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# NDDC Healthcare Delivery Project and Socio-Economic Wellbeing of People in Southern Senatorial District of Cross River State, Nigeria

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***Abstract***

*This study looked on the socioeconomic well-being of residents in the Southern Senatorial District of Cross River State, Nigeria, as well as the NDDC healthcare delivery scheme. For the study, a cross-sectional survey design was chosen. The study used both primary and secondary sources to collect its data. First-hand information collected from respondents during fieldwork served as the primary source. The main sources of data used for data collection were questionnaires (quantitative data), focus groups, and interviews (qualitative data). Reviews of scholarly empirical or theoretical works, including those found online, in journals, newspapers, textbooks, and other publications, constituted the secondary data source. 1,200 adult male and female respondents were chosen at random to form the study's sample. At the 0.05 level of significance, the study used Simple Linear Regression Analysis to evaluate its assumptions. The study's findings demonstrated a robust positive correlation between the socioeconomic well-being of the populace and healthcare delivery projects. Based on the findings, recommendations were made for, among other things: the government should use the NDDC to provide healthcare delivery services to communities without facilities; the commission's needs assessment strategy should be reexamined to reflect the needs of the populace; medical services and healthcare facilities should be improved; and everyone should have access to them, regardless of their socioeconomic or financial situation; finally, the NDDC should not be the only organization in charge of providing rural healthcare services.*

***Keywords:*** *Niger Delta Development Commission (NDDC), Healthcare Delivery, Government, Households, Economic Wellbeing*

## Introduction

Being in good health is essential to leading a fulfilling life on both a social and financial level. Households suffer greatly from poor health, which can lead to debilitation, significant financial costs, labor loss, and occasionally even death. Adults' health impacts their capacity to work, which supports the welfare of the home, especially the growth of the children (Asenso-Okyere, Chiang, Thangata & Andam, 2011). Because of limited access to healthcare, treatable illnesses frequently remain untreated. All sorts of development are only possible when people have access to healthcare services and can use them effectively.

According to Peters, Garg, Bloom, Walker, Brieger & Rahman (2008), access to healthcare services is a multifaceted process that includes the quality of care, geographical accessibility, availability of the appropriate sort of care for people in need, financial accessibility, and acceptability of service.

The availability, affordability, and quality of healthcare services, in addition to the users' personal traits and social and economic circumstances, all influence how often people utilize these services (Chakraborty, Islam, Chowdhury, Bari & Akhter, 2003; Manzoor, Hashmi & Mukhtar, 2009; Onah, Ikeako & Iloabachie, 2009).

Nigeria continues to have one of the lowest health indices in the world and, tragically, is responsible for 10% of maternal fatalities worldwide due to the dysfunctional and woefully underfunded state of the Nigerian health system. In the absence of an integrated system for disease surveillance, prevention, and management, the national health management information system is inadequate. Additionally, studies show that doctors, particularly those practicing in rural regions, have substantial absence rates (about 40%) (Hamid, Sadique, Ahmed & Molla, 2005). The issues faced by the rural population include high rates of mortality and morbidity (157 deaths per 1000 live births; NDHS, 2008), failure to meet international health and survival targets, and unequal access to healthcare facilities.

The federal, state, and municipal governments' attempts to modernize rural areas and/or enhance the socioeconomic well-being of the rural populace have not produced any discernible outcomes. The government has periodically launched initiatives to improve health care, open up rural areas, provide educational opportunities, supply agricultural inputs and literacy initiatives, and so on (Ihejiamaizu, 2002; Attah & Angioha, 2019). Nevertheless, the majority of these initiatives have changed the lives of rural residents just slightly or not at all. Even when some degree of effectiveness is noted, the programs cannot be sustained.

A condition of health, happiness, and/or prosperity is referred to as well-being. There are numerous aspects of wellbeing, including mental, psychological, social, emotional, and spiritual. Individuals with attention deficit/hyperactivity disorder, social problems, and indications of delinquent behavior are more likely to experience emotional and behavioral challenges when their SES is lower (DeCarlo, Wadsworth & Stump, 2011). The process of interacting with those around us is what we call social welfare. According to Po and Subramanian (2011), these interactions entail employing effective communication techniques, establishing and preserving meaningful relationships, valuing oneself and others, and putting in place support networks.

