International Journal of Advanced Research in Global Politics, Governance and Management | IJARGPGM
p-ISSN: 2636-686X | e-ISSN: 2636-6878
Volume 5, Number 1 October, 2025

Local Government Administration and Primary Healthcare Delivery in Akwa Ibom State, Nigeria

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Article DOI: 10.48028/iiprds/ijargpgm.v5.i1.03

Abstract

The main objective of this study was to investigate the impact of local government administration on primary healthcare delivery in Akwa Ibom. Specifically, it assessed the roles of Akwa Ibom State's third tier in the provision of essential drugs and facilitation of immunisation for the sustainable health management of its citizens. The study employed descriptive and survey methods, grounded in structural functional theory. Data were collected from both the primary and secondary sources. The study targeted six (6) local government areas in Akwa Ibom State, with a sample size of 384, using a stratified sampling technique. Data were analysed using the ordinary least squares simple regression technique in SPSS version 28. The study's findings revealed that local governments play a significant role in providing essential drugs for accessibility and facilitating immunisation programs at primary healthcare centres in Akwa Ibom State. Thus, it was recommended that Local Governments should improve procurement of essential drugs, ensure prompt facilitation of immunisation programs to prevent childhood morbidity and mortality, and ensure adequate and functional medical tools for accurate diagnosis and effective treatment of citizens at the Local Government levels of Akwa Ibom State.

Keywords: *Local government, administration, primary healthcare, essential drugs, immunisation programs*

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Background to the Study

Over time, roles assigned to the Nigerian local governments have evolved, such that they have gradually moved beyond regulatory roles and gained constitutional authority to deliver critical social services, as agents of grassroots development. This is synonymous with decentralisation advocacy, which argues that increased autonomy and citizen participation at the local level would promote accountability, enhance service delivery, and support good governance (Okojie, 2010; Mbon et al., 2025). The decentralisation of administrative structure is laden with political, fiscal, and administrative powers, enabling local governments to enact local laws, manage resources, and deliver services effectively.

Inadvertently, a stable and functional local government system is largely contingent on its ability to deliver essential services (Gberevbie et al., 2014; Ejue & Maduebueze, 2014; Ukpe, (2015), especially in democratic settings. Thus, primary healthcare (PHC) is one of the most critical services that local governments are tasked with. It encompasses a wide range of preventive, curative, and rehabilitative public health services, which collectively improve health outcomes. PHC is a fulcrum for human development, affecting indicators such as education, nutrition, and sanitation, which contribute to the Human Development Index (HDI).

The concept of PHC was globally endorsed in the Alma-Ata Declaration of 1978, positioning it as the cornerstone of national health systems (World Health Organisation, 1978). Its goal is to make healthcare services accessible, affordable, and community-oriented. PHC is also designed to offer early intervention for common illnesses and to support long-term health improvements through community-based strategies (Reid, 2008; Abdulraheem et al., 2012). In Nigeria, both the 2004 and 2016 National Health Policies recognize PHC as a key instrument for improving healthcare delivery. Implementation is largely decentralised to the local government level, which operates through a network of health districts, wards, and health centres. This framework is expected to provide citizens with direct access to care and encourage local participation through structures such as Village Development Committees (VDCs) and District Development Committees (DDCs) (Federal Ministry of Health, 2018; Gupta et al., 2004). Primarily, PHC services aim to address pressing health issues, such as maternal and child mortality, malaria, typhoid, infectious diseases, nutrition, immunisation, disease control, and access to essential drugs. This approach is to ensure that communities receive comprehensive and holistic care to address their health needs and challenges.

Statement of the Problem

The performance of local governments in providing primary healthcare services has been a subject of discussion in Nigeria, with concerns about the quality of healthcare services at the grassroots level. Despite enormous capital votes for healthcare development for the grassroots, the performance of local governments in primary healthcare service delivery is hampered by poor organisation, which undermines appropriate strategies to identify targeted objectives of delivering essential health services to the expected beneficiaries. In Akwa Ibom State, a survey of the primary healthcare centres across the three senatorial districts has shown deficiencies in the availability of essential drugs and routine immunisation, which should

strengthen the functionality of the health department. This study is necessitated to interrogate the degree of functionality of local government administration in the delivery of Primary Healthcare in Akwa Ibom State.

Objectives of the Study

The main objective of this study is to investigate the impact of Local Government Administration in primary healthcare delivery in Akwa Ibom State, Nigeria.

Specifically, the study seeks to:

1. Evaluate the role of the local government in the provision of essential drugs in Akwa Ibom State
2. Determine the role of the local government in the facilitation of immunisation programs in Akwa Ibom State

Research Questions

The following questions guided the study:

1. To what extent has the local government administration provided essential drugs to the inhabitants of the area in Akwa Ibom State?
2. How well does the local government system facilitate immunisation of the citizens in Akwa Ibom State?

