

**INTERNALLY GENERATED REVENUE AND PRIMARY HEALTH CARE
SERVICES IN OVIA NORTH EAST LOCAL GOVERNMENT ,AREA OF
EDO STATE(2010-2024**

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SSC2105778

**FACULTY OF SOCIAL SCIENCES
DEPARTMENT OF PUBLIC ADMINISTRATION
UNIVERSITY OF BENIN
BENIN CITY**

DECEMBER 2025.

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**BEING A RESEARCH PROJECT SUBMITTED TO THE DEPARTMENT
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DECEMBER 2025.

CERTIFICATION

We, the undersigned certify that this project is adequate in scope and was carried out by OGHENEKEVWE AKPOJOVWO, in the department of Public Administration, Faculty of Social Sciences, University of Benin, Benin City, Edo State, Nigeria; In partial fulfillment for the award B.Sc. Degree in Public Administration.

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Head of Department

Date: _____

DEDICATION

This project is dedicated to God almighty.

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My sincere and deepest gratitude, glory and honour to the Almighty God for His Provision, Infinite mercy, Grace and guidance that made this project a success.

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ABSTRACT

This study investigates how internally generated revenue (IGR) affects the delivery of primary healthcare (PHC) services in Ovia North East Local Government Area of Edo State between 2010 and 2024. The problem underlying this study arises from the persistent inadequacy of healthcare funding at the local government level despite the strategic role of PHC in community well-being, leading to irregular drug supply, poor infrastructure, and inconsistent service quality. The objective of the study is to determine the influence of IGR on the availability, quality, sustainability, and infrastructural development of PHC services. The study adopts a descriptive survey design and collects data from 120 PHC workers using a structured questionnaire, and the data are analyzed using frequencies, percentages, and mean scores. The findings reveal that IGR significantly improves the availability of essential drugs, enhances service quality, supports sustainable PHC operations, and contributes to infrastructural upgrading and the procurement of medical supplies, though challenges such as low tax compliance, weak revenue management, and limited institutional capacity hinder full optimization. The study concludes that IGR remains a critical determinant of effective PHC delivery in the local government area. It recommends strengthening revenue mobilization strategies, improving transparency and accountability in fund management, expanding the local revenue base, and enhancing investment in PHC infrastructure to ensure sustainable and quality healthcare services.

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

The role of primary health care (PHC) in Nigeria is central to achieving universal health coverage, ensuring that essential health services are accessible to all, particularly in rural and underserved areas. Primary health care services, being the first point of contact for individuals within the health system, are crucial in preventing and managing both communicable and non-communicable diseases. They are also essential for maternal and child health, immunization, disease surveillance, and health promotion activities that form the bedrock of a well-functioning healthcare system (Adeyi et al., 2020). However, despite its critical importance, financing for primary health care remains a significant challenge for local governments, particularly in Ovia North East Local Government Area (LGA) of Edo State, where limited resources have hindered the optimal delivery of services.

The Nigerian health system is predominantly funded through a combination of federal allocations, state government funding, and locally generated revenue. Internally Generated Revenue (IGR) refers to the funds that a local government raises internally through taxes, levies, fees, fines, and other revenue-generating

activities. IGR is an essential tool for improving the financial sustainability of local government services, including health care (Ogunleye & Olorunfemi, 2018). However, the ability of local governments to generate sufficient IGR remains constrained due to challenges such as a narrow tax base, poor tax compliance, and a lack of effective revenue collection mechanisms (Akinboade, 2020). In Ovia North East LGA, these challenges are compounded by the reliance on state and federal transfers, which often arrive late or fall short of expected amounts, leaving health facilities underfunded and ill-equipped to serve the growing population.

Research has shown that inadequate IGR severely impacts the quality and availability of primary health care services in many parts of Nigeria, with local governments struggling to meet the increasing demands for health services (Akpan & Osei, 2017). Ovia North East LGA is no exception, where the limited capacity to raise funds locally has meant that PHC services often rely heavily on unpredictable state and federal transfers, creating an unstable funding environment. This instability undermines efforts to maintain health infrastructure, pay healthcare workers, and purchase essential medical supplies.

In response to these challenges, there have been efforts to enhance IGR generation through various reforms. Local governments have explored strategies to improve tax administration, broaden the tax base, and diversify revenue streams (Adeyemi & Ogunleye, 2021). While some success has been reported in these

areas, Ovia North East LGA continues to face significant obstacles in effectively utilizing IGR for health services, primarily due to governance inefficiencies, poor financial management practices, and a lack of institutional capacity (Oluwaseun et al., 2019).

