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Local Government and Primary Health Care service delivery in South-Western Nigeria 2010–2015

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Abstract

Primary Health Care (PHC) is implemented by the local governments in Nigeria based on the notion that healthcare service delivery is efficient when it is closer to people. With the adoption of analytical research through secondary sources of data, this study assesses the local government performance in PHC service delivery and examines the challenges it faced in the south-western Nigeria states of Lagos, Ogun, and Ondo in the period of 2010–2015. The findings showed various PHC programmes implemented by the local governments of the selected states, which include Maternal and Child Reduction, Investment Case and *Eko* Free Malaria in Lagos state, *Araya* and *Gbomoro* in Ogun state, as well as the Mother and Child Hospitals and *Agbebiye* in Ondo state. However, findin gs showed similar challenges encountered by the local governments, which include multiplicity of stakeholders in the disbursement of PHC funds, lack of fiscal decentralisation of revenue to the local government, diversion of PHC funds as compared to other projects, and poor community participation in PHC, irregularity of or interference in the local government elections by the state government, exclusion and deviation from the key principles of PHC and lack of continuity in PHC programmes implemented. The general conclusion from the study is that the local government performance in PHC service delivery is weak. In order to enhance the present local government performance in PHC, the study recommends for the application and implementation of local government constitutional role in the management of the PHC service delivery.

Introduction

The argument in favour of the local governments stems from the notion that the autonomy and citizen participation in service delivery will promote good governance. The extent of the division of power has important implications for the functioning of local governments in the service delivery (Okojie, 2009; Arowolo, 2010; Abe, Monisola, 2014). Decentralisation provides opportunity for the local government to implement social services in urban areas, communities, and villages. The local governments possess political power to make bye-law and draft policies, fiscal power to collect and use revenue, and administrative power to provide and maintain social services (Abbas, Ahmed, 2012; Agba, Akwara, Idu, 2013). When social services are decentralised to the local governments, the quality of citizens' welfare improves.

Local government is a practical tool for rural change and development through social service delivery. The proximity of local government to the grassroots provide necessary conditions for valuable and viable delivery of social services required by the citizens (Adeyemi, 2013; Agba, Ogwu, Chukwurah, 2013; Ejue, Madubueze, 2014; Odalonu, 2015). Among other functions of local government there is the implementation and maintenance of Primary Health Care (PHC) in order to improve the welfare of the people. In particular, health, education, adequate nutrition, and sanitation are elements of PHC which also determine the Human Development Index (HDI). As a philosophical framework intended to guide the development of health care service delivery, PHC is designed to improve the health of citizens in order to attain the state's welfare (World Bank, 2011; Alenoghena, Aigbiremolen, Abejegah, Eboreime, 2014).

The acceptance of PHC as the basis for strengthening the health care system and improving health care service delivery was established through the Alma Ata Declaration in 1978 by the World Health Organisation in the present-day Kazakhstan. PHC is the basis of health care. It also ensures continuity of care. It is the first step to health care which provides community health care services (Reid, 2008; Abdulraheem, Olapipo, Amodu, 2012). The idea of introducing PHC is to care for common health problems in the community by providing preventive, curative, and rehabilitative services and bringing health care to the reach of the people (World Health Organization, 1978; Olise, 2007).

The National Health Policy of 2004 and 2016 viewed the PHC as an instrument of health policy implemented at the local government level in the community health centres and health posts. The division of the local government into 7 and 15 health districts/wards provides the opportunity for the citizens to maximise the benefits of the health care decentralisation, where the local people participate in PHC service delivery through the establishment of the Village Development Committee (VDC) and District Development Committee (DDC) (Gupta, Gauri, Khemani, 2004; Federal Ministry of Health, 2010; Abdulraheem et al., 2012). PHC service delivery focuses on prevailing health challenges in the community such as the maternal and child healthcare, malaria, typhoid and fever, as well as the method of prevention and control such as promoting adequate nutrition, prevention and control of locally endemic and epidemic diseases, immunisation against infectious diseases, and provision of essential drugs (World Health Organisation, 1978; Adeyemo, 2005; Mike, 2010; Alenoghena et al., 2014).

In Nigeria, local governments' performance in PHC service delivery has been well documented and the result of health care services rendered at the grassroots level have been criticised. Studies showed that local government performance in PHC service delivery is characterised by in appropriate organisation which results in poor health care, lack of appropriate strategies to identify targeted beneficiaries, lack of funds, and shortcomings in the way resources are allocated, expensed, and managed (Adeyemo, 2010; Agba et al., 2013; Jamo, 2013; Ejue, Madubueze, 2014). Also, extant literature showed that PHC facilities in Nigeria are in deplorable state as medical equipment are either absent or obsolete, medical personnel are inadequate, especially in rural areas, as well as the roles overlap among the levels of government with regard to the finance and implementation of PHC (Gupta, 2004; Abdulraheem et al., 2012; Obansa, Orimisan, 2013). However, there is a dearth of empirical research on local government and PHC service delivery in south-western Nigeria with specific reference to the period of 2010–2015.

Therefore, the objectives of this study are to assess the performance of local governments in PHC service delivery in south-western Nigeria in the period of 2010–2015 and examine the challenges they faced. The significance of this study is that it provides evidence for the evaluation and assessment of the existing PHC local government programme in Nigeria and also serves as blueprint for the realisation of effective and efficient performance of local governments in PHC service delivery. In addition to the introduction, this study conceptualises local government and PHC, and offers general overview of the PHC service delivery by the Nigeria local government. The subsequent sections describe the study area and methodology, explain the performance assessment and challenges faced by the local governments in PHC service delivery in the selected states, discuss the findings and offer conclusions.

The local government in Nigeria

The importance of local government in a democratic system cannot be overemphasised. As a government that is closer to the people, the local government is a form of local administration which maintains law and order, provides social services, and encourages the participation of people, thereby promoting grassroots development (Oviasuyi, Idadasiraojie, 2010). Goss (2001) claimed that the local government acts in a geographically defined area with a substantial degree of autonomy, separate legal entity, and power to provide certain public services, as well as power to collect tax and generate revenue. Jamo (2013) viewed the local government as a territorial sovereign entity that regulates its own affairs. In essence, local government is a basic instrument for rural transformation and development through the delivery of welfare services to rural and urban communities.

The political power of the local government empowers the representatives with the control of local affairs and also encourages active participation of the people in political activities (Sunday, Chinedum, 2014). The local government is mostly accessible to the people and it is also the first point of service delivery to the people. For example, King (1988) compared the relationship between the local government and the nation-state to that between a cell and the human body. According to him, the smallest cell, if unhealthy, could spread disease to the body. In essence, dysfunctional

local government in a nation-state could results in inadequate and poor social welfare services, exclusion of the local people from governance, and unresponsive government, all of which reduce state legitimacy and good governance. The local government serves as an instrument for the delivery of social services, it facilitates provision of social welfare and enables the locals to participate in the government (Chapman, 2010; Arowolo, 2010).

The local government is one of the levels of the government in a federal system, which is endowed by law with the control over local affairs (Onah, Amujiri, 2010). It is a segment of a constituent state that is established by law to provide social services and hold public affairs in its jurisdiction. As one of the levels of government which addresses the needs and aspirations of the citizens, local government extends administrative and political control to rural communities and also enhances the participation of people in governance at the grassroots level (Adesopo, 2011; Amujiri, 2012). In other words, local government is the basis of local authority with the power to act independently of external control from other levels of government.

