



Delivering the global visions: Sustainable Development Goals and politics of public healthcare provision in Nigeria

Casmir Chukwuka **Mbaegbu**^{1,5}, Christian Obinna **Ugwu**²,
Quentin C. **Chukwu**³ & *Kenneth N. **Dim**⁴

¹Department of Political Science, University of Nigeria, Nsukka,

^{2,3,4}Peace and Conflict Studies Unit, University of Nigeria, Nsukka,

⁵Health Policy Research Group, College of Medicine,
University of Nigeria, Enugu Campus.

*Corresponding author: kenneth.dim@unn.edu.ng

Abstract

The issue of government expenditure on healthcare services, particularly regarding quality, affordability, and accessibility, remains a subject of intense debate in Africa, especially in Nigeria. To what extent do the Sustainable Development Goal (SDG) 3 and its indicators align with primary healthcare schemes in Nigeria? SDG 3, which seeks to 'attain healthy life for all at all ages,' calls for global action as health is essential for sustainable development, and this study examines the challenges that hinder the delivery of the SDG 3 target in both urban and rural settings. We examine these challenges in relation to the International Financial Institutions' limitations on state participation in social security. Mixed methods of data collection, namely survey and documentary analysis, were employed. The study predicates its investigations on the theory of the post-colonial state, and contends that the reality of government dereliction of public healthcare provision is concealed in politics and government's avowal to unwholesome development theses that thrive on neo-liberalism. We recommend, amongst others, the need for sustained government support and efforts to

improve and expand access to healthcare at the primary healthcare (PHC) levels through an accountable model of health governance and strategies that align with the SDGs.

Keywords: Sustainable Development Goals, healthcare provision, primary healthcare, neo-liberalism, postcolonial state theory, development

Introduction

Several decades of grappling with global development initiatives, actions, projects, programmes, initiatives and policies have, tolerably, at best, resulted in meagre profits, as destitution, increasing disparities, social inequalities, exploitation, exclusion, a sharp decline in living and employment standards, and the progressive dismantling of government social security systems persist. Moreover, a few salient issues emanating from the activities of the various policies, enterprises or initiatives, despite their different names, reveal fundamental similarities in their conceptual foundations, indicators, outcomes, and impacts on destitution and underdevelopment. Poverty is a function of the structure and orientation of the political economy and the retrogressive state of its productive forces, which are supposed to drive industrialization, and catalyze economic growth and development (Onokwai, 2020). Africa's teeming population is increasing at a

geometric proportion and is faced with the challenge of providing sustainable development for its teeming population. The crisis of Africa's development trajectory has a direct link with excessive debt, reliance on the export of raw materials, economic disempowerment, leadership failures, unemployment and poverty, increasing rate of illiteracy, and dilapidated health system (Onuoha & Mbaegbu, 2022).

In Africa, particularly in Nigeria, the state-market interactions in development agenda and processes, especially since the post-independence era of the 1960s, have centred on the contestation over the development agency. Historically, Nigeria was among the 189 nations across the globe that supported the United Nations Millennium Declaration in New York in September 2000, which led to the confirmation of the eight fixed-term Millennium Development Goals (MDGs) and their indicators, to be achieved by individual nations by 2015 (OSSAP-MDGs 2015). The 2015 MDGs end-point

scorecard showed that Nigeria has made considerable progress in the achievement of MDGs, specifically, in the area of global primary education enrolment, gender parity in education, the containment of the spread of HIV and AIDS, the reduction of maternal mortality, as well as halving the percentage of persons living in extreme hunger for which it obtained acknowledgment from the Food and Agricultural Organization (FAO) in 2013. Despite such considerable success, a few of the targets could not be met as a result of pervasive poverty, security challenges, social disparity, lack of comprehensive development and youth joblessness (OSSAP-MDGs, 2015). There is still a high incidence of newborn and young child mortality. Hence, the implementation of the MDGs in Nigeria remains an unfinished business that needs to be aligned with the successor Sustainable Development Goals (SDGs) structure (OSSAP-MDGs, 2015; Nwosu, 2017).

African countries are signatories to the seventeen (17) SDGs, one hundred and sixty-nine (169) targets and five hundred (500) indices, which encompass a vast scope of development concerns ranging from ending poverty and hunger, enhancing health and education, making

cities more sustainable, combating climate change and preserving the environment (United Nations, 2015). The SDGs replaced the MDGs as reference goals for global development for the period 2015–2030. The SDGs are designed to address poverty alleviation in all countries and place sustainability at the heart of the development agenda, while recognizing the need to address the complex links between development and the environment.