Research Hypotheses

1. H_{01}: Local government administration does not significantly impact the provision of essential drugs to the citizens in Akwa Ibom State.
2. H_{02}: There is no significant impact of the local government administration on the facilitation of immunisation programs for the citizens in Akwa Ibom State.

Conceptual Review

Essential Drug

These are drugs that are considered to be of utmost importance and hence basic, indispensable, and necessary for the health needs of the population. Access to healthcare is a fundamental human right, and the availability of essential medicines is critical for achieving this goal. However, the World Medicines Situation (2004) reported that nearly 50% of Africa's population lacks access to essential drugs. In Nigeria, a 2002 baseline assessment by the Federal Ministry of Health revealed the low availability of essential medicines in public health facilities, resulting in frequent drug shortages, delayed deliveries, and poor stock management (Bennette et al., 2001).

In an attempt to improve drug availability, the Nigerian government introduced the Drug Revolving Fund (DRF) in 1988 under the National Health Policy. This initiative aimed to ensure a sustainable supply of affordable generic drugs across all healthcare levels (Uzochukwu et al., 2002). Under the DRF model, the revenue generated from drug sales is reinvested to restock medications, thereby ensuring continuity of supply, affordability, and equity in access (Ogbonna & Nwako, 2016). The National Drug Policy (2015) defines DRF as

a mechanism for maintaining uninterrupted drug availability within the health system. Nigeria formalised its first Essential Medicines List (EML) in 1989 via Decree 49, targeting lifesaving drugs for maternal and child health services. The list was further tailored to guide procurement under the Bamako Initiative, thereby reducing costs for both the health system and patients (Uzochukwu et al., 2017). The sixth edition of the EML, released in 2016, emphasises medicines for women and children in response to Nigeria's high neonatal (37 per 1,000) and under-five (120 per 1,000) mortality rates (United Nations International Emergency Trust Fund (UNICEF, 2016/2017).

While evaluations by Uzochukwu et al. (2002) and Abegunde & Asuzu (2013) found that BI-supported health centres had greater drug availability than their non-BI counterparts, other studies (e.g., Sambo et al., 2008) noted significant gaps in essential drug availability, challenging the initiative's effectiveness. In 1997, the government introduced the Petroleum Trust Fund (PTF) to support DRF schemes across all healthcare levels. However, the program, which was discontinued in 1999, failed because of weak technical oversight, poor financial management, political interference, and flawed procurement practices. These shortcomings result in overstocking, wastage, and expired drugs, especially in primary health centres (Ogbonna & Nwako, 2016).

Immunization Programme

An immunisation program refers to the organised efforts by the local government council to ensure the administration of vaccines to prevent infectious diseases, such as measles, polio, tuberculosis, and hepatitis. This includes vaccine procurement, distribution, storage, outreach activities, public awareness campaigns, and engagement with healthcare workers to ensure widespread immunisation coverage within the community. Immunisation is a crucial public health intervention that significantly reduces the morbidity and mortality from vaccine-preventable diseases. Local government administrations play a key role in facilitating immunisation programs by ensuring the availability, accessibility, and distribution of vaccines at the grassroots level. Most grassroots communities in developing countries, including Nigeria, are vulnerable places that need basic social services to improve the well-being of dwellers (Mbon & Ewium, 2001). Immunisation programmes in Nigeria are primarily guided by the National Programme on Immunisation (NPI), which operates under the supervision of the National Primary Health Care Development Agency (NPHCDA) (NPHCDA, 2015).

Local governments are responsible for coordinating immunisation activities within their jurisdictions, including routine immunisation, supplementary immunisation activities (SIAs), and outbreak response campaigns. These activities are often conducted in collaboration with state and federal health authorities, as well as international partners such as the World Health Organisation (WHO), the United Nations Children's Fund (UNICEF), and the Global Alliance for Vaccines and Immunisation (Gavi) (United Nations Digital Library, 2020). Additionally, local governments play a critical role in ensuring that vaccines reach underserved populations through targeted community outreach and educational initiatives.