The current study seeks to investigate the relationship between IGR and the performance of primary health care services in Ovia North East LGA from 2010 to 2024. It aims to explore the extent to which IGR mobilization has contributed to improving the quality of PHC services and to identify the barriers to efficient revenue utilization. Given the critical role of PHC in the achievement of the Sustainable Development Goals (SDGs), particularly SDG 3, which aims to ensure healthy lives and promote well-being for all, the importance of sustainable funding for primary health care cannot be overstated (World Health Organization, 2019).

By examining how IGR affects the delivery of primary health care in Ovia North East LGA, this study will contribute valuable insights into the potential of locally generated revenue to finance health services at the local government level, thereby improving service delivery and health outcomes in Nigeria's rural areas.

1.2 Statement of the Problem

The delivery of primary health care (PHC) services in Nigeria is vital to achieving universal health coverage and improving public health outcomes (Ogah,

2024; Adeyi et al., 2020). However, despite significant government efforts, the financing of PHC services in many local government areas, including Ovia North East LGA in Edo State, remains a challenge (Academy of Medical Sciences, 2021). A primary source of funding for local governments in Nigeria is Internally Generated Revenue (IGR), which includes funds raised through taxes, fees, fines, and levies (Ogunleye & Olorunfemi, 2018). While IGR has the potential to provide a more reliable and consistent funding stream for local government services, including health care, its effectiveness in financing PHC services in Ovia North East LGA has been limited due to various challenges.

These challenges include a narrow tax base, poor tax compliance, ineffective revenue collection practices, and limited capacity to manage the generated revenue service (Akpan & Osei, 2017; ResearchGate, 2017). As a result, the local government faces difficulties in adequately funding its PHC services, which has led to insufficient medical infrastructure, delayed salaries for health workers, and inadequate medical supplies, all of which undermine the quality of care provided to the population (International Policy Brief, 2023). Although there have been efforts to improve IGR mobilization in the region, these efforts have yet to yield the desired improvements in the quality and sustainability of PHC services (Adeyemi & Ogunleye, 2021).

Existing studies have predominantly focused on broader aspects of local government finance or on macroeconomic impacts, with limited attention paid to the specific link between IGR and PHC performance (Oluwaseun et al., 2019). The lack of focused research on how IGR directly influences the effectiveness and accessibility of PHC services in Ovia North East LGA presents a significant gap in the literature. This study, therefore, seeks to explore the relationship between IGR and the performance of primary health care services in Ovia North East LGA. The research will focus on the extent to which IGR has contributed to improving PHC infrastructure, medical supplies, and human resources in the area. Additionally, the study will identify the challenges in mobilizing and utilizing IGR for PHC services, offering recommendations to improve local government financing for better health outcomes.

1.3 Objectives of the Study

The broad objective of this study is to assess the impact of Internally Generated Revenue (IGR) on the performance of primary health care services in Ovia North East LGA. Specifically, the study aims to:

1. Evaluate the impact of IGR on the availability and quality of primary health care services in Ovia North East LGA.

2. Assess the relationship between effective IGR mobilization and the sustainability of primary health care services in the LGA.
3. Identify the challenges faced by Ovia North East LGA in utilizing IGR for the financing of PHC services.
4. Examine the influence of IGR on the improvement of health infrastructure and the provision of medical supplies in Ovia North East LGA.

1.4 Research Questions

Based on the identified gap, the following research questions guide this study

1. What is the impact of Internally Generated Revenue (IGR) on the availability and quality of primary health care services in Ovia North East LGA?
2. How does the effectiveness of IGR mobilization influence the sustainability of PHC services in Ovia North East LGA?
3. What are the key challenges faced by Ovia North East LGA in mobilizing and utilizing IGR for financing PHC services?
4. How does the utilization of IGR affect the improvement of health infrastructure and medical supply availability in Ovia North East LGA?

1.5 Hypotheses

The following null hypotheses will guide the study:

Hypothesis 1

Null (H₀): There is no significant relationship between Internally Generated Revenue (IGR) and the quality of primary health care services in Ovia North East LGA.

Research (H₁): There is a significant relationship between Internally Generated Revenue (IGR) and the quality of primary health care services in Ovia North East LGA.

Hypothesis 2

Null (H₀₂): The effectiveness of IGR mobilization does not significantly influence the sustainability of PHC services in Ovia North East LGA.

Research (H₁₂): The effectiveness of IGR mobilization significantly influences the sustainability of PHC services in Ovia North East LGA.

Hypothesis 3

Null (H_{03}): There is no significant impact of IGR on the improvement of health infrastructure and the provision of medical supplies in Ovia North East LGA.