Healthcare service delivery in Nigeria is a shared responsibility of the three levels of government (Rais, 1991). PHC is regulated by the Federal Government through the National Primary Health Care Development Agency (NPHCDA). The health care services at the Local Government Area (LGA) are led politically by a supervisory councillor and professionally and managerially by a PHC coordinator and aided by a deputy coordinator. The PHC coordinator gives an account to the supervisory councillor, who equally gives an account to the LGA Chairman (Federal Ministry of Health, 2004; Adeyemo, 2005). This is corroborated by Odii et al. (2022), who posited that the political and health system governance structures are interconnected. The LGA is the authority responsible for controlling, administering

and funding primary or grassroots healthcare. They are made up of elected leaders who are political office holders (LG chairpersons/councillors), and administrative heads (i.e., head of department of health (HOD)). The healthcare provisioning at the LGA is yet to see the anticipated changes with regard to capability, effectiveness and low-cost. Nigerian citizens continue to die from common illnesses like malaria, typhoid fever, cough, and so on, due to over-politicisation of domestic resource mobilization and the neglect of the PHC, which serve rural and hard-to-reach populations.

The current state of many of the PHC facilities in Nigeria shows that public healthcare provision is tied to political patronage, prebendal networks and elite connections. Thus, PHC services mirror political organization. The public healthcare delivery is mainly funded by the government, a trend which is now faced with poor funding, decreased efficiency, inadequate health facilities and poor maintenance. Limited health provisioning in the health sector is more skewed toward healthcare systems with projected high return, reinforced by the politics of urban-rural disparity in the allocation of healthcare resources (Abdulraheem et al., 2012; Kress et al.,

2016). Clearly, a noticeable lacuna exists between the current status of PHC fragile health provisioning in Nigeria and the targets of achieving SDG 3. Thus, very limited progress has been made on achieving the health SDG. Although extant literature is replete with scholarly research on healthcare provision, it has largely overlooked the challenges that undermine health provisioning at the PHC. Hence, the focus of this study is to interrogate the challenges that hinder the delivery of SDG Goal 3 in Nsukka LGA, Enugu State, Nigeria.

Literature review

The quest for sustainable development primarily drives the individuals, national governments and wider international community into social and economic prosperity for a secure future. Achieving health security is an essential condition for enduring development. Amid insecurity, climate change, economic recession, inequality, population displacement and poverty, less developed economies over the years struggled to mainstream the principles of sustainability in their development interventions and practices (Okolie et al., 2024). SDGs succeeded the MDGs as reference goals for international development for the period 2015–2030. The SDG 3 treats all key health priorities,

seeking to certify healthy lives and engender good health for everyone by the year 2030 (United Nations, 2017).

SDGs are seen as a chance to bring together diverse development efforts under a single framework (Numes et al., 2016). The seventeen (17) SDGs entail a considerably wider scope of issues than their predecessor MDGs. They strive to be universal– that is, appropriate to all states and not only developing states, and represent evidence of a universal movement to sustainable development (Vladimirova & Le Blanc, 2015). Murray (2015) identifies 23 health-related SDGs targets, while Le Blanc (2015) identifies seven targets related to health within the SDGs and asserts that health is linked to an additional eight goals. The World Health Organization (WHO) (2015), in a report, provides a more comprehensive list of health-related SDGs, which includes 27 targets plus all the health goal targets.

Good healthcare provisioning is an indispensable condition for sustained economic and social development and has implications for human wealth security and overall national development (Mbaegbu, 2017). This capacity has been undermined by poor budgetary provision by national governments and reinforced

by the neoliberal thesis, which discourages extensive state investment in essential social services like housing, water, and healthcare provisions. Mbaegbu et al. (2025) assert that the ongoing cuts to global health funding and constrained domestic health budgets undermine progress towards the achievement of universal health coverage (UHC) and other global health goals.

PHC continues to be recognised internationally as a crucial strategy for achieving the health-focused SDGs and UHC (Pettigrew, 2015; Puras, 2016). PHC resources provided at the community include health education, maternal and child care services, including family planning, treatment of locally prevalent and pandemic diseases, basic oral health services, immunisation, prevention and control of endemic diseases, treatment of endemic diseases and injuries, supply of essential drugs, primary laboratory and pharmaceutical care. The network of PHC facilities is designed to address the health needs of the community dwellers and constitutes the first interface between the people and the healthcare system (Nwokoro et al., 2022; Oussama & Mohammed, 2023).