One of the major challenges affecting immunisation coverage in Nigeria is inadequate funding and logistical constraints, particularly in rural areas where transportation and cold chain management are critical issues. The cold chain system is essential for vaccine storage and distribution, ensuring that the vaccines remain effective from production to administration. However, many primary healthcare centres in Nigeria lack adequate cold chain equipment, leading to vaccine wastage and reduced immunisation coverage (Federal Ministry of Health, 2019). Insufficient electricity supply, inadequate storage facilities, and poor transportation networks further exacerbate these challenges, making it difficult to maintain vaccine integrity. Despite these challenges, immunisation efforts have significantly improved in recent years owing to increased government commitment, donor support, and innovative community engagement strategies. The introduction of outreach programs, mobile vaccination units, and community health volunteers has helped bridge the gap in immunisation coverage, especially in hard-to-reach areas (Chotchoungchatchai, 2020). Also, the use of digital health solutions, such as electronic immunisation registries and mobile-based reminders, has enhanced vaccine tracking and improved uptake rates. The table below shows six datasets, each providing insights into the age of patients and types of vaccines received between 2021 and 2023, cumulatively highlighting the local government's level of provision of essential drugs and immunisation services in selected local government areas across Akwa Ibom State, Nigeria.

Table 1: Child Immunization at PHC, Ikot Etetuk, Ibekwe II, Ikot Abasi L.G.A

S/N	AGE	VACCINE	YEAR		
			2021	**2022**	**2023**
1.	>24hrs -2wks	Hep. BO	948	1887	---------
2.	0-2wks	OPVO	1011	775	52
3.	0-11months	BCGP	1101	1349	358
4.	6wks -11months	OPVT	1026	830	742
5.	6wks -11months	PENTA 1	874	1990	1109
6.	6wks -11months	PCV1	1047	1259	3664
7.	10wks -11months	OPV2	866	731	261
8.	10wks -11months	PENTA 2	953	1102	792
9.	10wks -11months	PCV2	953	1110	1848
10.	14wks -11months	OPV3	863	964	465
11.	14wks -11months	PENTA 3	1058	1297	297
12.	14wks -11months	PCV3	1081	1303	360
13.	14wks -11months	IPV	1018	793	241
14.	6-11months (100,000UI)	VITAMIN A	360	---------	---------
15.	12-23 months (200,000UI)	VITAMIN A	33	----------	---------
16.	9 -11months	MEASLES 1	1207	1640	451
17.	9 -11months	YELLOW FEVER	1207	1682	105
18.	9 -11months	MEN A	1137	1546	115
19.	18 -23wks	MEASLES 2	473	629	229
	TOTAL		**17,216**	**20,887**	**11,984**

Source: Unit of Statistics, Department of Health (2024).

Table 2: Child Immunisation at PHC, Ibekwe Akpan Nya, Mkpat Enin L.G.A.

S/N	AGE	VACCINE	YEAR		
			2021	**2022**	**2023**
1.	>24hrs -2wks	Hep. BO	548	887	30
2.	0-2wks	OPVO	500	235	80
3.	0-11months	BCG	60	1400	227
4.	6wks -11months	OPV1	120	620	96
5.	6wks -11months	PENTA 1	620	750	157
6.	6wks -11months	PCV1	977	980	1282
7.	10wks -11months	OPV2	433	664	320
8.	10wks -11months	PENTA 2	1903	1000	600
9.	10wks -11months	PCV2	1100	774	756
10.	14wks -11months	OPV3	663	833	285
11.	14wks -11months	PENTA 3	882	225	622
12.	14wks -11months	PCV3	61	769	33
13.	14wks -11months	IPV	40	384	362
14.	6-11months (100,000UI)	VITAMIN A	48	----------	---------
15.	12-23 months (200,000UI)	VITAMIN A	25	----------	---------
16.	9 -11months	MEASLES 1	1025	1200	1300
17.	9 -11months	YELLOW FEVER	30	987	428
18.	18 -23wks	MEASLES 2	23	28	300
	TOTAL		**9,070**	**11,751**	**6,878**

Source: Unit of Statistics, Department of Health (2024).

Table 3: Child Immunisation at PHC, Ata Obio Akpa, Oruk Anam L.G.A.

S/N	AGE	VACCINE	YEAR		
			2021	**2022**	**2023**
1.	>24hrs -2wks	Hep. BO	780	1744	---------
2.	0-2wks	OPVO	1342	882	72
3.	0-11months	BCGP	1224	1552	279
4.	6wks -11months	OPVT	1018	771	899
5.	6wks -11months	PENTA 1	784	2013	1221
6.	6wks -11months	PCV1	1120	1250	4338
7.	10wks -11months	OPV2	892	644	432
8.	10wks -11months	PENTA 2	688	1200	856
9.	10wks -11months	PCV2	951	1230	1955
10.	14wks -11months	OPV3	755	879	645
11.	14wks -11months	PENTA 3	1033	1260	971
12.	14wks -11months	PCV3	1000	1131	600
13.	14wks -11months	IPV	1102	882	412
14.	6-11 months (100,000UI)	VITAMIN A	670	---------	---------
15.	12-23 months (200,000UI)	VITAMIN A	55	----------	---------
16.	9 -11months	MEASLES 1	1420	1540	524
17.	9 -11months	YELLOW FEVER	88	1271	100
18.	9 -11months	MEN A	1137	1634	282
19.	18 -23wks	MEASLES 2	473	578	425
	TOTAL		**16,532**	**20,461**	**14,011**

Source: Unit of Statistics, Department of Health (2024).