Research (H_{13}): There is a significant impact of IGR on the improvement of health infrastructure and the provision of medical supplies in Ovia North East LGA.

1.6 Scope of the Study

This study focuses on the impact of Internally Generated Revenue (IGR) on the performance of Primary Health Care (PHC) services in Ovia North Local Government Area (LGA) of Edo State, Nigeria, covering the period from 2010 to 2024. The study will specifically examine the relationship between IGR mobilization and the quality, sustainability, and infrastructure development of PHC services in the region. The geographical scope of the study is limited to Ovia North East LGA, one of the 18 LGAs in Edo State, which has a unique mix of urban and rural populations, making it a suitable case for understanding local government financing and its effects on health services. The study will focus on key performance metrics of PHC services, including service availability, health infrastructure, medical supplies, and human resources, as these are directly impacted by IGR.

The time frame of the study is set from 2010 to 2024 to capture the trends in revenue generation and its impact on health services over the past decade. This period covers key changes in fiscal policies, health reforms, and shifts in local government financial management practices.

1.7 Significance of the Study

This study holds significant value for various stakeholders, including local government officials, health policymakers, researchers, and health service providers.

Government and Policymakers: By examining the role of IGR in financing PHC services, the study provides essential insights for local government authorities to better understand how local revenue can be more effectively mobilized and utilized for health services. The findings could guide policy adjustments to optimize revenue generation, improve fiscal management, and enhance the quality of healthcare delivery in rural areas.

Primary Health Care Providers: The study will offer practical insights into the challenges and opportunities associated with funding PHC services through local revenue sources. By identifying the key barriers to effective IGR utilization, it will

help health administrators and managers in Ovia North East LGA devise strategies to address these issues, ultimately leading to improved service delivery.

Academia and Research: This research contributes to the existing literature on local government financing for health services, specifically in Nigeria. It adds to the body of knowledge on the relationship between local government revenue generation and the performance of primary health care services, a topic that has been under-explored in the context of rural Nigeria.

Local Communities and Citizens: For the residents of Ovia North East LGA, the study holds value by addressing the challenges of underfunded health services. The research will potentially inform local government strategies aimed at improving the delivery of primary health care, thus improving health outcomes for the community. Understanding how IGR can improve healthcare accessibility and quality will benefit the public by ensuring better health infrastructure, more qualified healthcare personnel, and more reliable services.

Definitions of Terms

Primary Health Care (PHC): Primary Health Care refers to essential health services that are universally accessible, affordable, and provide comprehensive care at the first point of contact with the health system. These services address

health needs for both preventive and curative care, focusing on health promotion, disease prevention, treatment of common illnesses, and maternal and child health.

Internally Generated Revenue (IGR): Internally Generated Revenue is the revenue collected by local governments through various sources within their jurisdiction. This includes taxes, fees, levies, and fines imposed on individuals or businesses operating within the local government's boundaries. IGR is crucial for improving financial sustainability and reducing dependency on federal or state transfers.

Local Government Area (LGA): A Local Government Area (LGA) is an administrative division in Nigeria, responsible for providing essential services, including health care, within a designated geographical area. LGAs are the closest level of government to the citizens and play a vital role in the delivery of primary services, such as health, education, and infrastructure.

Sustainable Development Goals (SDGs): The Sustainable Development Goals are a set of global objectives established by the United Nations to address pressing global challenges, including poverty, inequality, climate change, and health. SDG 3 specifically focuses on ensuring healthy lives and promoting well-being for all at all ages.

Tax Base: The tax base refers to the total value of all taxable entities or individuals within a certain area or system. A broader tax base means more people or businesses are contributing to the revenue pool, which can improve the financial health of a local government or country.

Governance Efficiencies: Governance efficiencies refer to the effectiveness with which a government administers its functions and resources. Efficient governance leads to better allocation and utilization of resources, improving public service delivery and reducing waste.

Institutional Capacity: Institutional capacity refers to the ability of organizations, such as local governments, to effectively perform their functions.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

This chapter reviews extant literature relevant to Internally Generated Revenue (IGR) and Primary Health Care (PHC) services at local government level. It is organized into conceptual review, theoretical review, and empirical review. The section concludes with identified gaps that justify the present study on Ovia North-East LGA (2010–2024).

2.2 Conceptual Review

This section offers a conceptual review of the dependent and independent variables. It examines the basis and relationship between these variables, setting the groundwork for further analysis in the study.