Primary Health Care (PHC)

Primary Health Care (PHC) as a concept was formed by 134 countries, including Nigeria, in the Declaration of Alma Ata, Kazakhstan, on 12 September 1978. The international conference which was organised by the World Health Organisation (WHO) described the PHC as an attainment of health which is based on:

> (…) practical, scientifically sound, and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost which the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.
>
> (World Health Organization, 1978)

The WHO further identified five universal principles of PHC which are essential for health care, namely: equity, community participation, use of appropriate technology, self-reliance, and intersectoral collaboration. In other words, PHC is a grass roots approach which addresses the major health problem in the community through the provision of rehabilitative and curative services, as well as equitable health care for the people (Adeyemo, 2005; Olise, 2007; Abdulraheem et al., 2012). Primary Health Care, according to Abiodun (2010) is the provision of community healthcare which includes immunisation, maternal healthcare, child healthcare, and control of local endemic diseases, including malaria, tuberculosis, typhoid, diarrhea, as well as prevention of HIV/AIDS infection. Ajayi (2014) argued that PHC is the first stage of health care in the national health system, as well as the first stage of continuing healthcare system which brings healthcare as close as possible to the reach of the people at home and workplace.

Fundamental to the principle of PHC is the notion that major diseases in rural communities are preventable. This is essential for the functional PHC service delivery and constitutes a shift from centralised to decentralised healthcare provisions for rural areas where community diseases

are frequent (Paina, Peter, 2012). The PHC framework recognised the importance of healthy lifestyles as a means of disease prevention through supportive care for individual's health condition in the community. PHC is functional in health system where its values and principles are adopted into policy and implemented in practice (Eguagie, Okosun, 2010). To this end, the World Health Organisation (1978) outlined the following objectives of PHC:

a) accessibility and availability of health services to the reach of the people at home and work place;
b) prevention of major health problem that cause death and disease at a cost that the community can afford;
c) community must have the ability to maintain and effectively used the technology deployed, and
d) community must fully participate in the planning, delivery and evaluation of health services.

Reid (2008) described PHC as a unit of healthcare system which provides health services to the community. The minimum PHC service delivery identified by World Health Organisation (1978) includes safe water and basic sanitation, health education, and the method of preventing and controlling prevailing health challenges, growth monitoring and adequate nutrition, treatment of common diseases, provision of essential drugs, immunisation against infectious diseases, maternal and child healthcare including family planning, special care for high risk and referral support, and community mental health care. According to Obioha and Molale (2011), the essence of PHC service delivery is to ensure that health is affordable, accessible, and acceptable to the community. PHC service delivery is based on community participation through the establishment of village health committee which comprises local residents chosen without regard to political affiliations, sex, age or religion (Federal Ministry of Health, 2010). As a form of accountability mechanisms, the community is expected to actively participate in planning, organising and managing PHC service delivery in their respective villages (World Bank, 2010; Arowolo, 2010). Through this process, social, political and economic conditions of the community subsequently improve, as health status increase.

Moreover, referral system is one of the major factors that determine the functioning of PHC service delivery in the local government. Referral system in PHC is a bottom-top approach usually from the lowest level of care to the highest. Referral system is activated when the patient requires protracted inpatient care, expert advice or technical examination that is not available at the health centre. Eshemokha (2019) claimed that a two-way referral system is an organised practice in PHC where there is a relevant feedback communication from the higher health centre that receives the patient, to the lower health centre after the patient has been treated. A two-way referral system promotes idea exchange, knowledge transfer between health care providers, and also improves health care service delivery which decreases morbidity and mortality rates (Enabulele, Enabulele, 2018).

Primary Health Care service delivery by the Nigerian local governments

In Nigeria, issues related to health care as part of the welfare function of the state is enshrined in the concurrent legislative list. This implies that all the tiers of government are responsible for the management and functioning of health care service delivery. In practice, the National Health Policy provides guidelines on how this is effected by dividing the health care system into tertiary, secondary and primary health care with the federal, state, and the local governments in charge of each level, respectively. Before the introduction of PHC and during the independence in 1960, Nigeria operated a health care system which focused on curative medicine rather than preventive medicine (Aregbeshola, Khan, 2017). Between 1975 and 1980, Nigeria developed National Basic Health Services Scheme (NBHSS) which was regarded as the basis of PHC approach. The scheme focused on the provision of health facilities, training of health workers and community participation, intersectoral cooperation and the use of local technology in the provision of health care (Obionu, 2007; Mike, 2010; Fatusi, 2015). In 1985, PHC which was modelled after the Alma Ata Declaration was first adopted in fifty-two local government areas, while in 1988 the comprehensive national health policy, focused on PHC, was introduced.

The 1988 PHC programme put emphasis on preventive medicine and health care at the local government level, exclusive breast feeding, free immunisation for children, compulsory recording of maternal death, and a campaign against HIV/AIDS (Uneke, Ndukwe, Oyibo, Onwe, 2010; Aregbeshola, Khan, 2017). In 1992, Nigeria established the National Primary Health Care Development Agency (NPHCDA) for the purpose of continuing and sustaining the PHC agenda (Fatusi, 2015; Lambo, 2015). With the return of democracy in 1999, the constitution as amended empowers the local government to provide and maintain PHC service delivery. PHC service delivery is politically headed by supervisory councillor for health and administratively by health coordinator. The health coordinator reports to the supervisory councillor, while the supervisory councillor reports to the chairman of the local government who is elected by the people (National Primary Health Care Development Agency, 2004). The roles of each level of government in the functioning of PHC service delivery are explicitly stated in the 1999 Constitution. The federal government is assigned the responsibility of overall policy formulation and evaluation, the state government provides logistical support such as personnel training, planning and operation, whereas the local government is responsible for the execution and provision of PHC service delivery (Federal Ministry of Health, 2004; National Primary Health Care Development Agency, 2007).

The three types of health care that are recognised in Primary Health Care system are the Basic Health Clinic (BHC), the Primary Health Centre (PHC), and the Comprehensive Health Centre (CHC). The BHC is expected to serve communities with a population of 2000 to 5000 people, the PHC should serve communities with a population of 5000 to 20,000 people, whereas the CHC is expected to serve communities with a population of more than 20,000 people (Ogunniyi et al., 2000; Federal Ministry of Health, 2010). The BHC consists of a small health facility with limited resources and staff, which comprise Community Health Extension Worker (CHEW) who offers treatment of simple ailments and refers the serious health cases to the PHC and CHC. The PHC is managed by a Community Health Officer (CHO) or an experienced nurse,

with more staff and beds (usually 10) for admitting maternity and adult health cases which are referred from the BHC. The CHC, which is controlled by a doctor, has at most about 30 beds for admitting maternity, paediatric, and adult health cases, including patients referred from the PHC. In essence, the CHC is expected to have four PHC in its catchment area, while the PHC is expected have two BHC in its catchment area.