Generally, the condition of some of the primary health edifices leaves much to be

desired as they are in deterioration, poorly furnished and with staff accused of not being dedicated to work. The PHC has remained underfunded as a result of the politics of fund allocations and staff welfare in comparison to other health institutions at the sub-national and national levels. This has made PHC weak in terms of human resources for health, which are essential and drivers of health systems. The resultant effect of all these challenges in Nigeria is corruption, inefficiency, ineffectiveness and unhealthy politics of healthcare provision at the PHC level (Kress et al., 2016; Onwujekwe et al., 2019; Agwu et al., 2020). Added to these challenges are the level of health politicking by elites with respect to siting of PHC facilities, and budgetary allocations.

Politically, the health sector in general and PHC in particular have been undermined by power and the social networks and influence of politicians. Whereas occasionally admitted or averred, politicking can be the clear-cut or inferred causes of many problems encountered in the siting, working and operation of PHCs. Politicking acts as a method by which groups with power and influence get preferred outcomes or advantages. Debatably, politicking is connected with humanness, and this

drive is embedded in power dynamics, as reflected in the distribution of tasks and delineation of ranks (Vredenburg & Shea, 2010). The politically influential members of society or the elites leverage their connection to power to get benefits over others, more specifically when resources are scarce or when regulations are simply flaunted or circumvented without penalties. Extant literature has shown how power, politics and kingship determine the authoritative allocations of values in society at large and the health sector substructure in particular (Odii et al., 2022), and these have been deployed through the politics of who gets what, when, why and even how in delivering health outcomes in PHC facilities in Nigeria.

Theoretical framework

We predicated the analysis on the premise of some basic propositions emanating from postcolonial state theory. The notable exponents of the post-colonial state theory are Marx and Engels, who argue that the significant objective of the contemporary state is only a committee for overseeing the regular undertaking of the bourgeoisie (Marx & Engels, 1977). The theory posits that the state is a self-contained coercion and an unbiased monitor that takes care of the interests of every member of the

state. However, a society which emanated from conflicts within the classes produces an authority, the state of the most influential and economically dominant class, which by this process equally suits the politically ruling class and hence develop new method of impeding and manipulating the oppressed (Jakubowski, 1973). The state sovereignty in this class society is accordingly more evident than factual, for the state remains the contraption of the ruling class for duping and repressing the working class. It is in this light, given the milieu and specific manifestations of the Nigerian postcolonial state, that we can explicate and appreciate why the government uses the commonwealth at its disposal to allocate meagre resources to health and engage in primitive accumulation over the health of the local populace.

With regard to the application of the theory to the research, there appears to be a consistent attempt by succeeding governments in Nigeria to rationalize government expenditure on the basis of derivation, even development, need, national interest, continuity of government services, equality of states, population, equality of access to development opportunities, etc. The Nigerian government takes decision of

who gets what, when and how. In fact, the state determines the content, intent, process, application, and outcome of the political agenda of infrastructure (health) and financial allocations to it. However, the neoliberal dialectics of the global movement of capital reproducing the state in Nigeria and its policies boil down to private expropriation of public resources to the detriment of citizen healthcare provisioning. The point, however, is that the Nigerian state, due to its appendage to foreign capital and neo-colonial authoritarian control, has failed as a social manager, financier and facilitator for healthcare delivery to Nigerians.

The critical institutions of the state in Nigeria essentially carry out the interests of the ruling class, which depend on the primitive accumulation of the commonwealth at the detriment of the provision of social welfare. Moreover, the Nigerian leaders follow the line of least resistance and thrive on reckless and unregulated importation of foreign commodities rather than investing in productive ventures. These practices truncate development plans and entrench a politics of settlement and resource allocation to private interests. These conditions explain the challenges of healthcare delivery at the PHC stage in

Nigeria. The local and state governments are satisfied with the sharing of monthly allocations rather than providing adequate funding for health, especially PHC at the local government level. It is observed that there is poor funding for health, and the pursuit of a development paradigm that merely stultifies sustainable human development. Also, Nigeria has never made endeavours to get to the 15% point that was consented by the African states/WHO Declaration at Abuja in 2001 on Health.