2.2.1 Primary Health Care (PHC) and PHC Performance

Primary Health Care (PHC) is the first-contact, person- and community-oriented level of care that is universally accessible and affordable, delivered through integrated services that address most health needs across the life course. The 2018 Declaration of Astana re-affirmed PHC as the cornerstone for achieving Universal Health Coverage (UHC), while the WHO–UNICEF Operational Framework clarifies PHC as comprising primary care, essential public health functions, and multisectoral action anchored in communities (WHO, 2018; WHO & UNICEF, 2020). In performance terms, PHC systems are expected to provide first-contact accessibility, continuity, comprehensiveness, coordination, and people-centredness while producing equitable, high-quality outputs. Two complementary architectures guide measurement: the WHO–UNICEF PHC Measurement Framework (structures, processes, outputs, outcomes) and the Primary Health Care Performance Initiative (PHCPI) “Vital Signs” approach, which translates these functions into comparable indicators and profiles (WHO & UNICEF, 2022; Veillard et al., 2017).

At LGA level, service availability and functionality refer to whether facilities exist, are open and staffed as intended, and possess the minimum inputs to deliver services. WHO’s Service Availability and Readiness Assessment (SARA) and the Harmonized Health Facility Assessment (HHFA) define and measure

“general service readiness” and “specific service readiness,” including tracer items and functional infrastructure (WHO, 2015; WHO, 2022). In Nigeria, policy targets such as a functional PHC per ward and PHCUOR (PHC-Under-One-Roof) reforms emphasize making facilities truly operational—open on scheduled days, with essential equipment and utilities (NPHCDA, n.d.). Nigeria’s financing architecture reinforces functionality expectations. The ****Basic Health Care Provision Fund (BHCPF)**** operational guidelines instruct facilities to provide the routine PHC service package (based on the Ward Minimum Health Care Package) and to adhere to referral and service protocols, using funds to sustain availability, minor renovations, and basic inputs (FMOH, 2020). This links LGA financing to day-to-day operability, including opening hours and basic equipment readiness.

Coverage and utilization track whether priority interventions reach the population and whether people use PHC when needed. Standard indicators include antenatal care (ANC1 and ANC4+ contacts), DTP3/Penta3 and measles immunization, skilled birth attendance (SBA), and outpatient visits per 1,000 population, a proxy for first-contact use. These measures follow global metadata from WHO, WHO/UNICEF immunization guidance, and the WHO indicator registry, and are embedded in the WHO–UNICEF PHC measurement menu (WHO, 2015; WHO/UNICEF, 2023; WHO, 2023; WHO & UNICEF, 2022).

Readiness and commodities capture whether facilities can consistently deliver care without avoidable interruptions. SARA/HHFA propose using stock-out days for tracer medicines/consumables and functionality of essential equipment as core indicators, with stratification by service domain (e.g., child health, maternal health, NCDs) (WHO, 2015; WHO, 2022). For immunization services, readiness includes functional cold-chain, vaccine stock management, and adherence to logistics standards. Cold-chain performance is often assessed with the Effective Vaccine Management (EVM 2.0) framework, which specifies criteria for storage temperatures, equipment uptime, stock control, distribution, and maintenance practices; these are typically summarized with domain scores and used to target improvements in PHC facilities providing vaccines (WHO & UNICEF, 2019).

The workforce dimension focuses on density and mix of frontline cadres Community Health Extension Workers (CHEWs), nurses/midwives, and Community Health Officers per 10,000 population, and their distribution across wards. WHO's National Health Workforce Accounts (NHWA) provide the indicator specifications for sub-national densities, while Workforce 2030 sets the policy agenda for adequate, equitably distributed teams (WHO, 2017; WHO, 2016/2023). Nigeria's Minimum Standards for PHC** further stipulate staffing norms and roles for facility types, aligning cadres to the PHC package (NPHCDA, 2010/2012).

User experience and timeliness reflect whether care is acceptable, prompt, and respectful. The PHC measurement and PHCPI frameworks include people-centeredness, waiting time, first-contact accessibility, perceived quality, and effective referral/continuity as core performance attributes (WHO & UNICEF, 2022; PHCPI, 2020/2023). These aspects bridge structural readiness and outcomes by capturing how users actually experience PHC and how quickly they receive needed services. Referrals and outreach frequency are practical expressions of coordination and community linkage. BHCPF guidance explicitly requires prompt referral according to SOPs, while the WHO PHC framework prioritizes community linkages**, outreach, and continuity across levels. In LGAs, measuring referral rates/completion and the number of outreach sessions per month helps assess whether PHC is proactive and well-connected to higher levels of care (FMoH, 2020; WHO & UNICEF, 2022).