The performance of PHC service delivery in Nigeria largely depends on community participation and a support from community leaders. With the establishment of the National Primary Health Care Development Agency (NPHCDA) in 1992, community participation was first institutionalised through the creation of a Health District (HD) which was made up of committees, such as the Village Development Committee (VDC) and District Development Committee (DDC). The VDC consists entirely of the community members and is coordinated by the village head. The DDC is made up of a chairman of the VDC in the district and the representatives of the health sectors in the community with explicit duties and responsibilities of managing health activities at the village level (World Health Organisation, 1992; Ogunniyi et al., 2000). The introduction of the Ward Health System (WHS) and Ward Minimum Health Care Package (WMHCP) in year 2000 and 2001, respectively, utilised the existence of electoral ward for the delivery of PHC. Unlike the HD, which made use of a district difficult to demarcate, the WHS was based on the division of local government into 10 to 11 political wards as the basic unit for the delivery of the PHC services.

The WHS facilitate political and community support through the establishment of Ward Development Committee (WDC) and Health Facility Committee (HFC) which consist of selected community residents (National Primary Health Care Development Agency, 2004). In general, the responsibilities of the VDC, WDC and HFC include creation of demand, ensuring proper conduct of health services, community support, and participation in the implementation of PHC programme. The WHS which represents the current national health strategy makes use of a ward as the smallest geographical political structure comprising 10,000 to 30,000 population for the delivery of PHC services in a village health post located at a place usually donated by the community and managed by a Village Health Worker (VHW) (Eshemokha, 2019). The WMHCP introduced in Nigeria include control of transmittable diseases, mother and child care, adequate balanced diet, non-transmittable diseases, health education and community participation (National Primary Health Care Development Agency, 2007). The WMHCP represents the least of health care provision and treatment that PHC centres in Nigeria should provide to the citizens.

In order to avoid fragmentation and ensure integration of PHC, Nigeria formulated the Primary Health Care Under One Roof (PHCUOR) policy in 2011. The essence of the PHCUOR is to avoid duplication of functions and multiplicity of stakeholders in federal, state, and local governments in the management of PHC (Aregbeshola, Khan, 2017). The 2016 national health policy, which is the focus of the existing health care system, emphasised the importance of PHC to protect, prevent and restore the health of citizens in order they thrived in well-being. The policy is a legal framework for the organisation, provision and management of PHC service delivery in Nigeria. However, several challenges have hampered effective implementation of PHC at the local government level. Olukoya, Coker, Osibogun and Oshin (2014) maintained that delay in budget approval

and release of incomplete funds is among other factors that impede local government performance in PHC service delivery.

Local government performance in PHC service delivery is also undermined by structural and institutional weaknesses in health sector, poor management services, inadequate staff and funds. Olaniyan and Lawanson (2010) and Odalonu (2015) revealed that the introduced WMHC Ps are not effectively implemented as most wards in Nigeria offer little basic health services as a result of inadequate health personnel, medical equipment and pharmaceuticals needed to provide effective PHC service delivery. While the prevalence of fake drugs and substandard products make it complex, local governments lack technical and managerial capacity to manage PHC which resulted in inadequate and poor infrastructural facilities and obsolete equipment, particularly in rural areas and villages (Owoeye, Adedeji, 2013; Alenoghena, 2014). More so, PHC system is facing the challenges of gross mismanagement, corruption at the local government level, inadequate health professionals, as well as dearth of data which render planning, policy implementation and health care system weak (Sanda, 2014; United States Agency for International Development, 2014; Oyeneyin, Aladenola, 2019). It is on this basis that this study evaluated the performance and examined the challenges of PHC service delivery in south-western Nigeria in the period of 2010–2015.

The area of study and methodology

The performance of local government in Primary Health Care (PHC) service delivery in Nigeria varies across states. The study area focused on the South-West which was purposively selected out of the six geopolitical zones in the country. The South-West comprises six states out of the thirty-six states in Nigeria. In order to ensure proper and adequate representation of samples, three states were selected from the South-West through simple random sampling technique – Lagos, Ogun, and Ondo states. While these selected states have different historical background in culture, values and native language, similar characteristics of these states are that the indigenes are mainly from Yoruba race which is among the major ethnic groups in Nigeria, and speak Yoruba and English as official languages.

The state capital of Lagos is located at Ikeja. The state was created on 27 May 1967 through the Transitional Provision Decree No. 14. Lagos state is divided into three senatorial districts, 20 Local Government Areas (LGAs) and 47 Local Council Development Areas (LCDAs). The state shares boundaries with Ogun state and the Benin Republic. The state capital of Ogun is located at Abeokuta. The state was created on 3 February 1976 from the old western region. Ogun state is divided into three senatorial districts, 20 Local Government Areas (LGAs) and 37 Local Council Development Areas (LCDAs). The state shares boundaries with Lagos and Oyo states, and the Benin Republic. Ondo state capital is located at Akure. The state was created on 3 February 1976 from the old western region. Ondo state is divided into three senatorial districts and 18 Local Government Areas (LGAs). The states hares boundaries with Ogun, Osun, Ekiti, Kogi, and Edo states.

This study made use of analytical research design which is relevant for the understanding of cause-effect relationships between two or more variables (local government and PHC). Analytical

research design involves critical thinking and evaluation of the fact where the researcher explains why and how a particular phenomenon functions. The research design is appropriate for assessing the performance and examining the challenges of local government in PHC service delivery through the use of existing data which remove vagueness in deduction and conclusion. In essence, secondary data from desk review, official documents and scholarly works formed the basis of analysis and discussion. Local government performance assessment and challenges in PHC service delivery was systematically addressed under the sub-themes of three of the selected states.

Performance assessment and challenges of Primary Health Care service delivery in Lagos state (2010–2015)

The Lagos state board of PHC was created through the health sector reform law of 2006. In compliance with part six of the health reform, a PHC board of 12 members was inaugurated in February 2009 for the purpose of planning, budgeting, monitoring, and evaluation of PHC programme, as well as retreating, promoting, training, and staff development of PHC employees (Lagos state Ministry of Health, 2010). Lagos state has over 329 PHC facilities excluding private health providers and the health policy thrust includes free community-based PHC services, provision of comprehensive secondary healthcare services, and institution of the health sector reform programme (Lagos State Ministry of Health, 2010; Mohammed, 2020). Minimum health package of care in Lagos state include control of transmittable diseases (malaria, tuberculosis, HIV/AIDS), child survival (immunisation and diarrhea diseases), maternal and newborn care, nutrition, non-transmittable diseases prevention, health education, and community mobilisation (Lagos State Ministry of Health, 2012).

The period under review witnessed the launch of some PHC programmes in Lagos state. In 2012, for example, the state launched Maternal and Child Reduction programme for the purpose of reducing high maternal and infant mortality rates in line with the Millennium Development Goal 4, 5 and 6 (Lagos State Ministry of Health, 2012). In order to make health care accessible to the citizens, the state government embarked on a programme called Investment Case. This programme was initiated to reduce disparity in health care and also seek to extend coverage of essential health services to the citizens (United Nations International Children Education Fund, 2012). Also, the Eko Free Malaria programme was adopted in Lagos as a medical treatment for malaria and the provision of each household with at least two insecticides nets (Baje, 2014). The *Eko* Free Malaria programme is aimed to lessen the disease burden of malaria. The period under review also experienced the continuous implementation of school health programme. The programme was designed for school pupils to promote healthy lifestyle and obtain adequate benefit from education where the environment is conducive for learning (Ileyemi, 2022).