The imbalance connected with healthcare from the imperial era has remained unchanged, even though more hospitals and skilled manpower now appear to be accessible. This situation justifies the individual-driven idiosyncrasy of the ruling class and the subordination of healthcare to a private-enterprise ideology of wealth accumulation. The weak economic base of political leaders who see public position as a means of strengthening their economic base through primitive capital accumulation coincides with the government's withdrawal (from funding) of essential social services. Hiding under the minimalist (reduction of government spending) argument, the political leaders misappropriate the funds for their own selfish and personal gratification. Thus,

the Nigerian government allocates a paltry percentage of its health financial plans to municipal hospitals, while leaving hinterland dwellers without suitable health infrastructures.

Government disbursement on social safety nets, particularly in the health departments, has been decreasing as a result of the government's avowal to unwholesome development theses that thrive on neo-liberal policy of cut or reduction in government spending, which reinforces corruption, lack of political will, and partisan political considerations of the ruling class. There is ample evidence to show that healthcare provisioning is meagre in agrarian communities. The poor state of hospital infrastructure at the PHC impedes citizens in the community from seeking medical care. Thus, these rural and hard-to-reach dwellers have been made to grapple with higher morbidity and mortality rates across virtually all disease categories.

Methodology

Study area

The study is in Nsukka LGA, Enugu State, and Southeast Nigeria. It is an urban LGA with 37 communities, mainly urban communities and a few rural ones. It has 3 public secondary and 23 public primary

health facilities. Healthcare facilities are supplied to the urban communities through a combination of district hospital, cottage hospital, private health facilities and faith-based hospitals, while the healthcare provisioning to the rural communities is carried out by the PHCs and some health posts located across the communities. The choice of Nsukka LGA is justified by the rural and urban characteristics.

Data collection

The study adopted a mixed-method approach of data gathering, namely, survey and documentary methods. The survey and documentary methods of data collection were comprised of Focus Group Discussion, field observations, reference to relevant literature, and questionnaire survey of respondents. The lead investigator (first author) and co-authors visited all 19 health facilities within three months (August – October 2023). The questionnaire titled; Utilization of Public Primary Healthcare Facilities Questionnaire was adopted for data gathering. The questionnaire was made up of two sections, A and B. Section "A" contained bio-data details about the respondents. Section "B" consisted of two clusters with 3 items or statements each. The response options to the items in

section B of the instrument were based on a four-point scale with response options of Very Strong Progress (VSP), Strong Progress (SP), Fair Progress (FP) and Weak Progress (WP) with numerical values of 4, 3, 2, and 1, respectively. Out of the 190 copies of the questionnaires administered, 181, representing 95.26 per cent of the sample, were retrieved and dissected with Statistical Package for Social Sciences (SPSS).

Selection of study participants

One hundred and ninety (190) participants were intentionally chosen for the research, and they are made up of trained health practitioners who were mainly Officers in Charge (OIC) and community users of PHCs in the 9 urban and 10 rural public primary healthcare facilities. They were interviewed within the study period. Introduction letters detailing the objective of the study were given to every chosen OIC. Thereafter, we went to all the chosen health facilities and got the approval of the community users of the PHCs after describing the research and illuminating the advantages and hazards. Interviews were arranged with agreed-upon participants on days and times that were suitable.

Data analysis

Numerical and qualitative data interpretations were used in the research. Descriptive statistics of mean and standard deviation were adopted to ascertain the extent of delivery of the SDGs 3 into the health-care needs of the people of Nsukka LGA, Enugu State. SDG 3 served as the independent variable, while the politics of public healthcare provision served as the dependent variable. The interpretation of the mean was based on the actual limits of numbers, where a mean of 3.50–4.50 connotes Very Strong Progress (VSP), 2.50–3.49 connotes Strong Progress (SP), 1.50–2.49 connotes Fair Progress (FP), and 0.50–1.49 connotes Weak Progress (WP) (adapted from Nworgu, 2015). Verbatim quotes were used to corroborate the quantitative data through systematic logical inductions.