For this dissertation, PHC performance will be proxied by a composite PHC Performance Index (PHCPI) built from standardized indicators spanning coverage (e.g., ANC4, Penta3, measles, SBA, OPD use) and readiness (e.g., stock-out days, equipment/cold-chain functionality). Indicator selection will align with the WHO–UNICEF PHC measurement menu and PHCPI Vital Signs domains to ensure comparability and relevance to Nigeria’s PHC service package (WHO & UNICEF, 2022; PHCPI, 2023).

Methodologically, each indicator will be transformed to a common scale (e.g., z-scores), directionally harmonized so that higher values consistently reflect better performance, and aggregated using transparent weights (equal or data-driven) with sensitivity checks. Where feasible, indicators will be disaggregated by ward/PHC facility to reveal within-LGA variation consistent with NHWA sub-national workforce metrics and PHCPI profiling practice (WHO, 2017; Veillard et al., 2017).

Primary data sources will include routine HMIS/DHIS2 extracts (utilization and coverage), LGA facility supervision checklists (functionality, opening days), logistics records (stock-outs, cold-chain), and HRH registries (staff counts by cadre). When available, recent SARA/HHFA rounds and immunization EVM assessments will be used to validate readiness estimates and fill gaps, ensuring indicator metadata follow the WHO/UNICEF technical specifications (WHO, 2015; WHO, 2022; WHO & UNICEF, 2019; WHO & UNICEF, 2022).

Anchoring PHC performance to Nigeria's policy instruments PHCUOR, the Ward Minimum Health Care Package, and the BHCPF ensures the index reflects what LGAs are mandated and financed to deliver: functional PHC facilities, routine service readiness, community outreach, and effective referrals. This framing also supports later econometric analysis linking Internally Generated

Revenue (IGR) to PHC performance, by tying fiscal capacity to concrete, policy-specified outputs at facility and ward levels (NPHCDA, n.d.; FMoH, 2020).

2.2.2 Internally Generated Revenue (IGR) at LGA Level

Internally Generated Revenue (IGR) refers to all own-source revenues that a local government council raises within its jurisdiction distinct from intergovernmental transfers. In Nigeria's decentralized framework, the 1999 Constitution assigns LGAs core local functions (e.g., basic services, markets, sanitation) and the authority to raise certain local revenues to help finance those functions; in fiscal federalism terms, IGR underpins local autonomy, accountability, and responsiveness (Federal Republic of Nigeria, 1999; Oates, 1972; Ahmad & Brosio, 2006). Typical LGA IGR sources include property-related rates (often called tenement rates where applicable in state laws), market and motor-park dues, business premises registration, signage/advert permits, slaughter-slab fees, environmental and inspection fees, licensing, and court fines. In developing-country settings, these bases are attractive because they are geographically immobile, administratively observable, and conceptually linked to local benefits features long emphasised in the local public finance literature (Bahl & Linn, 1992; Bird, 2010; Franzsen & McCluskey, 2017).

Well-designed IGR matters for service delivery because it provides discretionary resources for operations and maintenance, small capital works, and

“last-mile” inputs that higher-tier transfers may not reliably cover. Empirically, greater own-source effort is associated with stronger local performance and, under the right governance conditions, better human-development outcomes—mechanisms consistent with fiscal-decentralisation theory and cross-country evidence on subnational finance (Martinez-Vazquez & McNab, 2003; Smoke, 2015). However, the predictability and timeliness of IGR collections are as important as their level. Irregular or highly seasonal cash inflows complicate cash management, constrain procurement of commodities, and can disrupt frontline services. Public financial management (PFM) guidance for subnational governments therefore stresses credible forecasting, regular in-year releases, and sound cash-management practices benchmarked, for example, by the PEFA Subnational Framework (PEFA Secretariat, 2016; Pattanayak & Fainboim, 2011).

Local revenue mobilization in many African LGs is hampered by structural constraints: a narrow and informal tax base, weak property registers/cadastrals, low compliance, costly manual collection, and limited taxpayer services. Studies from anglophone Africa document pervasive fragmentation of fee/levy instruments and the administrative burden of numerous small charges with low yield but high political salience (Fjeldstad & Heggstad, 2012; Moore, 2013). Governance and integrity risks also matter. Cash-based point collections, weak internal controls, fragmented bank accounts, and discretionary waivers can produce leakage and

erode public trust. International assessments show that transparency (timely publication of tariffs, clear legal bases), consolidated cash management, and audit/sanction regimes are associated with better collection efficiency and lower leakages (de Renzio, 2009; PEFA Secretariat, 2016).