The environment of Lagos state poses significant challenges to PHC service delivery. Being the most populous state in Nigeria, Lagos has the PHC facilities pressed for space as a result of large number of patients. The World Bank (2011) and Mustapha et al. (2012) revealed that most health centres in Lagos cannot provide 24 hours service as a result of irregular supply of

electricity and water, as well as lack of drug in health centres and poor transparency and administrative mechanism for purchasing and dispensing of drugs. Moreover, fraudulent practice persists among the nurses to purchase drugs on private basis and sell them to patients at high prices (Onwuzoo, 2021). As argued by Otokpa (2018) and Olanipekun (2013), most PHC facilities and equipment are locked up and not in use after commissioning, referral system is less functioning and majority of workers are ad-hoc private trained health workers. Moreover, the National Bureau of Statistics (2014) showed that private health centres provide about 60–70% of health services in the states, most of which are unregulated.

Community participation in PHC service delivery in Lagos state is below expectation. Abimbola et al. (2015) claimed that community participation in PHC is weak because of the limited knowledge of the community who perceived the PHC facilities as government owned properties which reflect in the preference for informal health providers. Aregbeshola, Onigbogi and Khan (2017) and Uzochukwu et al. (2018) were of the opinion that interference from the federal and state governments have contributed to inaccessibility of funds by local government for the implementation of PHC. Similarly, Olukoya, Coker and Osibogun (2014) maintained that the long waiting period when the budget is announced and when funds are released make it difficult for local government to plan for PHC progamme. In addition, the roles of PHC stakeholders are not aligned, coordination system is weak, and there is a lot of data which resulted in weak performance in the planning and policy formulation of health system in Lagos state (United States Agency for International Development, 2014).

Performance assessment and challenges of Primary Health Care service delivery in Ogun state (2010–2015)

With the exclusion of private health facilities, there are over 200 PHC centres owned by Ogun state which provide mother and child health services and simple health care (Ayinla, 2017). Among others, Ogun state health policy thrust is based on improving the public health institutions and enhancing their utilisation to promote quality life, on renewing and strengthening the delivery of PHC for the purpose of promoting child survival strategies such as immunisation, creating alternatives for health care fund through the Ogun state health insurance scheme, and enhancing public/private participation in health care service delivery (Ogun State Ministry of Health, 2010). The state minimum health package of care include prenatal care, immunisation, promotion of health activities like nutrition services, health education, behavioural change in communication relating to transmittable and non-transmittable diseases, simple health care services such as deworming and anti-malaria treatment, tuberculosis treatment under Directly Observed Treatment Scheme (DOTS), and support for HIV/AIDS treatment (Ogun State Ministry of Health, 2010).

The period under review witnessed some implementation of PHC service delivery in Ogun state. In conjunction with the African Health Markets for Equity (ALME), Ogun state launched the *Araya* (Good Health) programme in 2014 in order to facilitate better health care for the people. The programme which was a re-launched Community-Based Health Insurance Scheme

(CBHIS) was designed to provide access to PHC for certain groups of people, such as the pregnant mothers, children under age of five and the elderly people aged 70 and above (Pharm Access Foundation, 2015). Moreover, *Araya* was a pro-poor health care programme which subsidized cost of health care for the citizens (Channels Television, 2016). Also in 2014, the state government launched *Gbomoro* (Child Sustenance) programme as a cash transfer scheme for pregnant mothers to be used as transport allowance for every antenatal visit to health centres in order to increase access to basic health and nutrition (PM News, 2014; The Nation Newspaper, 2014).

Onohwosafe (2014) showed that only a quarter of the state health facilities have minimum requirement health care package and only about 10% of the households have one mosquito net. Suleiman and Onaneye (2014) claimed that the population that lack basic PHC services reside in rural areas, which constitutes about 40–50% of the total population. Corroborating this viewpoint, Israel and Sunday (2013) argued that the proportion of PHC facilities that provide basic emergency services, including obstetric, is low in the *Odogbolu* (rural) local government areas, relative to health facilities and services available in *Ifo* (urban) local government areas. Ogun state also faces the challenge of shortage of medical personnel to meet the citizens' demand for health care. A survey of health care personnel in 2012 indicated one doctor per 2992 patients and one nurse per 1411 patients (National Bureau of Statistics, 2014). In the same vein, Olatunji (2021) argued that only about 215 nurses are available in the state to manage about 448 health facilities.

The public-private partnership is weak and the major services provided by public and private health centres are clinic-based with little extension to home and communities (Adeneye, Musa, Afocha, Adewale, Ezeugwu, 2021). Many PHC facilities in Ogun state are not properly sited and the referral system is weak, which consequently diminished the continuum of health care system. The proliferation of medicine vendors and drug hawkers further increase the problem of irrational use of drugs in the state (Premium Times, 2012; Omonona, Obiasesan, Aromolaran, 2015). Moreover, the approved funds for PHC are often not used for the intended purpose. Adeneye, Musa, Afocha, Adewale and Ezeugwu (2021) showed that the PHC funds are diverted to other projects which consequently reduces the local government performance in PCH service delivery. Other challenges confronting local government performance in PHC service delivery in Ogun state include bureaucratic bottleneck and lack of transparent procedure in the disbursement of PHC funds which resulted in mismanagement and poor delivery of PHC programmes (Onohwosafe, 2014; Tijani, Okareh, Soladoye, Adegboyega, 2015).

Performance assessment and challenges of Primary Health Care service delivery in Ondo state (2010–2015)

The Ondo State Primary Health Care Development Board (OSPHCDB) was signed into law in 2012 with the aim to develop and ensure adequate functioning of the PHC in the state. The health policy of the state put emphasis on the eradication of diseases to enable the citizens live a social, economic, and productive life, and thereby attaining the national target of increasing the life expectancy of the citizens (Ondo State Ministry of Health, 2010). About 75.2% of the health facilities are used for PHC and 21.0% of them are used for secondary health care (Ondo State Ministry of Health, 2010).

Before 2010, the World Bank claimed that Ondo state had the worst maternal and child health indices in south-western Nigeria due in part to high rate of maternal mortality and morbidity (Mimiko, 2017). In response to this, the state embarked on several PHC programmes in 2010. For example, the Mother and Child Hospital was initiated as a free medical care for women and children between age zero and five in order to reduce delay in health care provided at health centres (Fatusi, 2013; Gbadamosi, 2018). The Mother and Child Hospital was established to help the state accomplish the Millennium Development Goals (MDGs) which focused on the reduction of mother and child mortality (Mimiko, 2016). In 2014, the state launched the *Agbebiye* (Safe Motherhood) policy as a free medical care programme for pregnant women and children below age of five in order to reduce mother and child mortality rate in the state (Fajimbola, 2012; Oyeneyin, Aladenola, 2019). More so, the programme was used to discourage and stop traditional and medical practitioners from carrying out pregnancy delivery in their homes, and also to provide financial remuneration and skills acquisition for traditional birth attendants on every pregnant woman who is referred to the government hospitals where there are skilled birth attendants (Mimiko, 2016; Oyeneyin, Osunmakinwa, Olagbuji, 2021).