Table 4: Child Immunisation at PHC, Afaha Ikot Ebak, Essien Udim L.G.A.

S/N	AGE	VACCINE	YEAR		
			2021	**2022**	**2023**
1.	>24hrs -2wks	Hep. BO	498	2012	---------
2.	0-2wks	OPVO	1000	867	300
3.	0-11months	BCGP	908	1410	540
4.	6wks -11months	OPVT	1130	900	800
5.	6wks -11months	PENTA 1	748	1453	1047
6.	6wks -11months	PCV1	1235	1920	1000
7.	10wks -11months	OPV2	667	632	612
8.	10wks -11months	PENTA 2	539	1024	801
9.	10wks -11months	PCV2	1021	1123	1673
10.	14wks -11months	OPV3	638	973	561
11.	14wks -11months	PENTA 3	1248	1371	792
12.	14wks -11months	PCV3	1100	900	368
13.	14wks -11months	IPV	1012	805	412
14.	6-11 months (100,000UI)	VITAMIN A	630	---------	---------
15.	12-23 months (200,000UI)	VITAMIN A	400	----------	---------
16.	9 -11months	MEASLES 1	1180	1000	400
17.	9 -11months	YELLOW FEVER	1026	1002	238
18.	9 -11months	MEN A	1020	1432	347
19.	18 -23wks	MEASLES 2	700	926	922
	TOTAL		**16,700**	**19,750**	**10,813**

Source: Unit of Statistics, Department of Health (2024).

Table 5: Child Immunisation at PHC, NungUdoe, Ibesikpo Asutan L.G.A

S/N	AGE	VACCINE	YEAR		
			2021	**2022**	**2023**
1.	>24hrs -2wks	Hep. BO	480	655	42
2.	0-2wks	OPVO	300	258	65
3.	0-11months	BCG	90	1224	732
4.	6wks -11months	OPV1	1021	780	76
5.	6wks -11months	PENTA 1	710	530	753
6.	6wks -11months	PCV1	776	821	1126
7.	10wks -11months	OPV2	534	769	521
8.	10wks -11months	PENTA 2	1507	1028	900
9.	10wks -11months	PCV2	900	651	647
10.	14wks -11months	OPV3	842	500	480
11.	14wks -11months	PENTA 3	732	478	277
12.	14wks -11months	PCV3	70	963	48
13.	14wks -11months	IPV	55	420	531
14.	6-11months (100,000UI)	VITAMIN A	61	----------	---------
15.	12-23 months (200,000UI)	VITAMIN A	33	----------	---------
16.	9 -11months	MEASLES 1	50	1135	1100
17.	9 -11months	YELLOW FEVER	44	1930	842
18.	18 -23wks	MEASLES 2	66	102	632
	TOTAL		**8,271**	**12,244**	**8,772**

Source: Unit of Statistics, Department of Health (2024).

Table 6: Child Immunisation at PHC, Idoro, Uyo L.G.A

S/N	AGE	VACCINE	YEAR		
			2021	**2022**	**2023**
1.	>24hrs -2wks	Hep. BO	600	2001	45
2.	0-2wks	OPVO	1123	75	68
3.	0-11months	BCGP	980	1000	287
4.	6wks -11months	OPV 1	1005	68	560
5.	6wks -11months	PENTA 1	487	--------	--------
6.	6wks -11months	PCV1	946	1302	1285
7.	10wks -11months	OPV2	499	755	357
8.	10wks -11months	PENTA 2	1220	954	921
9.	10wks -11months	PCV2	724	1022	1224
10.	14wks -11months	OPV3	542	881	56
11.	14wks -11months	PENTA 3	1238	784	332
12.	14wks -11months	PCV3	1111	1255	480
13.	14wks -11months	IPV	995	870	1196
14.	6-11 months (100,000UI)	VITAMIN A	200	---------	---------
15.	12-23 months (200,000UI)	VITAMIN A	42	----------	---------
16.	9 -11months	MEASLES 1	98	1020	360
17.	9 -11months	YELLOW FEVER	113	987	1020
18.	9 -11months	MEN A	---------	1436	1223
19.	18 -23wks	MEASLES 2	367	426	91
	TOTAL		**12,290**	**14,836**	**9,505**

Source: Unit of Statistics, Department of Health (2024).