Reform experiences point to practical levers: digital billing and e-receipting, bank-based/POS payments, taxpayer identification and registries, GIS-enabled property databases, and integration with Treasury Single Account (TSA) arrangements to reduce cash leakages and speed lodgements. These are pillars of the emerging “GovTech” agenda and of contemporary property-rate reforms in Africa (World Bank, 2020; Franzsen & McCluskey, 2017; Pattanayak & Fainboim, 2011). The composition and quality of IGR are as important as its size. Stable, broad-based sources (e.g., property rates, business premises) are preferable to distortionary or “nuisance” levies that raise little revenue but impose high compliance costs, invite harassment, or harm local commerce. Sound benefit-based user charges can complement broad bases, but should be simple, predictable, and transparently linked to service costs (Bird & Zolt, 2005; IMF, 2015).

Tax morale and voluntary compliance rise when taxpayers see credible service delivery and fair, predictable rules. Participatory tariff setting, grievance redress, and public reporting on how IGR is used (especially for visible local services such as primary health care, water, sanitation, and markets) strengthen the

social contract and willingness to pay (OECD, 2019; Moore, 2013). For empirical analysis, IGR performance can be operationalized through (i) level real per-capita IGR; (ii) effort IGR as a share of total LGA revenue; (iii) composition/quality share from broad, stable bases versus minor levies; (iv) predictability/volatility rolling variance of monthly or annual collections; and (v) timeliness/execution collection-to-lodgment times and in-year release to service departments. These metrics align with international guidance and allow rigorous testing of how IGR translates into service performance, including for PHC (Bird, 2010; PEFA Secretariat, 2016; Martinez-Vazquez & McNab, 2003).

In Nigerian, aligning IGR reforms with state laws and harmonized schedules (to avoid multiple taxation), simplifying rate structures, and earmarking transparent, limited proportions for service priorities (while safeguarding flexibility) can enhance legitimacy and outcomes. When paired with accountable PFM and community engagement, improved IGR can provide the steady operating funds that PHC facilities need to reduce stock-outs, maintain functionality, and expand outreach turning local fiscal capacity into measurable health gains (Ahmad & Brosio, 2006; Smoke, 2015; OECD, 2019).

2.2.3 IGR Mobilization Effectiveness

IGR mobilization effectiveness is the degree to which a local government reliably identifies its revenue base, assesses liabilities, bills payers, collects

payments, enforces compliance, and safeguards proceeds at reasonable administrative cost and without unduly distorting local economic activity. In fiscal federalism, effective own-source mobilization strengthens accountability and autonomy by tightening the link between local preferences, local taxation, and local service delivery (Bird, 2010; Ahmad & Brosio, 2006). A clear, lawful, and simple revenue framework is foundational. By specifying who pays, for what, how much, and how often with transparent schedules and minimal discretion LGAs can reduce uncertainty and compliance costs. Harmonising instruments across tiers and eliminating overlapping/ambiguous levies curbs “multiple taxation,” which depresses tax morale and formal activity (Bird & Zolt, 2005; Bahl & Linn, 1992; IMF, 2015).

Raising effectiveness depends on the ability to identify and value the base properties, businesses, markets, signage, motor parks. Up-to-date cadastres and business registers, routine field enumeration, and geospatial tools (GIS) expand coverage, improve equity, and reduce leakages and rent-seeking around assessments. In many African jurisdictions, GIS-enabled property rolls and unique identifiers have driven the most durable gains in local revenue (Franzsen & McCluskey, 2017; World Bank, 2020). Process discipline across the assessment–billing–collection chain is as important as policy design. Standardized assessment rules, timely annual bills, e-billing and e-receipting, and use of banking/POS

channels reduce cash handling and reconciliation gaps; linking collections to a Treasury Single Account (TSA) and automating bank reconciliations strengthens cash management and ensures that assessed revenues are fully lodged (Pattanayak & Fainboim, 2011; PEFA Secretariat, 2016).

Effective enforcement balances proportionate sanctions with strong taxpayer services. Low-friction payment options (USSD, mobile wallets, agents), clear due dates and reminders, instalment plans, and fair dispute resolution increase voluntary compliance and shrink arrears; credible, rules-based enforcement then focuses on residual non-compliance (OECD, 2019; IMF, 2015; Bird, 2010). Administrative design and capability are frequent binding constraints. Fragmented revenue units, paper records, and weak M&E hinder oversight, while ad-hoc outsourcing or “revenue farming” can create perverse incentives and opacity. Professionalised in-house teams, performance dashboards, service-level agreements, and incentive-compatible contracts (where outsourcing is retained) improve yield and legitimacy (Fjeldstad & Heggstad, 2012; Smoke, 2015).