Owoeye and Adedeji (2013) maintained that rapid urbanisation in Akure has largely resulted in crowded dwellings, high pollution rate, poor household facilities, and a lackadaisical attitude of people toward unhygienic environment. This condition has led to increase in the spread of diseases such as malaria, typhoid fever, diarrhea, cholera, dysentery, and other transmittable diseases prevalent in the state (Owoeye, Sogbon, 2012). Moreover, the state health system and governance strategies are weak due in part to lack of continuity in the PHC programme, lack of accountability and transparency in PHC fund, and inadequate allocation of funds for health care which resulted in poor delivery of PHC services at the local government level (Owoeye, 2013). The World Health Organisation (2011) reported that Ondo state health care system lacked effective integration and linkages in the health services.

The cost of healthcare services in Ondo state government hospitals is higher compared with the private health facilities. Owoyemi (2014) showed that the cost of health care services and hospital admission in Ondo state has been on increase and patients often have little or no money left to procure required drugs. Meanwhile, most of the free health care schemes which provide succour and relief to mothers and children only function at the Mother and Child Hospital and are not applicable to patients in general hospitals (Adedeji, Folorunsho, 2014; Gbadamosi, 2018). Also, the Mother and Child Hospital scheme was managed and controlled directly by the office of the governor and not the state ministry of health which raises the concern for transparency and accountability in health care services provided in the state (World Health Organisation, 2011). Other challenges of local government in PHC service delivery in Ondo state, as noted by Owoeye (2013), include multiplicity of PHC stakeholders with, overlapping responsibilities from the state and local governments, lack of local government autonomy, inadequate health facilities and weak community participation, diversion of the PHC funds to other projects and poor monitoring of the PHC funds by the local government.

Discussion of findings

This study assessed the local government performance in PHC service delivery, and examined the challenges of local government in the performance of PHC service delivery in south-west Nigeria. Based on the analysis of the objective from the three selected states, it is necessary to discuss some the findings of the study. One important findings of the study which similarly impedes the performance of local government in PHC programme in the selected states is the lack of local government autonomy. In Nigeria, the constitution stipulates that local government elections are to be conducted by the State Independent Electoral Commission (SIEC). However, local government elections are hardly conducted and tenure for local government chairmen differs from state to state. In some states where local government elections are conducted, the executive governor of the state plays the role of a godfather who anoints a preferred candidate that wans the chairmanship election. Where the governor's candidate does not win the election, councillors impeachment power is used by the state governor to intimidate the local government chairman to the extent he could no longer perform his constitutional duties. In many states where local government elections are not conducted or postponed, the state governor established caretaker or transition committees for the local government (Nwanna, 2014; Ojo, 2021).

The removal of the Ondo state governor in 2009 based on the court of appeal judgment regarding the 2007 governorship election led to the replacement of another governor who nullified the local government election that was conducted in 2007 and established caretaker committees to oversee local government administration. The local government election that was later conducted in 2011 was fuelled by violence, rigging and snatching of ballot box which paved the way for the ruling political party to install their preferred candidates (Wilson, 2013). In Lagos and Ogun states, the 2012 local government elections were described as fraudulent by the opposition political parties and also recorded low turnout as voters boycotted the election as a result of imposition of candidates. In some cases, voters were denied the right to vote for their preferred political parties (Olatunji, 2013). In essence, irregularity of or interference in the local government elections affect legitimacy of the local government chairman or appointed caretaker chairman to implement PHC programmes and also reduce community participation in PHC service delivery since the elected local government chairman or the appointed caretaker chairman are alien to the people.

Findings from this study also revealed the lack of local government financial autonomy as one of the major bane confronting the performance of local government in PHC service delivery. Local government financial autonomy includes fiscal autonomy to impose and collect tax, constitutional inclusion in federal allocation and 10% of state internally generated revenue (Nwanna, 2014; Abdulhamd, Chima, 2015). However, these three sources of revenue hardly complement the performance of local government in PHC service delivery. Page and Wando (2022) claimed that tax and rates collected by local governments and federal government allocation to local government are diverted to state government projects as against the provision of health facilities in the local government. Moreover, the State Joint Local Government Account (SJLGA) established in section 162 (6) of the 1999 constitution as amended adversely affected the performance of local government in the provision of service delivery as funds and allocation meant for local government are

delayed or inadequate. Although the local government now receives federal allocation directly, state governments often demand expensive charges which consequently affect the provision of social service in the local government (Page, Wando, 2022). Studies by Owoeye (2013) and Tijani et al. (2015) corroborated that delay, mismanagement and unintended use of PHC fund in Ondo and Ogun states resulted in poor provision of PHC service delivery in the local governments. Similarly, it was revealed that local government dependence on Lagos state government resource allocation impedes the functioning of the PHC where most health facilities in rural areas are unable to carry out administrative activities due to insufficient funds (Mustapha et al., 2012; Olukoya et al., 2014).

Another findings from this study which limit the performance of local government in PHC service delivery in the selected states is the exclusion and deviation from the key principles of PHC. While it is necessary that programmes are initiated and developed in line with the frameworks of PHC, exclusion and deviation from key principles of PHC could result in inadequate and poor provision of PHC service delivery. This study identified various PHC programmes implemented in the local government of the selected states which include Maternal and Child Reduction, Investment Case and *Eko* Free Malaria in Lagos state, *Araya* and *Gbomoro* in Ogun state, as well as the Mother and Child Hospitals and *Agbebiye* in Ondo state. However, these programmes are limited in totality as key principles of PHC like essential health care, equity, community participation, use of appropriate technology, and intersectoral collaboration are missing. Essential health care is scarce in PHC facilities, there is concentration of PHC facilities in urban areas to the disadvantage of the rural areas and community participation in PHC service delivery is weak (Owoeye, 2013; Isreal, Sunday, 2013; Abimbola et al., 2015).

More so, technological equipment is obsolete or lacking and the health care collaboration with other sectors like the economy is weak, as households make use of quacks nurses who provide care as result of lack of resources to attend PHC facilities or purchase drugs (Olaniyan, Lawanson 2010; Otokpa, 2018). Similarly, the findings showed that PHC programmes are not implemented to provide for continuity and consolidation of health care service delivery. In the states like Ondo and Ogun, where different political parties have governed, several PHC programmes were discontinued and abandoned without completion, while new programmes which are totally different from successive administration are initiated. In other words, abandonment and discontinuation of PHC projects and programmes consequently affect service delivery and community participation.

Conclusions

As a grassroots health care system, PHC promote healthy lifestyle and ensures that diseases, injury, and short-term health issues and most chronic conditions are managed at the local government level. In Nigeria, local government is accountable for the implementation of PHC service delivery which includes healthcare (illness diagnosis and treatment plan, immunisation, pregnancy care, delivery and postnatal care, drug dispensing and dosage administration), growth monitoring and adequate nutrition, safe water, sanitation, health education, special care for high risks, and referral support. Since most of these provisions are available in the PHC centres, local government

performance is a major factor in determining the quality and standard of health care service delivery in Nigeria. This study assessed the performance of local government in PHC service delivery, and examined the challenges of local government in PHC service delivery in the south-western states of Lagos, Ogun, and Ondo in the period of 2010–2015.