Our way of life, our belief systems, our customs, and our value systems all have an impact on social wellbeing. According to Zachariah, Boman, Mergler, and Furlong (2015), the World Health Organization, wellbeing is a resource for healthy living and a good state of health that goes beyond the absence of disease and allows us to perform effectively on all levels—psychologically, physically, emotionally, and socially. To put it another way, socioeconomic wellbeing is defined as allowing individuals to reach their full potential, engage in creative and productive employment, build strong interpersonal bonds, and make significant contributions to the community (Foresight Mental Capital and Wellbeing Project, 2008).

As a result, rural regions continue to be undeveloped and lack the essential facilities needed to provide a high standard of living. As a result, the wealthiest urban areas and the rural poor have a growing disparity (Angioha, Nwagboso, Ironbar & Ishie, 2018). As a result, Ering (2005), Ering, Nwagbara, and Ushie (2006) contended that a lack of public participation frequently affects the ownership and sustainability of the country's rural development programs. Numerous NDDC programs and projects have been started and carried out in rural communities in Cross River State, it has been noted. These initiatives included solar electrification, drinkable water supply, health care, education, social welfare services, and agriculture.

The majority of the state's rural population still cannot meet their basic needs and have remained underdeveloped; this socioeconomic situation is observed in the Cross River rural communities, where most of the rural infrastructures, such as pipe borne water, rural electrification, roads, schools, and health facilities, are both in short supply and in poor state of disrepair (Ojong, Iji & Angioha, 2019). Despite these projects and programs, however, rural poverty had persisted and the socio-economic wellbeing of the rural communities has not significantly improved over time. As a result, good health among rural residents guarantees greater human development because it is a major factor in the rapid economic, social, and political development of rural communities (Bushy 2008 defines health as a person's entire state of physical, mental, and social wellbeing as opposed to just the absence of disease or infirmity). Anam (2012) claims that a community's health status can be used as a yardstick for measuring the wealth of that community. According to Ajala, Sanni, and Adeyinka (2005), one of the main causes of Nigeria's rural communities' underdevelopment is their inability to obtain health care facilities. The author also emphasized that sufficient resources and accessibility for health care are necessary for rural communities to experience sustained rural development.

As a result, several Nigerian governments have worked to provide their citizens with access to healthcare services. The development of medical education, the enhancement of public health care systems, and the delivery of primary health care (PHC) in numerous rural areas were noteworthy among these initiatives. Nonetheless, throughout the years, the nation has not given explicit attention to equity in the planning and distribution of health care facilities. In many rural sections of the nation, where some areas are frequently ignored, there are few public and private health care facilities (Onokerhoraye 1999).

The unwell must be brought to the closest clinic because many rural communities lack clinics. In addition, rural clinics frequently lack proper supplies and qualified medical staff, and they demand payment before offering services. Rural residents consequently frequently lack access to any form of healthcare. Since healthcare access and utilization are essential to wellness and human capital, they are of great relevance to rural development (Aghion et al., 2010). When it comes to evaluating labor productivity, healthcare availability and utilization may be more significant in rural areas where physical jobs are more prevalent than schooling.

**Statement of the problem**

Despite the many development initiatives that NDDC has worked on since its founding, the Niger Delta region continues to suffer numerous socioeconomic difficulties. Specifically in the Southern Senatorial District of Cross River State, Nigeria, these difficulties include a lack of healthcare infrastructure, subpar medical professionals, and inadequate facilities, limited funding for healthcare in certain areas, and high healthcare costs (charges in the health facilities). These difficulties are causing a high death rate as well as an epidemic of diseases like cholera, typhoid, malaria, diarrhea, and guinea worm. As was previously noted, women and children from low-income households are more susceptible to these health issues. To ensure socioeconomic well-being, it is necessary to address the disparities in wealth distribution, age distribution, and quality of life between urban and rural areas worldwide. It is impossible to ignore rural communities and their surroundings since they require extra care to achieve socioeconomic status and overall well-being. When it comes to the sustainability of rural communities, socioeconomic well-being plays a major role in both the social and economic spheres. A growing interest in socioeconomic well-being metrics to progress towards sustainability is linked to sustainable development and human well-being and quality of life. Thus, this study looked at the connection between NDDC health care delivery initiatives and the socioeconomic well-being of residents in Cross River State, Nigeria's Southern Senatorial District.