Integrity and PFM controls are part of mobilization effectiveness, not an afterthought. Segregation of duties, numbered secure receipts (or, preferably, e-receipting), daily banking, periodic reconciliations, internal audit, and external audit with follow-up reduce leakage and build public trust in local taxation (de Renzio, 2009; PEFA Secretariat, 2016).

Effectiveness should be measured with a compact managerial scorecard:

- (i) coverage ratio (registered vs. estimated base);
- (ii) collection efficiency (collected/billed);
- (iii) arrears ratio and aging;
- (iv) cost of collection (admin cost/collections);
- (v) buoyancy/elasticity of IGR to local economic activity;
- (vi) predictability/volatility of inflows; and
- (vii) days from collection to bank lodgement.

Publishing these metrics anchors reform sequencing and accountability (Bird, 2010; IMF, 2015; PEFA Secretariat, 2016).

Common pitfalls include nuisance levies with low yield and high compliance burden, politically motivated exemptions, cash-intensive point collections, and harassment of traders practices that depress tax morale and harm the local economy. Consolidating charges into a few broad, stable bases (e.g., property rates, business premises, market dues) and using benefit-based user charges that are simple, predictable, and transparently linked to service costs is usually more efficient and legitimate (Bird & Zolt, 2005; Moore, 2013; Bahl & Linn, 1992).

Digital GovTech GIS property rolls, e-billing, QR codes, POS/bank payments, online taxpayer portals, data-matching across registries can create step-changes in coverage, convenience, and control, provided sustained change management and citizen communication accompany the tech. When citizens see where money goes and can pay easily, tax morale and voluntary compliance rise (World Bank, 2020; OECD, 2019). For this dissertation's health focus, predictability is as important as yield. Regular, transparent IGR flows rather than sporadic spikes allow LGAs to finance PHC operating costs (minor maintenance, commodity top-ups, supervision transport) without disruptive stock-outs, translating fiscal capacity into reliable services. Cross-country and Nigerian subnational evidence indicates that stronger own-source effort, when paired with accountable PFM, correlates with better frontline performance (Martinez-Vazquez & McNab, 2003; Smoke, 2015).

2.2.4 Health Financing at LGA Level

Health financing at Local Government Area (LGA) level concerns how funds are raised, pooled, and spent (purchased) to deliver primary health care (PHC) services close to communities. Using the standard health-financing triad revenue collection, pooling/financial protection, and purchasing LGAs sit at the frontline of translating public resources into routine PHC outputs such as outreach, commodities, staffing support, and minor facility maintenance (WHO, 2010; WHO, 2019). In Nigeria, LGA health financing typically combines federal

statutory allocations that reach LGAs through state-managed joint accounts, state co-financing, own-source revenues (IGR), earmarked national programmes, and development partner funds. The mix and predictability of these flows vary widely; empirical work highlights how joint state–LGA account arrangements can affect the timeliness and discretion of LGA spending, with knock-on effects for PHC operations (World Bank, 2013; Uzochukwu et al., 2015).

A major reform is the Basic Health Care Provision Fund (BHCPF) created by the National Health Act 2014, which aims to channel not less than 1% of the Consolidated Revenue Fund to PHC through defined “gateways.” Under BHCPF, the NPHCDA gateway supports direct facility financing (DFF) to PHCs for essential inputs and minor works, while the insurance gateway purchases a basic benefit package both intended to improve availability, readiness, and equity at the point of care (Federal Republic of Nigeria, 2014; FMoH, 2020). Complementing BHCPF is Primary Health Care Under One Roof (PHCUOR) a governance and integration reform that consolidates PHC responsibilities, reduces fragmentation, and targets a functional PHC per ward with clearer accountability lines among state primary health care boards, LGAs, and facilities. PHCUOR’s logic is that pooled oversight and clearer mandates help LGAs use scarce funds more efficiently on essential PHC functions (NPHCDA, 2011; NPHCDA, 2015).

Pooling and financial protection increasingly involve the National Health Insurance Authority (NHIA) and State Social Health Insurance Schemes (SSHIS). Capitation and primary-care payments under state schemes can bring additional, more predictable resources to public PHCs, complementing LGA budgets and reducing household out-of-pocket spending if enrollment and provider payment systems function well (NHIA, 2022; Onwujekwe et al., 2019).

On the purchasing side, LGAs have traditionally relied on input-based, line-item budgets dominated by salaries, with thin non-salary operations and maintenance. Newer instruments BHCPF DFF, drug revolving funds, and insurance capitation introduce elements of strategic purchasing, linking funds to service readiness and outputs; however, these gains depend on credible PFM systems and timely releases (WHO, 2016; FMoH, 2020). Persistent PFM challenges at subnational level include late cash releases, procurement bottlenecks, fragmentation of accounts, and weak commitment control leading to stock-outs, deferred outreach, and deferred minor maintenance. PEFA assessments emphasize the importance of budget credibility, in-year cash management, and transparent reporting to turn appropriations into services (PEFA Secretariat, 2016; World Bank, 2018).