Theoretical Framework

Structural-Functionalism Theory

Structural functionalism, as introduced by Herbert Spencer (1820), views society as a complex system composed of interdependent parts that work together to ensure stability and meet collective needs. The theory posits that every unit within a system, whether organisations, institutions, or social forces, should be examined based on its explicit and implicit functions. Functionalism emphasises the organic interdependence of structures, suggesting that dysfunction in one part disrupts the balance and affects the entire system. This perspective promotes clarity in role definition, respect for institutional boundaries, coordination, and oversight (Udenta & Udenta, 2019). Within this framework, the local government is considered an essential component of the social structure, contributing to the overall functioning and equilibrium of society.

Empirical Review

Numerous studies have examined the nexus between the local government administration and primary healthcare delivery services in Nigeria. These studies have revealed how administrative structures, fiscal arrangements, and governance practices at the local level influence healthcare outcomes. Abdul-Baqi (2020) assessed drug procurement and utilisation in Shira LGA, Bauchi State. The study revealed inefficiencies in drug supply, poor funding, lack of qualified personnel, and widespread management shortages, all of which hindered effective PHC service delivery.

Okwuwa et al. (2020) explored infant mortality and access to PHC in Bwari Area Council, Niger State. Through a mixed-methods approach, they found that socio-economic characteristics such as urban residence, higher education, and civil service employment facilitated better access to healthcare and zero infant mortality in the study area. However, they highlighted Nigeria's persistent rural health disparity and called attention to structural inequality in governance models.

Oyeyemi et al. (2023) assessed PHC utilisation in Lagun Community, Oyo State. While awareness and availability of services were satisfactory, affordability and accessibility were below WHO standards. The study recommended more public health education, wider insurance coverage, and better engagement between healthcare providers and residents.

Afia et al. (2024) assessed the role of primary healthcare in disease prevention among pregnant women in Uyo, Akwa Ibom State. A descriptive survey of 384 pregnant women revealed a significant positive impact of primary healthcare services. The study recommended increased awareness campaigns and health counselling during pregnancy. Maganty et al. (2023) explored infrastructural barriers to healthcare access in rural areas. Their findings highlighted poor road networks, inadequate transportation, and weak health infrastructure as key constraints. The study emphasised the need for infrastructural investment to reduce rural health disparities. Akpvino (2025) examined innovative strategies for rural healthcare delivery in Nigeria. The study identified telemedicine, mobile clinics, public-private partnerships, and community outreach as effective approaches for improving healthcare access. It advocates for integrated efforts involving technology, trained community health workers, and local engagement.

Methodology

The study used descriptive and survey methods, and data were gathered using a questionnaire instrument, which was analysed with the ordinary least square's simple regression technique through SPSS version 28 statistical tools. The study population consisted of 1,426,702 primary healthcare workers in six (6) healthcare centres in Akwa Ibom State and the beneficiaries of healthcare services in the respective local areas. The Cochran derivative (finite) formula was used to determine the sample size of 483 from a total of 1,426,702.

Table 7: Population of the Study

Local Government Area	**Population**
Ikot Abasi	169,188
MkpátEnín	226,190
OrukAnam	219,301
EssienUdim	246,594
IbesikpoAsutan	175,037
Uyo	390,392
Total	**1,426,702**

Source: (Ministry of Economic Development, AKS.)

Sample Size and Sampling Procedure

Samples for the study were collected using the Cochran derivative (finite) formula

$$SS = \frac{(Z^2 * P * (1-P) * N)}{(E^2 * (N-1) + Z^2 * P * (1-P))}$$

Assuming:

Z = 1.96 (95% confidence level)

P = 0.5 (estimated proportion, for maximum variability)

N = 1426702(population size)

E = 0.05 (desired margin of error)

Substituting these values:

$$\frac{(1.96^2 X\ 0.5\ X\ (1-0.5)\ X\ 1426702)}{((0.05)^2 X\ (1426702-1) + (1.96)^2 X\ 0.5\ X\ (1-0.5))}$$

$$\frac{(3.8416)\ \ 0.25\ (1426702)}{(0.0025\ X\ 1426701) + (3.8416\ X\ 0.25)}$$

$$\frac{1370204.60}{3566.75 + 0.9604}$$

$$\frac{1370202.68}{3567.7104}$$

SS = 384

Questionnaires were administered using the purposive sampling technique, and a weighted sampling formula was adopted to aid sharing across the six local government areas. Weighted sampling was calculated by first determining the percentage of each faculty member in the population. This was followed by calculating the weighted sample size for each local government area by determining the percentage of each subject (LGA) relative to the sample size (384).

$$\text{Weighted sample size} = \frac{\text{Total sample size X Population of each community}}{\text{Total population}}$$

Table 8: Distribution of Questionnaire

Local Government Area	Population	Weighted Sampling (number of questionnaires distributed)
Ikot Abasi	169,188	46
MkpátEnín	226,190	61
OrukAnam	219,301	59
EssienUdim	246,594	66
IbesikpoAsutan	175,037	47
Uyo	390,392	105
Total	**1,426,702**	**384**

Source: Researchers Computation, 2024.