## Objective of the study

This article aims to investigate the relationship between the socio-economic well-being of people living in the Southern Senatorial District of Cross River State, Nigeria, and health care delivery programs funded by the Niger Delta Development Commission (NDDC).

## Hypothesis

Ho: There is no significant relationship between socio-economic well-being of the populace and the NDDC healthcare delivery initiative.

## Literature review

It is well recognized in human civilization that universal access to high-quality healthcare can lead to better health outcomes and a decrease in health disparities. Reducing disparities in healthcare accessibility has been greatly aided by the NDDC's implementation of health care services. Furthermore, everyone considers being in excellent health to be a requirement, which turns using healthcare into a profitable endeavor. Everyone needs to be in good health, and the choice of a certain healthcare system is influenced by supply and demand; after all, need for healthcare is derived. People do not want health care for its own sake, but rather for the benefits that come with good health. In Nigeria, the problem of rural residents' health concerns and the necessity of addressing it are becoming increasingly apparent (Hamid, Sadique, Ahmed & Molla, 2005). The rural areas are severely lacking in qualified practitioners. Problems such a lack of adequate health infrastructure, the prevalence of chronic illnesses and impairments, physical and financial hurdles, and the existence of chronic diseases complicate access to health care in rural areas (Ricketts, 2009).

The lack of basic infrastructure in the Niger Delta explains why locals are always pushing for resource management as a way to meet their demands for socioeconomic development in the area. As a last resort to press home their demands for the socioeconomic development of the area, it culminated in youth restlessness, hostage-taking, militancy, and violence (Adeyemo, 2003). Nonetheless, the public unrest and actions were seen as a danger to the safety and tranquility of the Nigerian state. Under President Olusegun Obasanjo's direction, the Federal Government established the Niger Delta Development Commission (NDDC) in 2000 through the NDDC (Establishment Act) 2000, No. 6 Law of the Federal Republic of Nigeria, in response to this threat and the reality of poverty and underdevelopment in the Niger Delta region. This was done to ensure the socio-economic development of the region (FGN, 2000; NDDC, 2008).

As a strategic intervention organization, NDDC has a clear mandate to develop, plan, and carry out projects and programs for the socioeconomic development of the Niger Delta region. It is also tasked with developing the region's infrastructure and transforming it into a politically peaceful, socially stable, economically viable, and ecologically regenerative area. (ANEEJ, 2004:22). According to Alaibe (2007), if NDDC is given the right opportunities, the Niger Delta Regional Development Master Plan, which is the NDDC working plan, can solve the region's problems with poverty and underdevelopment. Since its founding, the NDDC has undertaken a number of initiatives aimed at achieving the socioeconomic development of the area. These include community-based programs and projects that involve building community roads, bore holes, free medical treatment, electricity, cottage hospitals, schools, and other facilities. The goal of these initiatives and programs is to promote the socioeconomic growth of the area. Nevertheless, given that the region's poverty and underdevelopment indices are still rising, it appears that the NDDC's programs and projects are either

insufficient there or are failing to achieve their intended goals for the socioeconomic development of the region (Ibeanu, 2008).

Asuquo and Mboho (2024) examined socio-economic development initiatives and primary healthcare services in the Nigerian state of Akwa Ibom, specifically in the Ikot Ekpene Local Government Area. In order to identify the different methods and tactics used by the local government for primary healthcare services and socioeconomic development initiatives, the study adopted the Participatory Development Theory. Two hundred and ten (210) respondents were chosen at random from two clans in the Local Government Area using a survey research approach. Focus group discussions (FGD) were used in addition to an interview schedule and structured questionnaire to help elicit data. Tests for validity and reliability were conducted on the instruments. Statistical Package of Social Sciences (SSPS) Version 20.0 was utilized to assist in the analysis of data using the simple percentage and the ordinary least square simple regression technique. The results demonstrated, among other things, the wide range of methods, tactics, and approaches used by the local government in socioeconomic development initiatives and the provision of primary health care services.