Determination of the sample size

There are 32 (11 urban and 21 rural) public PHC facilities in Nsukka LGA, Enugu state (Nsukka District Health Board, Nsukka LGA, 2017). A disproportionate stratified random selection technique was adopted to draw 10 users each from the 9 public primary healthcare facilities in the urban areas, while 10 users each were drawn from 10 randomly selected government primary healthcare infrastructures in the hinterland areas, making a total number of 190 (90 from urban and 100 from rural areas) respondents for the study. The 190 respondents constituted the sample of this study from which relevant data were collected. Thus, the sample of the study based on the disproportionate stratified random selection method is shown in Table 1 below

Table 1: Sample size of Nsukka Local Government Area public primary healthcare facilities, officers interviewed and users

S/N	Name	Location	Disproportionate stratified random sampling of PHC Users
1	Agbamere Model Health Centre	Urban	10
2	Ajuona Obimo Health Clinic	Rural	10
3	Aloruno Health Post	Urban	10
4	Amaogbodo Ogbozalla Health Post	Rural	10

5	Ede-oballa Health Centre	Rural	10
6	Edem Health Post	Rural	10
7	Ehandiagu Health Centre	Rural	10
8	Isi Enu Health Centre	Urban	10
9	Nru Health Post	Urban	10
10	Nsukka Health Centre	Urban	10
11	Obimo Health Centre	Rural	10
12	Ibagwa-Agu Health post	Rural	10
13	Ibagwa –Ani Health Centre	Rural	10
14	Lejja Health Centre	Rural	10
15	Opi Health Centre	Urban	10
16	Umuoyo Health Centre	Urban	10
17	Ogbagu-Obukpa Health Post	Urban	10
18	Nguru Health Centre	Urban	10
19	Opi Agu Health Centre	Rural	10
Total			190

Source: Author's Compilation (2023)

Analysis of respondents

As a corollary to the above, out of the 190 administered questionnaires, 181(95.26%) were returned and subsequently analysed. The response rate of 95.26% was therefore considered adequate for the study. The ages of the targeted users ranged from 1 month to 65 years. The above targeted users also showed that 13.2% of the respondents are fathers, 59.3% are mothers (aged mothers and nursing mothers), and 27.5% are children above 10years old and adults. The respondents were literate,

with educational attainment levels distributed as follows: 29.6%, 30.8% and 39.6% respectively.

Similarly, the ages of the OICs or the Community Health Practitioners (CHP) interviewed at the public PHC facilities located within metropolitan and hinterland areas ranged from 35 years and above. Similarly, the educational qualifications of the CHP or the OICs of the Public PHC facilities showed that 26.5% were Community Health Officers (CHO), 33.7% were Senior Community

Health Extension Workers (SCHEW), and 39.8% were Junior Community Health Extension Workers (JCHEW). Thus, all

respondents possessed one professional qualification or the other. This is indicated in Table 2:

Table 2: Educational Qualifications/Ranks of the Community Health Practitioners (CHP)

S/N	Educational Qualifications/Ranks	Percentage Attainment (%)	Frequency
1	Community Health Officer (CHO);	26.5%	26
2	Senior Community Health Extension Worker (SCHEW)	33.7%	34
3	Junior Community Health Extension Worker (JCHEW)	39.8%	40

Result

The result of the analysis showed that there is fair progress in procreative, parental and newborn health; prevention of transmissible, non-contagious and environmental ailments; and increased health financing of the SDG 3 ($\bar{X}$ =1.51, SD=.41 for urban and $\bar{X}$ =1.73, SD=.48 for

rural). Similarly, there is fair progress in the politics of public healthcare provision, and thus it undermined SDG 3 ($\bar{X}$ =1.77, SD=.65 for urban and $\bar{X}$ =2.03, SD=.71 for rural) parts of Nsukka LGA, Enugu State. The mean and standard deviation value of urban and rural users for SDG 3 (items 1-3) is shown in Table 3.

Table 3: Descriptive analysis of data on SDG 3

Items/Statements	Location	N	Minimum	Maximum	Mean	Std. Deviation
1. Reproductive, maternal and child health	Urban	87	1	4	1.56	.76
	Rural	94	1	4	1.77	.96
2. Communicable, non-communicable and environmental diseases	Urban	87	1	4	1.62	.84
	Rural	94	1	4	1.80	.82
3. Increased health financing	Urban	87	1	4	1.34	.68
	Rural	94	1	4	1.63	.88
Grand Mean	Urban	87	1	4	1.51	.41
	Rural	94	1	4	1.73	.48

Key: N = Number of respondents, $\bar{X}$ = mean, SD = Standard Deviation. Analysis based on actual limit of numbers, where a mean of 3.50-4.50 connotes Very Strong Progress (VSP), 2.50-3.49 connotes Strong Progress (SP), 1.50-2.49 connotes Fair Progress (FP), and 0.50-1.49 connotes Weak Progress (WP) (Adapted from Nworgu 2015)

The means for all the items, including the grand mean, ranged from 1.50 to 2.49, indicating fair progress in SDG 3. The standard deviations for the items ranged from 0.41 to 0.96, which shows that the responses of the respondents were close

to each other and to the mean. Thus, there is fair progress in procreative, parental and newborn health; prevention of transmissible, non-contagious and environmental ailments; and increased health financing of the SDG 3.

