeria is a cosmopolitan nation with diverse opinions on the causes of illness. Health policy, planning, and implementation are negatively impacted by these diverse understandings. A few possible examples will suffice to illustrate the impact of culture on the WHO activities in Nigeria.

The 2003 polio vaccination boycott in Northern Nigeria serves just one illustration of how culture has an impact. The political authorities in the north, who asserted that the vaccine had been tainted with anti-fertility substances and maintained that it would not be given to children until it was proven otherwise, gave voice to the agitations of the religious leaders.

The boycott may also be traced to long-running disagreements over the definitions of polio according to biomedicine and Hausa culture. Polio is known in Hausa as Shan-Inna. Between western science and biomedicine and Hausa culture, there are different perspectives on the etiology of this illness. According to biomedicine, polio is a disease that may be avoided by using scientific immunization techniques. Polio, on the other hand, is regarded in Hausa tradition as a disease of the afterlife. There is a widespread belief among the Hausa populations that Shan-Inna is a strong female spirit that eats human limbs [46]. There are further polio treatment options available from Hausa traditional healers. The process begins with satisfying the desires of the feminine spirit, which is typically done in exchange for the restoration of a person's limb. It is believed that if a patient's limb is not recovered, it means that the feminine spirit could not be appeased.

In Nigeria, another cultural practice that is detrimental to public health is female genital mutilation (FGM). FGM is a cultural practice that different Nigerian societies engage in [47]. It entails the forcible removal of a girl's genitalia in whole or in part. It can have a variety of negative repercussions, such as infection, mortality, obstetric and sexual problems, and mental health issues. It's interesting to note that because to the active participation of the WHO and the Nigerian government, the act has steadily declined in metropolitan areas.

However, as the frequency is still significant in rural regions, these initiatives should be actively expanded there. It is challenging to determine, however, how much cultural beliefs, either particularly or generally, affect how people react to western health programs, which the World Health

Organization stood for. This is so because other factors frequently have an effect on them. It is clear that in the case of polio in Nigeria, both polio and routine immunization coverage rates began to fall in the early 1990s, before the political conundrum. Other factors, such as inadequate health systems and service delivery, can be blamed for the sharp rise in polio cases that occurred between 2001 and 2003 prior to the political boycott.

The governments and communities of the northern states demonstrated the flaws in how international programs are set up for Western-driven campaigns by suppressing the Polio Eradication Initiative. It became clear that decisions about global development issues, like the polio eradication, are made in settings that are very different from the local reality of targeted societies. This is what Hakan Seckinelgin refers to as the pervasive colonial mindset within the context of foreign policy [48]. As a result, there is now conflict of interest between important global goals and local priorities. These international health interventions had been characterised by the non-inclusion of local communities, who are the beneficiaries, in decision-making, thereby undermining the role of community leaders. Community leaders may contribute to health research or delivery success or failure.

Nigeria is also bedeviled with weak health care systems. Health improvement is essentially the function of adequate local infrastructure. However, several decades of neglect have negatively impacted health care infrastructure in the country. The health sector could not produce the expected result. Nigeria is still battling with achieving universal health coverage. The difficulty of maintaining adequate access to medical facilities has persisted. In Nigeria, there is also an urban bias in the supply of healthcare facilities. It is clear that urban residents have easier access to medical facilities than rural residents do. Despite a noticeable increase in health infrastructure since 1999, these hospitals typically have inadequate staff, are badly maintained, and have insufficient drug supplies. Complementary infrastructures for delivering health services, like access roads and a steady electricity supply, are also lacking.

Recurrent expenses have always consumed a sizable portion of the money allocated to the public health sector in annual health budgets. Unfortunately, staff costs like paying staff emoluments frequently accounted for up to 90% of recurring expenses, leaving relatively little for service operation and equipment upkeep. The impact of the expenditure has been constrained due to the regular and unrestrained devaluation of the Naira, which resulted in actual reductions in expenditures when assessed in the dollar equivalent, despite the enormous increases in the real volume of naira budgeted for and spent on health.

Because a major portion of the pharmaceuticals used in the nation or their raw materials are imported and paid for in hard currency, the little that was left over for drugs and consumables experienced an additional drop in purchasing power as a result of the naira's indiscriminate depreciation. Resources have been wasted as a result of poor management techniques. Ineffective relationships have also been impacted by governance deficiencies and security issues.