Mafimisebi and Oguntade (2011) looked on the use of traditional and Orthodox medicines in farming households in Ekiti State, Nigeria, and the disparities in health infrastructure between rural and urban areas. The state's access to health facilities was determined to be 68.9%, with a larger percentage in urban than rural areas. Additionally, they discovered that urban farmers spend more than rural farmers on conventional and traditional medicine. The study found that 91.7 percent of rural household heads preferred using traditional medicine to treat non-life-threatening illnesses. They said that the research area's access to healthcare was insufficient. Nigerian health care spending, health care status, and national output were all examined by Eneji et al. (2013). The researchers discovered that there is disparity in health care access in Nigeria due to the country's poor health spending. The authors ascribed Nigeria's poor health status to a number of factors, including inadequate government spending on health, ignorance and unhealthy behavior, bad living conditions, poverty and unemployment, and limited infrastructure and health resources.

Festus et al. (2014) looked into the connection between rural Cross River State, Nigeria, poverty reduction, and health capital. For the study, primary data were used. The study revealed a significant correlation between health capital characteristics, such as the demand for healthcare, the affordability and accessibility of healthcare, and the percentage of household income allocated to health care, and the alleviation of rural poverty. Festus et al. (2014) also noted that the provision of health care services in rural Nigeria was hampered by a lack of access to contemporary medical professionals and financial issues. Using a control function method, Adeoti and Awoniyi (2014) examined the status of child health and the demand for health care services in Nigeria. They discovered that a child's health state is greatly impacted by the child's gender, the mother's educational level, the size of the household, and the sector.

## Theoretical framework

### Big-Push Theory

Paul N. Rosenstein-Rodan's 1943 Big-push theory serves as the foundation for this investigation. The "big-push" theory's basic thesis is that, in order to overcome development barriers and set an underdeveloped economy on the path to progress, a complete program including a minimal amount of investment is required. Theorist emphasized that for a development program to have any possibility of success, a minimum number of resources must be allocated to it. Establishing self-

sustaining growth in a nation is similar to taking an airplane off the ground. Before the craft may take to the air, it must reach a certain critical ground speed. According to the notion, starting the economy "bit by bit" will not successfully put it on the path of development; rather, a minimum level of investment is required for this. It requires gaining the external economies resulting from the concurrent development of industries that are technically linked. For economic development to be launched successfully, therefore, indivisibilities and external economies deriving from a minimal quantity of investment are a prerequisite.

Three distinct categories of external economies and indivisibilities were identified by Rosenstein-Rodan.
1. Distinctions within the function of production.
2. Demand's indivisibility
3. The diversification of the savings supply

When the big-push theory is used to this study, it clarifies the changes that have occurred in the Southern Senatorial District of Cross River State since the Niger Delta Development Commission (NDDC) was founded almost twenty years ago. Since its founding, NDDC has supplied a sizable number of healthcare facilities, which has improved the lives of those living in the area. More grounded assumptions about indivisibilities in the production functions form the basis of the theory. It looks at the route to equilibrium rather than just the circumstances at an equilibrium point. Therefore, it is essentially an investment theory that addresses imprecise markers in developing nations. An underdeveloped economy is brought to an optimal position in such imperfect markets by a high minimum quantum of investment, not by a price mechanism.

## Methodology

For the study, a cross-sectional survey design was chosen. Because this strategy can employ data from a large number of respondents or subjects and is directed by purposive selection, it is deemed acceptable. More specifically, study groups are chosen based on pre-identified differences rather than by chance in a cross-sectional design, which is predicated on existing differences rather than interventional changes. The study used both primary and secondary sources to collect its data. First-hand information collected from respondents during fieldwork served as the primary source. The key sources for this study were the questionnaire (quantitative data), focus group discussions, and interviews (qualitative data). Reviews of scholarly empirical or theoretical works, including those found online, in journals, newspapers, textbooks, and other publications, constituted the secondary data source. 1,200 adult male and female respondents were chosen at random to form the study's sample. At the 0.05 level of significance, the study used Simple Linear Regression Analysis to evaluate its assumptions.

## Results

### Hypothesis one

Hypothesis one states that there is no significant relationship between socio-economic well-being of the populace and the NDDC healthcare delivery initiative. Linear regression was adopted in testing the hypothesis at .05. alpha level. The result is presented in Table 1.