Similarly, with regard to the mean and standard deviation values of urban and rural users for politics of public healthcare provision (items 1–3: provision of essential drugs; disparities in access, quality and outcomes of healthcare within and among urban and rural dwellers; and poor political will and management of human resources for health) are indicated in Table 4.

Table 4: Descriptive analysis of data on the politics of public healthcare provision

Items/Statements	Location	N	Minimum	Maximum	Mean	Std. Deviation
1. Inadequate provision of essential drugs	Urban	87	1	4	1.93	.97
	Rural	94	1	4	2.19	1.03
2. Disparities in access, quality and outcomes of healthcare within and among rural and urban dwellers	Urban	87	1	4	1.52	.85
	Rural	94	1	4	1.78	.92
3. Poor political will and management of human resources for health	Urban	87	1	4	1.86	1.00
	Rural	94	1	4	2.13	.99
Grand Mean	Urban	87	1	4	1.77	.65
	Rural	94	1	4	2.03	.71

Key: N = Number of respondents, $\bar{X}$ = mean, SD = Standard Deviation. Analysis based on actual limit of numbers, where a mean of 3.50-4.50 connotes Very Strong Progress (VSP), 2.50-3.49 connotes Strong Progress (SP), 1.50-2.49 connotes Fair Progress (FP), and 0.50-1.49 connotes Weak Progress (WP) (Adapted from Nworgu, 2015).

The means for all the items, including the grand mean, ranged from 1.50 to 2.49. This implies there is fair progress in the politics of public healthcare provision. The standard deviations for the items ranged from 0.85 to 1.03, which shows that the responses of the respondents were close to each other and to the mean. Therefore, there is fair progress in the politics of public healthcare provision, and thus it undermined SDG 3 in the hinterland and metropolitan settings of Nsukka LGA, Enugu State. The following responses justify the above results.

There is inadequate financing of PHC facilities and services at all levels of government, especially in rural areas. According to the Community Health Officer at Ibagwa Agu Health post, there is poor funding for maintenance of the infrastructure, for the purchase of health consumables and other medical products.

The government renovated this place, putting only new zinc and ceiling, even painting they did not paint; they have not finished this one. They went and removed the roof of this other one, saying they will complete both of them, but now they say they have no money to continue and it has been like this for one year now (Community

Health Officer, Rural Location, August 4 2023).

Another Community Health Officer in Ogbagu-Obukpa health post complained of low-paid salary step of health officers in Nsukka LGA, avowing that other LGA pay better.

Nsukka Local Government is poor in salary; they are not paying us well; the other local governments' staff are getting much more than us in their salary. Somebody in level 12 here is paid eighty-five thousand, and someone in level 13 is ninety-six thousand, but in other local governments, someone in level seven is one hundred and eleven thousand. Where did we go wrong, and who did we offend? (Community Health Officer, Urban Location, August 10 2023).

In Nsukka LGA, the PHC centre has been abandoned by the government to rot. This is the case in Ajuona Obimo Health Centre, as narrated by the OIC:

The situation of the health centre had affected patients' patronage of the facility. We lack drugs, doctors, nurses and lab facility, and these make us not to see

patients. We don't have lab for basic tests. Some existing medical equipment, including delivery tools are old. When I came here, it was a glorified health centre and even till now, it is a shadow of itself, which is why the community members do not come here (OIC, Rural Location, September 15 2023).

Discussion of findings

The descriptive analysis in Tables 3 and 4 showed that SDG 3 and the politics of public healthcare provision exhibited a similar pattern of outcomes, respectively. Arising from the review of extant literature– (United Nations, 2016, 2017; Numes et al., 2016), it can be deduced that SDG 3 addresses key health concerns, such as access to safe, effective, high-quality, and reasonably priced medications and immunizations for everyone, as well as reproductive, maternal, and child health, in addition to non-communicable, communicable and environmental related diseases. With regard to the politics of public healthcare provision, the findings revealed inadequate provision of essential drugs, disparities in access, quality and health outcomes of healthcare within and among rural and urban dwellers and these are undermined by poor political

will and management of human resources for health. This was enabled by corruption and inefficiency in the management of public healthcare. The above findings are consistent with Naher et al. (2020) and *Onwujekwe* (2020), who opined that corrupt tendencies and poor leadership in low and middle-income nations undermine the provision of vital, high-quality healthcare services for the poor, hard-to-reach and underprivileged populations, which leads to unfavourable health consequences in communities.