Another issue that has adversely affected the ties between Nigeria and the World Health Organization is corruption. The money needed for developmental programs, especially health, is severely depleted by corruption. The health care industry in Nigeria is especially vulnerable. Relationship issues between the WHO and Nigeria due to corruption may indicate that money set aside for WHO initiatives in the nation is not being distributed properly. More concerning is the fact that the money never reached the lowest levels, where they are most needed.

For instance, people at many healthcare facilities across the nation can purchase the free mosquito-treated nets offered as part of the WHO's malaria control programs. More concerning is the practice of certain WHO consultants and political leaders of diverting vehicles, bicycles, and motorcycles for personal use. Due to these potential for corruption, the issue of transparency and accountability has come to light. Sadly, these elements either do not exist or are not strictly adhered to. These issues have culminated in Nigeria's failure to continue programs started by the WHO.

Insecurity in Nigeria has no doubt affected the smooth operations of the WHO in Nigeria. The factors that give rise to insecurity in Nigeria, such as Boko-haram, kidnappings for ransom, kidnappings for rituals, occultism, farmers and herders crises, are almost taking society back to a state of nature where human life was predatory and short. Some implications of insecurity are that it takes away the privilege of enjoying the fundamental values of life such as prosperity, freedom and happiness. It is apparent that insecurity has led to deterioration of health arising from the direct causalities of conflict and indirect effects through breakdown in service provision and health infrastructure.

Insecurity has resulted in numerous displaced people, food insecurity, and many violent victims despite the assistance provided by the WHO and partners. Displacement from infrastructure increases the danger of infectious diseases, water-borne illnesses, and inadequate sanitation. Particularly, since the start of the COVID-19 outbreak, 10.6 million people in north-east Nigeria have needed urgent assistance. The foregoing has demonstrated the factors that forestall the realization of the desired benefits from the relations between Nigeria and the WHO.

6. CONCLUSIONS

So far, we have demonstrated in this article the various challenges militating against the smooth relations between Nigeria and the WHO. The WHO-Nigeria collaboration has faced serious challenges from three major thematic areas namely the global health environment, the impediments that emanate from WHO, and those from the Nigerian environment. These challenges include, among others, the growth of global health actors, the perception of the WHO as bureaucratic and ineffective, the WHO's incapacity to address the issues brought on by globalization, cultural practices that have an impact on health, insecurity, and corruption. The end effect of all these difficulties was Nigeria's inability to continue the admirable programs that the WHO had started as part of its responsibility to provide services for global public health.

The global health architecture has changed since the 1990s, shifting away from its governance from the WHO towards donors. However, the derivable benefits of being a member of the WHO cannot be overemphasised. The WHO has the advantage of representative legitimacy. The World Health Organization's unmatched reputation for establishing international standards is one of its comparative advantages. Health systems all throughout the world use the useful guidelines, reports, and training manuals produced by it.

Because of the WHO's high credibility as a scientifically sound, technically sound, and impartial organization, more people choose to rely on and adhere to its technical standards. The WHO's success in this area is a result of both its nearly universal participation in its governance structure and its capacity to assemble specialists into committees to assist establish best practices. There is no question about the WHO's reliability or technical proficiency. In light of this, Nigeria's sustained collaboration with the WHO would substantially ensure its development.

Based on these conclusions, the following recommendations can be made.

Recommendations for the WHO: The WHO can reposition itself at the centre stage of international politics. This is imperative because the WHO will always be affected by international politics as a Westphalian system. Accordingly, political negotiation and international diplomacy stand out as critical instruments for significant improvements in global health and a concomitant reduction in gross disparities in health and access to care. Given the changing global health landscape, the WHO needs a total reappraisal of its purpose, roles, responsibilities, budget allocations and work plan.

Recommendations for Nigeria: Foreign Service or health professionals in Nigeria can cultivate the technical expertise and diplomatic skills of health diplomacy. The linkage between health and foreign policy could be deepened to actualise the promises of health diplomacy. Nigeria's health officials who represent the country in different health fora could be trained in the art of diplomacy. The Nigerian delegation to the World Health Assembly may want to consider the inclusion of career diplomats at the Foreign Affairs Ministry. Strict adherence to the World Health Organisation allocation benchmark of 15 percent of the total budget expenditure and the faithful implementation of the budget allocation to the health sector is imperative at this point. It is possible to promote the development of infrastructure that supports the delivery of health services, such as access roads and energy. Vulnerable populations and those who require the most medical attention are too far from the nearest health centers. Recommendations for Partnership: Nigeria will need to make sure that the operations of all actors in the health industry are properly coordinated. Moreover, Nigeria could ensure the sustainability of the WHO programmes to attain the full benefit of the relations.

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