**Table 1: Summary of linear regression results of the relationship between healthcare delivery project and the socio-economic wellbeing of the people**

| | | | | | |
|---|---|---|---|---|---|
| R | .766 | | | | |
| R Square | .586 | | | | |
| Adjusted R Square | .585 | | | | |
| Std. Error | 3.543 | | | | |
| Model | SS | Df | MS | F | Sig. |
| Regression | 7085.217 | 1 | 7085.217 | 564.483 | .000 |
| Residual | 4995.573 | 1198 | 12.552 | | |
| Total | 12080.790 | 1199 | | | |
| B = .772 | t = 23.759 | p< .05 | | | |

An R-value of.766 was found in the results, indicating a high positive correlation between the socioeconomic wellbeing of the population and the healthcare delivery initiative. Additionally, it was shown that the independent variable (healthcare delivery project) explains 58.5% of the overall variance in the socioeconomic welfare of the population, with other variables not included in the model accounting for the remaining 41.5% of the variance. After closely examining the regression analysis's analysis of variance portion, an F-statistic of 564.483 with a p-value of.000—less than the alpha threshold of.05 at 1 and 1198 degrees of freedom—was found. As a result, the alternative hypothesis was kept and the null hypothesis was rejected. In conclusion, there is a strong correlation between the socioeconomic well-being of residents in Cross River State's Southern Senatorial District and the healthcare delivery initiative.

**Discussion**

The results of this study demonstrated a strong correlation between the socioeconomic well-being of residents in Cross River State's Southern Senatorial District and healthcare delivery projects. This discovery offers a foundation for comprehending the part healthcare delivery initiatives play in raising people's quality of life. It demonstrated how having access to these medical facilities and services enhances people's overall health and shields them from all illnesses and disorders. People can go about their jobs, enterprises, farms, and other places of employment where they can earn resources to improve their own and their family members' lives, knowing that their health is guaranteed.

This result validates the findings of Fetus et al. (2014), who discovered a positive correlation between the reduction of rural poverty and health capital variables (health care demand, accessibility, and affordability of health care as well as the percentage of household income dedicated to health care). Additionally, Mafimisebi and Oguntade (2011) found that while 68.9% of the state's population had access to health services, this percentage was higher in urban than rural areas. Additionally, they discovered that urban farmers spend more than rural farmers on conventional and traditional medicine. The study found that 91.7 percent of rural household heads preferred using traditional medicine to treat non-life-threatening illnesses. They said that the research area's access to healthcare was insufficient. Mafimisebi and Oguntade (2011) found that the money that urban and rural households spend on health care represents capital outflows that lower personal incomes. When citizens receive sufficient health care from the NDDC or another organization, not only will life expectancy grow but household income will also rise as a result of savings. A strong healthcare delivery system is a prerequisite for economic growth. In the same manner that a population free from disease will contribute minimally to the meaningful growth of society, so too will a sound and healthy populous.

## Conclusion

The need for better healthcare services for everyone has grown as residents of Cross Rive State's southern senatorial district rely more and more on the NDDC's healthcare systems and services to meet their demands. Specifically, the NDDC focused its productive activities that may improve the socio-economic well-being of the populace on healthcare delivery in the southern senatorial district of Cross River State, Nigeria. Nonetheless, these initiatives have contributed to the improvement of the socioeconomic well-being of the populace by lowering the prevalence of several illnesses, such as cholera, typhoid, malaria, guinea worm, diarrhea, and unsafe childbirth, among others.

## Recommendations

The findings led to the following suggestions being made:

I. The government should provide healthcare delivery services to communities without facilities through the NDDC.
II. Regardless of socioeconomic or financial level, medical services and healthcare facilities should be enhanced, made accessible, and inexpensive for everyone. 2. The commission's needs assessment technique should be reexamined to represent the perceived needs of the people.
III. The NDDC shouldn't be the only organization in charge of providing healthcare services in rural areas.
IV. The Local Government Area and other levels of government should allocate more funds to the health sector so that medications and vaccines can be provided to fight the numerous deadly diseases that affect children.
V. To eradicate the numerous diseases that kill children, there needs to be a stronger emphasis on comprehensive and efficient public health education.
VI. Sustaining excellent health requires maintaining a minimal level of health, as well as improving housing, water, sanitation, environment, and food supply.

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