The infant mortality rate at urban area is 13 fatalities per 50 live births in 2021, compared to 21 fatalities per 50 live births in 2021 in the rural area, according to the data from the Nsukka District Health Board, Nsukka LGA. Similarly, the rate of maternal death declined slightly from 19 fatalities per 100 live births to 9 fatalities in 2021 for urban areas and from 41 fatalities per 100 live births to 15 fatalities in 2021 for rural areas. Also, 15 per cent of children receive all recommended childhood immunizations, which include measles, BCG, three doses of each of diphtheria, pertussis, and tetanus (DPT and polio), for urban areas, while 8 per cent for rural areas. However, only 21 per cent of females in the rural areas have the ability to seek professional birth attendants, while 55 per cent of

females in the urban areas have such access. While 85 per cent of people in metropolitan areas have access to sanitary facilities, 71 per cent of people living in agrarian areas do not. The above finding is similar to an earlier study conducted in India that recorded the current disparity in under-five mortality between rural and urban areas, and showed that Indians in remote areas always die at a higher rate than Indians in metropolitan areas (Kumar et al., 2022).

Using simple mean and standard deviation descriptive statistics, the SDG 3 dimension, namely illnesses related to reproduction, maternal and child health; infectious, non-communicable, and environmental diseases; as well as increased health financing, were analysed. The result of the analysis also showed that SDG 3 was undermined by the politics of public healthcare provision, which manifested in inadequate provision of essential drugs; disparities in access, quality and outcomes of healthcare within and among rural and urban dwellers. Empirical evidence from the interview and field work revealed fair progress in the provision of basic health-care service delivery on attainment of the SDG 3 in Nsukka LGA PHC, Enugu State, Nigeria and particularly in the

hinterlands; however, substantial efforts are still required to fully achieve SDG 3 in the present and beyond. In an earlier study by Ekenna et al. (2020), the evidence was similar to this study as there were significant gaps identified in PHC delivery, which require substantial interventions to advance UHC, a critical prerequisite for achieving health-related SDG targets. The above points were corroborated by the OIC at the Lejja Health Centre:

We lack the basic equipment that this health centre needs, including the drugs that we use to treat patients. To deliver a baby in a labour ward during the rainy season is a big challenge as we have leaking roofs. We usually move our patient to the palpation room and stay there to conduct the delivery; there are no light and security people. As a result, we cannot run night shifts (OIC, Rural Location, October 5 2023).

Another critical flaw relates to the availability of common and necessary medications. The majority of health facilities are merely consultation rooms, with limited or no drug supplies. Because medications are not easily accessible, patients' only alternative is to patronize

pharmacies that frequently sell counterfeit medications. This always results in further deterioration of patients' health. As a result, Nsukka PHC facilities receive little funding, which results in subpar services. Due to their lack of exposure to high-quality healthcare, the majority of the rural communities these centres are meant to serve accept whatever services they receive as the best and rarely lodge complaints. They often resort to the services of quacks or traditional healers when they are unable to access the required medical treatments. Evidence from our visits to urban and rural areas in Nsukka LGA indicated that user charges for health care in the public PHC are costly, which can lead to resorting to other means at the time of illness. This corroborates the interview granted by the OIC of Nsukka Health Centre. According to him,

Normally, when people fall sick, they spend part or all of their savings on paying for treatment either at the nearby "chemist" or "nurse", traditional doctor, clinic or hospital etc. They also tend to look for the cheapest options- if the health centre charges are more than they can afford and they are unable to raise the

required amount, they either request for the drug to be left out, they leave the health centre and look for a cheaper place (which sometimes are operated by unqualified personnel/quacks) (OIC, Urban Location, August 25 2023).

The OIC of Agbamere Model Health Centre corroborated the above and even went further to say that political interference has affected primary healthcare services in rural areas.