This study found out that while there are various established PHC programmes in the selected states, the local governments performance are similarly affected by implementation gap in the delay of PHC funds, diversion of PHC funds to other projects, poor community participation, lack of financial autonomy of local government, as well as multiplicity of the PHC management bodies in the states and local governments. The study concluded that the local government performance in PHC service delivery is weak as a result of the lack of local government autonomy, exclusion and deviation from the key principles of PHC and lack of continuity in PHC programmes implemented by the local government. As regards the continuity of government PHC programmes most of the programmes are no longer in existence, lack adequate facilities and have obsolete medical equipment. More so, lack of local government autonomy and state government diversion of local government and PHC funds to other projects, as well as lack of accountability and transparency in PHC department, has further weakened local government performance in PHC service delivery. Drawing from this conclusion, the study recommended that local government should be accorded constitutional role in the management of PHC service delivery. This will enable the local government to control and monitor PHC fund solely for efficient service delivery without interference from the state government. This will also enable the application of local government autonomy where PHC funds will be directly accessible to the local government for efficient service delivery. The stakeholders involved in the disbursement of the PHC funds should be streamlined in order to reduce delay, resource leakages, and less time-consuming process in the disbursement of PHC by the local government.

References

Abbas, B., Ahmed, B.M. (2012). Challenges of Democratization at the Grassroots in Nigeria: Case Study of Taraba State. *Research on Humanities and Social Sciences*, *2* (7), 98–108.

Abe, T., Monisola, J. (2014). Citizen Participation and Service Delivery at the Local Government Level: A Case of Ise/Orun Local Government in Ekiti State, Nigeria. *Journal of Law, Policy and Globalization*, 2224–3240.

Abdulhamd, O.S., Chima, P. (2015). Local Government Administration in Nigeria: The Search for Relevance. *Commonwealth Journal of Local Governance*, *18*, 181–195.

Abdulraheem, I.S., Olapipo, A.R., Amodu, M.O. (2012). Primary Health Care Services in Nigeria: Critical Issues and Strategies for Enhancing the Use by the Rural communities. *Journal of Public Health and Epidemiology*, *4* (1), 5–13.

Abiodun, A.J. (2010). Patients Satisfaction with Quality Attributes of Primary Health Care Services in Nigeria. *Journal of Health Management*, *12* (1), 39–54.

Abimbola, S., Olanipekun, T., Igbokwe, U., Negin, J., Jan, S., Martiniuk, A., Ihebuzor, N., Aina, M. (2015). How Decentralisation Influences the Retention of Primary Health Care Workers in Rural Nigeria. *Global Heath Action*, *8* (1), 1–20.

Adedeji, Y.M.D., Folorunso, C.O. (2014). *Pollution Management in Housing Environment and Health of Urban Dwellers: A Case Study of Residential Area of Akure City in South-Western Nigeria*. Proceedings of the International Conference of the School of Environmental Technology, Federal University of Technology, Akure.

Adeneye, A.K., Musa, A.Z., Afocha, E.E., Adewale, B., Ezeugwu, S.M.C. (2021). Perception of Community-based Health Insurance Scheme in Ogun State, Nigeria. *Global Journal of Infectious Diseases and Clinical Research*, *7* (1), 1–21.

Adesopo, A.A. (2011). Inventing Participatory Planning and Budgeting for Participatory Local Governance in Nigeria. *International Journal of Business and Social Science*, *2* (7), 1–20.

Adeyemi, O. (2013). Local Government and the Challenges of Service Delivery: The Nigeria Experience. *Journal of Sustainable Development in Africa*, *15* (7), 1–15.

Adeyemo, D.O. (2005). Local Government and Health Care Delivery in Nigeria. A Case Study. *Journal of Human Ecology*, *18* (2), 149–160.

Agba, M.S., Akwara, A.F., Idu, A.Y. (2013). Local Government and Social Delivery in Nigeria: A Content Analysis. *Academic Journal of Interdisciplinary Studies*, *2* (2), 455–462.

Agba, M.S., Ogwu, S.O., Chukwurah, D.C.J. (2013). An Empirical Assessment of Service Delivery Mechanism in Idah Local Government of Kogi State, Nigeria, from 2003 to 2010. *Mediterranean Journal of Social Science*, *4* (2), 621–635.

Ajayi, A. (2014). An Assessment of Primary Health Care in Kosofe Local Government Area of Lagos State. *American Journal of Medicine*, *2* (1), 1–19.

Alenoghena, I., Aigbiremolen, A.O., Abejegah, C.,Eboreime, E. (2014). Primary Health Care in Nigeria: Strategies and Constraints in Implementation. *International Journal of Community Research*, *3* (3), 74–79.

Amujiri, B.A. (2012). Local Government Community-Participation in Execution and Management of Development Projects. *International Journal of Research in Arts and Social Sciences*, *26* (8), 201–217.

Aregbeshola, B.S., Khan, S.M. (2017). Primary Health Care in Nigeria: 24 Years after Olikoye Ransome-Kuti's Leadership. *Front Public Health*, *5* (48), 127–131.

Aregbeshola, B.S., Onigbogi, O.O., Khan, S.M. (2017). Challenges and Opportunities to Access Health Care in Urban Slums of Lagos State in Nigeria. *Pakistan Journal of Public Health*, *7* (1), 11–18.

Arowolo, D. (2010). *Local Government Administration and the Challenges of Rural Development in Nigeria.* In: A. Agagu, L. Afinotan, D. Arowolo, T. Lawal (eds.), *Public administration in Nigeria.* Alabi-Eyo & Co.

Ayinla, R. (2017). Ogun Improves Primary Healthcare, Set to Rehabilitate 57 Healthcare Centres. *Business Day*. Retrieved from: https://businessday.ng/health/article/ogun-improves-primary-healthcare-set-to-rehabilitate-57-healthcare-centres (18.01.2020).

Baje, A.O. (2014). Governor Fashola Achievement in the Health Sector. *Daily Independent*, 3 December. Retrieved from: https://www.dailyindependent.com.ng/governor-fashola-achievement-in-the-health-sector (11.06.2019).

Chapman, R.A. (2010). *Freedom of Information and Local Government: Concepts and Issues*. In: R. Chapman, M. Hunt (eds.), *Freedom of Information: Local Government and Accountability*. London: Ashgate.

Channels Television (2016). *Ogun Launches Araya Scale up Health Scheme*. Retrieved from: https://www.channelstv.com/2016/07/12/ogun-launches-araya-scale-up-health-scheme (19.03.2022).

Eguagie, I., Okosun, V. (2010). The Role of Primary Health Care in Nigeria. Health Care Delivery System: Problems and Prospects. *Knowledge Review*, *21* (1), 1–22.

Ejue, E.A., Madubueze, M.C. (2014). Corruption and Service Delivery in Local Government System in Nigeria: A Content Analysis. *International Journal of Business and Social Science*, *10* (1), 97–107.

Enabulele, O., Enabulele, J.E. (2018). A Look at the Twoway Referral System: Experience and Perception of Its Handling by Medical Consultants/Specialists among Private Medical Practitioners in Nigeria. *International Journal of Family and Community Medicine*, *2* (3), 126–132.

Eshemokha, U. (2019). *The A–Z of Primary Health Care (PHC) in Nigeria*. Retrieved from: https://nimedhealth.com.ng/2019/06/12/the-a-z-of-promary-health-care-in-nigeria/?amp (12.03.2022).