Sampling Technique

A stratified random sampling technique was adopted to ensure adequate representation of key population subgroups. This method involved dividing the population into distinct strata based on specific characteristics, followed by random sampling within each stratum.

Method of Data Collection

The data were collected using structured questionnaires. The instrument targeted selected respondents at healthcare centres and was composed of closed-ended items formatted on a 4-point Likert scale, with assigned weights to enable quantitative analysis.

Table 9.

Response	Weight (Points)
Strongly Agree (SA)	4
Agree (A)	3
Disagree (D)	2
Strongly Disagree (SD)	1

Test of Reliability of the Research Instrument

To ensure internal consistency, the questionnaire was tested using Cronbach's alpha, and the results of 0.81 reveal high reliability. In social science research, a value above 0.7 is considered acceptable. All questionnaire items were reviewed and approved by the project supervisor to confirm their clarity and relevance.

Test of Validity of the Research Instrument

The study instrument underwent content validity assessment to ensure comprehensive coverage of the research topic. A panel of five experts comprising dissertation supervisors, a Public Administration lecturer from Akwa Ibom State University, and three healthcare professionals (a Deputy Director, a Principal Community Health Extension Worker, and a Nurse/Midwife from PHC Idoro Obio, Uyo LGA) evaluated the tool. Based on their assessment, the Content Validity Index (CVI) was calculated to be 0.80, exceeding the acceptable threshold of 0.78 for expert panels of 6–10 members. This result confirms the relevance, clarity, and adequacy of the questionnaire.

Models Specification

This study models the relationship between Local Government Administration (L.G.A) and various components of Primary Healthcare Delivery (PHD) in Akwa Ibom State. The functional form is:

$PHD = f(L.G.A)$

Where PHD is captured through the following indicators, each modelled using a simple linear regression:

i. $HF = \alpha_0 + \beta_1(L.G.A) + \varepsilon_t$ — *Healthcare Facilities*
ii. $HE = \alpha_0 + \beta_1(L.G.A) + \varepsilon_t$ — *Healthcare Equipment*
iii. $ED = \alpha_0 + \beta_1(L.G.A) + \varepsilon_t$ — *Essential Drugs*
iv. $IP = \alpha_0 + \beta_1(L.G.A) + \varepsilon_t$ — *Immunisation Programmes*
v. $HES = \alpha_0 + \beta_1(L.G.A) + \varepsilon_t$ — *Health Education and Sensitisation*

Where;

i. α_0 = Intercept
ii. β_1 = Coefficient of L.G.A
iii. ε_t = Error term

Measurement/Operationalisation of Variables

The variables addressed in the study were local government administration and primary healthcare delivery. Primary healthcare delivery was the dependent variable, while local government administration was the independent variable. In this study, specific variables such as essential drugs and immunisation programs were measured using an instrument with confirmed validity and reliability.

Table 10: Operationalisation of Variables

Variable	Type	Indicators	Measurement Items	Scale
Local Government Administration	Independent	Funding, supervision, policy implementation, and human resources	Respondents' perceptions of LG roles in PHC delivery	4-point Likert scale
Primary Healthcare Delivery	Dependent	Healthcare facilities, equipment, essential drugs, immunisation programmes, and health education	Availability and adequacy of services and resources	4-point Likert scale
Essential Drugs	Sub-variable	Availability, affordability	Frequency and adequacy of drug supply	4-point Likert scale
Immunization Programmes	Sub-variable	Coverage, frequency	Regularity and participation in immunization activities	4-point Likert scale

Decision Rule

The independent variable is considered statistically significant if the absolute value of the computed t-statistic exceeds the critical t-value at the 5% significance level, with degrees of freedom equal to n – 2 (where *n* represents the number of observations and 2 is the number of estimated parameters).

The null hypothesis is rejected if the calculated F-statistic exceeds the critical F-value at the 5% significance level and the degrees of freedom of n – 2. Alternatively, statistical significance is confirmed if the p-value of the F-statistic is less than 0.05, indicating that the result falls within an acceptable threshold.