Politics has spoilt everything. The government contributed to the health center's low customer traffic and inadequate service delivery. Politics and selfishness on the part of the leaders affected the government's earlier proposed renovation and upgrade of the health facility, and even in employing staff for the health facility. Employment is on the basis of political interest and greediness. This makes the facility to lack dedicated and experienced staff. These inexperienced staff working in the health facility are relatives and friends of the government in power, and the moment they are deployed to a

health facility, off they go. They are lazy and truant. And their political backbones determine what health facility they will be posted (OIC, Urban Location, September 20 2023).

From the above, it can be deduced that the major critical factors that contribute to the under-performance of the Nigerian health system, and particularly the PHC, are political and social networks. Earlier studies have argued that health officers may be in political ties—sometimes referred to as "godfathers"—with elected politicians in the political system or local government, with whom they trade votes and other types of support in exchange for protection. These officers often take pleasure in having connections with strong, prominent individuals, which enables them to go against the constituted authority without being sanctioned (Sharma, 2010; Odii et al., 2022).

There are significant infrastructural, equipment and manpower inadequacies in Nsukka PHCs. PHC, as the fulcrum for reducing disease burden and achieving the health-related SDGs in Nigeria, is not functioning optimally in most rural areas where it is needed most. Thus, in Enugu State, nay Nigeria, the amount spent on

social welfare, particularly on the health sector, has decreased as a consequence of the government's avowal to unwholesome development theses that thrive on the neo-liberal policy of reducing government spending.

Government policies and actions significantly affect the health of the people. The health financial allocation is still less than the recommended 15 per cent that the Nigerian government signed up to under the Abuja Declaration in 2001. Since then, the budget pattern has continuously declined in value, creating concerns that the nation may not achieve the SDG3 of 'ensuring healthy lives and promoting well-being for all at all ages' by 2030.

Conclusion

The study has shown that the health status/provision at the public PHC centres in Nsukka LGA is poor and that healthcare financing is weak. The study's findings demonstrated that cuts in government expenditures on health influence the kind and quality of services that the impoverished can access. Thus, the poorest people living in both remote communities and metropolitan locations in Nsukka LGA have the greatest difficulty accessing the health services they need. These barriers lead to low usage of medical services and inadequate

health outcomes. The study found that political considerations and influences in public healthcare provision have undermined SDG 3. To improve this, much needs to be done to make progress towards the attainment of SDG 3 and other health-related goals.

This study was able to establish that there is a weak link in all the indices and indicators of SDG 3 and public healthcare provision in Nsukka LGA, Enugu State, Nigeria. The implication of these findings is that the public PHC system at Nsukka LGA continues to be underfunded, has insufficiently trained personnel, operates with subpar infrastructure, and has an insufficient essential medicine supply. The public's access to high-quality health care is nevertheless impacted by these shortcomings. Thus, there is an inherent political dimension in public healthcare provision, which manifests in government negligence of the PHC centres, which are central to the healthcare needs of the rural populace. Nigeria's plan for development is bedevilled by inadequate coordination between and among the different levels of government, which is periodically brought about by the dynamics of the system. The intended PHC reform of the delivery system in terms of affordability and efficiency has not occurred. The politics in primary

healthcare provisions, wrapped in political patronage poses a risk to the realization of UHC, as it undermines basic healthcare services for underserved and hard-to-reach communities. The OICs were left on their own to act as attendants, doctors, and nurses. These roles are combined into one, which does not bode well for the delivery of high-quality healthcare for the populace.

Following the above results, this study puts forward the following policy recommendations:

1. There should be sustained government policy thrusts and efforts to improve and expand access to healthcare, and to raise patient satisfaction with the standard of care received in both the urban and rural areas of PHC facilities. This can be achieved through local and multi-sectoral collaboration at the PHC levels; digitizing health records and the establishment of e-health platforms to track the allocation and utilization of healthcare funds. In addition, the use of local stakeholders for oversight functions would prevent the diversion of funds.

2. There is a need for a strong link and enhanced multi-sectoral synergy between the government and non-state health groups to improve PHCs, as well as to integrate and localize the identified actions and realities of urban and rural dwellers into a broader framework of the SDGs. This can be achieved by ensuring that PHC systems reflect communal ownership and the socio-economic context of the people. Such an approach would replace neo-liberal restrictions with a participatory and accountable model of health governance that aligns with the attainment of the SDGs.

ORCID

Casmir Chukwuka Mbaegbu: Orcid no: <https://orcid.org/0000-0001-6118-6206>

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