Fatusi, A.O. (2015). *Public Health Leadership, Policy Development and the Nigerian Health System*. Paper Presented at the Introduction Program of the Institute for Government Research Leadership Technology, Abuja. Retrieved from: http://www.instituteforgovernmentresearch.org/images/abuja2015/abuja2015.docx (20.01.2022).

Fatusi, A.O. (2013). *Situation Analysis of Maternal, Newborn and Child Health in Ondo State*. Draft Report.

Fajimbola, T. (2012). Abiye Safe Motherhood: A Case of Leadership in Turning the Tide of Maternal Mortality in Nigeria. *Nigerian Health Journal*, *2* (3), 1–15.

Federal Ministry of Health (2004). *Revised National Health Policy.* Abuja: Federal Ministry of Health.

Federal Ministry of Health (2010). *National Health Strategic Development Plan*. Abuja: Federal Ministry of Health.

Gbadamosi, H. (2018). Ondo Mother and Child Hospitals. Eight Years later. *Nigerian Tribune*. Retrieved from: https://tribuneonlineng.com/ondo-mother-and-child-hospitals-eight-years-later/ (23.03.2022).

Goss, S. (2001). *Making Local Governance Work*. New York: Palgrave.

Gupta, M.D., Gauri, V., Khemani, S. (2004). *Decentralized Delivery of Primary Health Services in Nigeria: Survey Evidence from the States of Lagos and Kogi*. Africa Region Human Development Working Paper Series No. 70. Washington, DC: The World Bank.

Ileyemi, M. (2022). Lagos Launches Eye Programme for Students across Schools. *Premium Times*. Retrived from: https://www.premuimtimesng.com/news/more-news/510513-lagos- launches-eye-programme-for-students -across -schools.html (14.04.2022).

Isreal, A., Sunday, O. (2013). Infrastructural Distribution of Healthcare Services in Nigeria: An Overview. *Journal of Geography and Regional Planning*, *2* (5), 1–20.

Jamo, I.A. (2013). Local Government Administration in Nigeria: A Chronological Perspective from 1861 to 2012. *A Journal of Historical Research, Department of History, Ahmadu Bello University Zaria*, *2* (3), 1–6.

King, M.C. (1988). *Localism and Nation Building.* Ibadan: Spectrum Books.

Lagos State Ministry of Health (2010). *Lagos State Government Strategic Health Development Plan (2010–2015)*. Lagos.

Lagos State Ministry of Health (2012). *Launch of the Maternal and Child Mortality Reduction Programme*. Lagos.

Lambo, E. (2015). *Primary Health Care: Realities, Challenges, and the Way Forward*. Paper presented at the First Annual Primary Health Care Lecture, Abuja. Retrieved from: http://nigeriahealthwatch.com/wp-content/uploads/bsk-pdf-manager/1160_2015_Primary_Health_Care_Presentation_Final_NPHCDA_1216.pdf (15.10.22).

Mike, E. (2010). *Community Participation in Primary Health Care Services in Nigeria*. Retrieved from: www.ngnhc.org/. (17.01.2018).

Mimiko, O. (2016). *Post MGDs: Sustaining Health Gains*. Speech Delivered at the 2016 State Council on Health Held at International Event Centre, Akure.

Mimiko, O. (2017). Experiences with Universal Coverage of Maternal Health Care in Ondo State, Nigeria, 2009–2017. *African Journal of Reproductive Health*, *21* (3), 9–16.

Mohammed, S. (2020). Lagos Govt Assesses 329 Primary Health Care Centres, to Commission 23 More Centres. *Nigerian Tribune*. Retrieved from: https://www.tribuneonlineng.com/lagos-govt-assesses-329-primary-health-care-centres-to-commission-23-more-centres (14.03.2022).

Mustapha, O.G., Adepoju, W., Ehikioya, A., Ogbonnaya, O., Adeniyi, A., Dolu, L.A. (2012). The Sorry State of PHCs. *The Nation Newspaper*. Retrieved from: https://thenationonlineng.net/the-sorry-state-of-phcs/amp/ (19.10.2019).

National Bureau of Statistics (2014). *Annual Abstract of Statistics*. Nigeria National Bureau of Statistics.

National Primary Health Care Development Agency (2004). *Ward Health Service Operational Guide*. Abuja, Nigeria.

National Primary Health Care Development Agency (2007). *Ward Minimum Health Care Package*. Abuja, Nigeria.

Nwanna, C.R. (2014). Local Government Elections in Nigeria: A Comparative Analysis of Three States. *International Journal of Humanities Social Sciences and Education*, *1* (11), 180–192.

Obansa, S.A.J., Orimisan, A. (2013). Health Care Financing in Nigeria: Prospects and Challenges. *Mediterranean Journal of Social Sciences*, *4* (1), 1–19.

Obioha E.E., Molale, M.G. (2011). Functioning and Challenges of Primary Health Care (PHC) Program in Roma Valley, Lesotho. *Ethno-Medicine*, *5* (2), 73–88.

Obionu, C.N. (2007). *Primary Health Care for Developing Countries.* Enugu: Delta Publications.

Odalonu, H.B. (2015). Challenges Confronting Local Government Administration in Efficient and Effective Social Service Delivery: The Nigerian Experience. *International Journal of Public Administration and Management Research*, *2* (5), 12–22.

Ogun State Ministry of Health (2010). *Ogun State Government Strategic Health Development Plan (2010–2015)*. Ogun.

Ogunniyi, S.O., Faleyimu, B.L., Makinde, O.N., Adejuyigbe, E.A. (2000). Delivery Care Services Utilization in an Urban Population. *Niger Journal of Medicine*, *9* (3), 81–85.

Ojo, J. (2021). LG Elections and Administration in Nigeria. Retrieved from: https://punchng.com/lg-election-and-adminstration-in-Nigeria (3.08.2022).

Olatunji, D. (2021). NANNM Laments Shortage of Nurses in Ogun. *Punch Newspaper*. Retrieved from: https://punchng.com/nannm-laments-shortage-of-nurses-in-ogun/ (13.10.2022).

Okojie, C. (2009). *Decentralization and Public Service Delivery in Nigeria*. NSSP Working Paper 4. Abuja, Nigeria: International Food Policy Research Institute.

Olanipekun, V.S. (2013). *Introduction to House-to-house Inspection: Procedures, Contents, and Form*. Paper presented at a Training Workshop for Environmental Health Officers in Primary Health Care Development Agency, organised by the Occupational Health and Safely Division of the Department of Public Health, Federal Ministry of Health, in collaboration with World Health Organisation, 21 May.

Olaniyan, O., Lawson, A. (2010). *Health Expenditure and Health Status in Northern and Southern Nigeria: A Comparative Analysis Using NHA Framework.* Paper presented at the 2010 CSAE Conference Held at St. Catherine College, University of Oxford, Oxford, UK.

Olise, P. (2007). *Primary Health Care for Sustainable Development.* Abuja: Ozege Publications.

Olukoya, A., Coker, H., Osibogun, A., Oshin, O. (2014). *Administrative Analysis of the Nigerian Public Health Sector*. Report prepared for the USAID.

Omonona, B.T., Obaisesan, A.A., Aromolaran, O.A. (2015). Health-care Access and Utilization among Rural Households in Nigeria. *Journal of Development and Agricultural Economics*, *7* (5), 195–203.