Data Presentation

A total of 384 copies of questionnaires were distributed to participants in the Local Government Areas using the purposive sampling technique. Of the 384 questionnaires distributed, 372 (96.8%) were completed and returned. Therefore, 372 questionnaires were collected, and the data from the respondents were used for the analysis as outlined below. The table below shows the distribution of completed and returned questionnaires, that were used for data analysis.

Table 11: Questionnaire Administration

Local Government Area	No. of questionnaires distributed	No. of questionnaires completed and returned	Percentage (%) of Questionnaire completed and returned
Ikot Abasi	46	45	12.1
MkpátEnín	61	59	15.9
OrukAnam	59	58	15.6
EssienUdim	66	64	17.20
IbesikpoAsutan	47	47	12.6
Uyo	105	99	26.6
Total	**384**	**372**	**100**

Source: Field Survey, 2024

Results

This section focuses on the respondents' responses to the questions regarding the three (3) relevant variables selected for the study. The tables show the responses, frequency, percentage and interpretations.

Table 12: Responses on the Role of the Local Government in the Provision of Essential Drugs

S/N	Statements	SA	A	D	SD	Total
1.	Local government provides essential drugs for healthcare delivery in your health centre	172 (47.3)	165 (44.4)	23 (6.2)	8 (2.2)	372
2.	Provision of essential drugs has aid in improving the health of the local dwellers.	135 (36.3)	164 (44.1)	48 (12.9)	25(6.7)	372

Source: Field Survey (2024)

Table 12 shows that 47.3% of respondents strongly agreed that local governments provide essential drugs for healthcare delivery, while 44.4% agreed, 6.2% disagreed, and 2.2% strongly disagreed. For item six, 36.3% strongly agreed that the provision of essential drugs has improved the health of residents, 44.1% agreed, 12.9% disagreed, and 6.7% strongly disagreed.

Table 13: Responses on the Role of Local Government in Facilitating Immunisation Programme

S/N	Statements	SA	A	D	SD	Total
1.	Local government facilitates the availability of immunisation programmes in your health centre	171 (46.0)	84 (22.6)	81 (21.8)	35 (9.4)	372
2.	Immunisation coverage facilitated by the LG is more adequate within the community due to the efforts of the local government	181 (48.7)	127 (34.1)	37 (9.9)	27 (7.3)	372

Source: Field Survey (2024)

Table 13 indicates that 46.0% of respondents strongly agreed that the local government facilitated the availability of immunisation programs in their areas. Additionally, 22.6% agreed, whereas 21.8% and 9.4% disagreed and strongly disagreed, respectively. Regarding item eight, 48.7% strongly agreed that immunisation coverage in the community was adequate due to local government efforts, 34.1% agreed, 9.9% disagreed, and 7.3% strongly disagreed.

Test of Hypotheses

Hypothesis One

H_{01}: Local government administration does not significantly impact the provision of essential drugs to the citizens in Akwa Ibom State.

Table 14: Analysis Results for Hypothesis One

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.440[a]	.194	.192	.447

a. Predictors: (Constant), LGA

ANOVA [a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	17.771	1	17.771	88.984	.000[b]
	Residual	73.892	370	.200		
	Total	91.663	371			

a. Dependent Variable: ED

a. Predictors: (Constant), LGA

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	1.691	.202		8.376	.000
	LGA	.520	.055	.440	9.433	.000

a. Dependent Variable: ED

Source: Researchers' Computation (2024).

The findings from Table 14 revealed that even without Local Government Administration (LGA) input, the availability of essential drugs (ED) maintains a baseline of 1.691 units. This suggests that, in the absence of further LGA contributions, healthcare facilities (HF), equipment (HE), and essential drugs (ED) would remain positively available. However, each unit increase in LGA involvement resulted in a 0.520-unit increase in essential drug availability, indicating a statistically significant and positive relationship. This is supported by a t-statistic of 9.433 and a p-value of 0.000, which is well below the threshold of 0.05. The correlation coefficient (R = 0.440) indicated a moderate positive link between LGA contributions and ED availability. Nevertheless, the coefficient of determination ($R^2 = 0.194$) shows that only 19.4% of the variation in ED is attributable to LGA efforts, with 80.6% influenced by other factors, such as federal or state interventions, donor support, private sector participation, or health policy shifts. The F-statistic of 88.984 (p = 0.000) confirmed the model's statistical reliability, justifying the rejection of the null hypothesis. In summary, although LGA plays a notable role in enhancing access to essential drugs, broader systemic factors also contribute significantly.

Hypothesis Two

H_{02}: There is no significant impact of the local government administration on the facilitation of immunisation programs for the citizens in Akwa Ibom State.