Onah, R.C., Amujiri, B.A. (2010). *Local Government in Nigeria Structure: Role and Expectation*. National Workshop on the Local Government Structure and Potentials for Socio-Economic Development of Nigeria: Ibadan, 28–30 July.

Ondo State Ministry of Health (2010). Ondo State Government Strategic Health Development Plan (2010–2015). Ondo.

Onohwosafe, P.S. (2014). Provision of Healthcare Services as Correlates of Incidence of Occupational Diseases among Cement Factory Workers in Ogun State. *Journal of Social Sciences*, *7* (1), 19–26.

Onwuzoo, A. (2021). Inside Lagos PHCs where Nursing Mothers Are Forced to Pay N100 before Child Immunisation. *Punch Newspaper*. Retrieved from: https://punchng.com/inside-lagos-phcs-where-nursing-mothers-are-forced-to-pay-n-100-before-child-immunisation/ (14.03.2022).

Otokpa, R. (2018). *Investigation: Moribund Primary Healthcare Centres Are Fuelling Infant, Maternal Mortality*. International Centre for Investigative Reporting. Retrieved from: https://www.icirnigeria.org/investigation-moribund-primary-healthcare-centres-are-fuelling-infant-maternal-mortality/ (8.04.2019).

Oviasuyi, P.O., Idada, W., Isiraojie, L. (2010). Constraints of Local Government Administration in Nigeria. *Journal of Social Sciences*, *24* (2), 81–86.

Owoeye, J.O. (2013). A Study on Environmental Habitability of Core Residential Neighbourhood in Akure, Nigeria. *American Journal of Research Communication*, *1* (2), 140–153.

Owoeye, J.O, Adedeji, Y.M.D. (2013). Poverty, Sanitation and Public Health Nexus: Implications on Core Residential Neighbourhood of Akure, Nigeria. *International Journal of Developing Societies*, *2* (3), 96–104.

Owoeye, J.O., Sogbon, O. (2012). Reducing the Environmental Health-risk of Vulnerable Group in High-density District of Akure, Nigeria. *Academic Journal of Interdisciplinary Studies*, *1* (2), 123–135.

Oyeneyin, L., Aladenola, O. (2019). Confidential Enquiries into Maternal Deaths in Ondo State, Nigeria: A Comparative Analysis. *BMC Pregnancy Childbirth*, *19* (514), 51–67.

Oyeneyin, L., Osunmakinwa, O., Olagbuji, Y. (2021). Incorporating Traditional Birth Attendants into the Mainstream Maternal Health System in Nigeria: An Evaluation of the Ondo State Agbebiye Program. *African Journal of Reproductive Health*, *25* (4), 82–88.

Owoyemi, A. (2014). *Reflections on Health Care in Ondo State*. Retrieved from: https://vceplayer.netiseb.co.ukpmi.orgTestking.orgshms.edu. (20.05.2018).

Paina, L., Peters, D. (2012). Understanding Pathways for Scaling up Health Services through the Lens of Complex Adaptive Systems. *Health Policy Plan*, *27* (5), 365–373.

Page, M.T., Wando, A.H. (2022). *Halting the Kleptocratic Capture of Local Government in Nigeria*. Carnegie Endowment for International Peace. Working Paper. Retrieved from: https://carnegieendowment.org/2022/07/18/halting-kleptocratic-capture-of-local-government-in-nigeria-pub-87513 (16.04.2022).

PharmAccess Foundation (2015). Nigeria's Ogun State Continues to Expand Araya Health Insurance Scheme. Retrieved from: https://www.pharmacsess.org/update/nigeria's- ogun-state-continues-to-expand-araya-health-insurance-scheme/ (19.03.2022).

PM News. (2014). *Amosun Launches Community Health Insurance Scheme*. Retrieved from: https://www.pmnewsnigeria.com/2014/04/29/amosun-launches-community-health-Insurance-scheme/?amp=1 (17.02.2019).

Premium Times (2012). 2,599 Medicine Shops Licenced to Operate in Ogun State. Retrieved from: https://www.premiumtimesng.com/news/93651-2599-medicine-shops-licenced-to-operate-in-ogun-state.html (20.06.2017).

Reid, M. (2008). Nigeria Still Searching for Right Formula. *Bulletin of the World Health Organisation*, *86* (9), 663–665.

Sanda, H.U. (2014). Media Awareness and Utilization of Antenatal Care Services by Pregnant Women in Kano State, Nigeria. *Journal of Social Science Studies*, *1* (2), 1–19.

The Nation Newspaper (2014). Amosun Inaugurate Health Insurance Scheme. Retrieved from: https://thenationonlineng.net/amosun-inaugurate-health-insurance-scheme/ (12.11.2021).

Tijani, M.A.O., Okareh, O.T., Soladoye, M.O., Adegboyega, T.T. (2015). Healthcare Wastes Management in Primary Health Care Settings: Case Study of Ikenne Local Government, Ogun State, Nigeria. *Journal of Public Health*, *1* (3), 1–19.

Suleiman, I.A., Onaneye, O. (2014). Pharmaceutical Care Implementation: A Survey of Attitude, Perception, and Practice of Pharmacists in Ogun State, South-Western Nigeria. *International Journal of Health Research*, *4* (2), 91–97.

Sunday, O.J., Chinedum, I.G. (2014). Mushrooming Appointed Caretaker Committee: A Quagmire to Grass Roots Democracy in Nigeria. *International Journal of Sociology and Anthropology*, *6* (7), 214–220.

United Nations Children Education Fund/Federal Republic of Nigeria (2011). *The Nutritional Status of Women and Children in Nigeria*. Lagos, Nigeria.

United States Agency for International Development (2014). *Governance Initiative in Nigeria: A Strategic Assessment of PHC and Local Government*. Lagos, Nigeria.

Uneke, C.J., Ndukwe, C.D., Oyibo, P.G., Onwe, F. (2010). Development of Health Policy and Systems Research in Nigeria: Lessons for Developing Countries. *Health Policy*, *6* (1), 109–126.

Uzochukwu, B., Onwujekwe, E., Mbachu, Ch., Okeke, Ch., Molyneux, S., Gilson, L. (2018). Accountability Mechanisms for Implementing a Health Financing Option: The Case of the Basic Health Care Provision Fund (BHCPF) in Nigeria. *International Journal of Equity in Health*, *17* (100), 50–63.

Wilson, G. (2013). The Politics of Local Government Reforms and Democratic Governance in Nigerian Local Governments. *Journal of Developing Country Studies*, *3* (1), 136–143.

World Bank (2010). *Improving Primary Health Care Delivery in Nigeria. Evidence from Four States*. Africa Region Human Development Department. Washington, DC.

World Bank (2011). *Improving Primary Health Care Delivery in Nigeria*. Washington, DC.

World Health Organisation (1978). Declaration of Alma Ata Report of the International Conference on Primary Health Care 6–12 September. Alma Ata, USSR.

World Health Organisation (1992). *Local Government Focused Acceleration of Primary Health Care: The Nigerian Experience*. Report.

World Health Organisation (2011). *The Abuja Declaration: Ten Years on*. World Health Organization, Geneva. Retrieved from: http://www.who.int/healthsystems/publications/Abuja10.pdf (15.03.2019).

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