Table 15: Analysis Results for Hypothesis Two

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.430[a]	.182	.192	.417

a. Predictors: (Constant), LGA

ANOVA [a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	16.571	1	16.571	89.881	.000[b]
	Residual	73.892	370	.200		
	Total	90.663	371			

a. Dependent Variable: IP

a. Predictors: (Constant), LGA

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	1.888	.202		7.276	.000
	LGA	.521	.055	.440	8.333	.000

a. Dependent Variable: IP

Source: Researchers' Computation (2024).

The analysis in Table 15 revealed that in the absence of Local Government Administration (LGA) input, the immunisation program (IP) maintains a baseline value of 1.888 units. This suggests that immunisation programs would still function, to some extent, even without additional LGA support. However, each unit increase in LGA involvement led to a 0.521-unit increase in immunisation program (IP) performance. This relationship is statistically significant, with a t-value of 8.333 and a p-value of 0.000, well below the 5% threshold, and the correlation coefficient (R = 0.440) indicates a moderate positive association between LGA and IP. Nonetheless, the coefficient of determination ($R^2 = 0.192$) shows that only 19.2% of the variation in immunisation programs is explained by LGA contributions, while 80.8% is influenced by other variables such as state or federal interventions, donor support, or health sector policies. The F-statistic of 89.881 (p = 0.000) confirmed the model's statistical validity, justifying the rejection of the null hypothesis. In summary, while LGA support significantly contributes to immunisation efforts, additional external factors also play a critical role.

Discussion of Findings

Findings on Objective 1: To evaluate the role of the local government in the provision of essential drugs in Akwa Ibom State.

The result obtained from the analysis showed a statistically significant positive relationship between Local Government Administration's (LGA) contributions and Essential Drugs (ED) provisions. Specifically, the findings indicate that a unit change in LGA contributions led to an

increase of 0.520 units in ED, suggesting that LGA contributions have a positive impact on ED provisions. However, the results also indicated that only 19.4% of variations in ED are explained by LGA contributions, while 80.6% of the variation is due to other factors. This suggests that while LGA contributions are important, other factors such as national health policies, healthcare infrastructure, and community participation also play a significant role in determining ED provisions.

This finding is supported by the study by the assertion of Stover et al. (2016) that local governments play a critical role in ensuring the availability and accessibility of essential drug services, particularly in rural and underserved areas. Also, Wouters & Kuha (2024) agree that the effective decentralisation of healthcare services, including essential drugs, to local governments can improve the responsiveness and accountability of healthcare systems, particularly in low- and middle-income countries. However, Reich (2000) views the local government administration as an external stakeholder in the health sector, arguing that reliance on external stakeholders to provide essential drug services may create dependency and undermine the autonomy and capacity of local government administration to address healthcare needs, thereby perpetuating inequities in healthcare access and outcomes.

Findings on Objective 2: To determine the role of the local government in the facilitation of immunisation programs in Akwa Ibom State.

The result from hypothesis two revealed a statistically significant positive relationship between Local Government Administration's (LGA) contributions and facilitation of immunisation (IP) programs. This indicates that a unit change in LGA contributions leads to an increase of 0.520 units in IP, suggesting that LGA contributions have a positive impact on the facilitation of IP. However, the result also indicates that only 19.4% of variations in IP are explained by LGA contributions, while 80.6% of the variation is due to other factors. This suggests that while LGA contributions are important, other factors such as national health policies, healthcare infrastructure, and community participation also play a significant role in determining IP provisions. This finding is supported by Stover et al. (2012), who found that local governments play a critical role in ensuring the facilitation of routine immunisation services, particularly in rural and underserved areas. The findings of this study highlight the importance of considering multiple stakeholders and factors in sustaining healthcare services, particularly immunisation services. While Local Government contributions play a role, they are not the sole determinants of healthcare outcomes. A comprehensive approach that addresses the complex interplay between factors is necessary to improve healthcare access and outcomes.

Conclusion

The findings from this study underscore the significant yet limited impact of Local Government Administration (L.G.A.) on primary healthcare delivery in Akwa Ibom State. While L.G.A. contributions play a crucial role in providing essential drugs and immunisation, the relatively low explanatory power of these contributions suggests that other stakeholders are equally, if not more, influential in shaping healthcare outcomes.

Recommendations

Based on the findings, the following recommendations were made:

1. The local government councils should improve procurement, distribution, and stock management of essential drugs by establishing a reliable supply chain partnership with state and federal government agencies, NGOs, and international bodies such as the WHO and UNICEF to ensure a steady supply of essential medicines and vaccines and conduct bi-monthly stock monitoring and reporting.
2. Local governments should ensure a more expansive degree of the facilitation of immunisation programs as an important means of preventing childhood morbidity and mortality. Achieving and maintaining high levels of immunisation coverage is a priority for all healthcare systems.

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