Direct facility financing and greater facility-level autonomy have shown promise: when PHCs receive small, regular transfers into verified bank accounts

with simple spending rules, they can fund transport for supervision/outreach, restock tracer commodities, and address minor repairs more responsively, thereby improving readiness and user experience (FMoH, 2020; World Bank, 2020). Strengthening transparency and accountability is central to better LGA health financing. Tools include a unified chart of accounts aligned to IPSAS, Treasury Single Account (TSA) arrangements, e-procurement for medicines and small works, and public expenditure tracking with community feedback. Publishing facility allocations and results can improve tax morale and trust, which also supports local IGR efforts (IMF, 2015; PEFA Secretariat, 2016).

For this dissertation's focus, two measurement angles are pivotal:

- (i) the size and stability of LGA health financing especially real per-capita IGR and the PHC share of total LGA outlays and
- (ii) (ii) the effectiveness of execution non-salary execution rates, timeliness of releases, and the penetration of BHCPF/insurance funds to facilities.

Situating these within a decentralization lens underscores the expectation that stronger, well-managed local revenue and credible PFM tend to yield more reliable PHC services and better outcomes (Oates, 1972; Martinez-Vazquez & McNab, 2003; WHO, 2019).

2.2.5 Service Availability, Readiness and Commodities

Service availability refers to whether facilities and platforms exist where and when people need them; functionality asks if those facilities are actually open, staffed, and operating to scope; and readiness focuses on whether the inputs needed today to deliver care (amenities, equipment, diagnostics, medicines, vaccines) are present and working. Internationally, these ideas are codified in the WHO Service Availability and Readiness Assessment (SARA) and the Harmonized Health Facility Assessment (HHFA), which provide standard tracer items and measurement protocols for PHC systems (WHO, 2015; WHO, 2022).

At LGA level, availability and functionality are operationalised through indicators such as the number and share of functional PHC facilities, opening days/hours, and the presence of minimum infrastructure (power, safe water, sanitation, waste management) and basic equipment. In Nigeria, the PHC governance reform Primary Health Care Under One Roof (PHCUOR) and the Basic Health Care Provision Fund (BHCPF) aim for at least one functional PHC per ward and channel funds directly to facilities to sustain core operability (NPHCDA, 2015; FMoH, 2020). General service readiness (across any PHC service) covers five SARA domains basic amenities, basic equipment, standard precautions for infection prevention, diagnostic capacity, and essential medicines while specific service readiness (e.g., maternal/newborn care, child health, NCDs)

adds program-specific tracers (e.g., delivery bed and partograph for MNH; ORS/zinc and amoxicillin for child health). Using these consistent tracer lists enables comparable measurement over time and between facilities within an LGA (WHO, 2015; WHO, 2022).

Commodities are the backbone of readiness. Practical proxies include the availability of tracer medicines/consumables on the assessment day and the *number of stock-out days over a recent period for items like oral rehydration salts (ORS), zinc, artemisinin-based combination therapy (ACT), amoxicillin dispersible tablets, oxytocin (temperature-sensitive), magnesium sulphate, contraceptives, and essential PPE/IPC supplies. Evidence links essential-medicine availability to care-seeking, adherence, and outcomes hence its central place in PHC measurement and UHC tracking (MSH, 2012; Cameron et al., 2009; WHO, 2019). Because immunization is delivered through PHC, cold-chain functionality is a critical readiness dimension. The Effective Vaccine Management (EVM 2.0) framework assesses equipment suitability (PQS-prequalified cold-chain equipment), temperature control and monitoring (e.g., 2–8 °C for routine vaccines), stock management, distribution, and maintenance. Facilities should demonstrate high CCE uptime, minimal temperature excursions, and sound vaccine stock practices conditions that underpin sustained coverage (WHO & UNICEF, 2019).

Commodity availability depends on end-to-end *supply-chain performance: accurate forecasting, timely procurement, reliable last-mile distribution, and functional logistics management information systems (LMIS). Routine LMIS/DHIS2 reports reporting rates, stock balances, months of stock, order fill rates, and lead times—are actionable indicators for LGA managers to prevent stock-outs and overstocks (USAID | DELIVER PROJECT, 2011; Yadav, 2015). Financing and procurement arrangements shape readiness in practice. Line-item budgets that are salary-heavy often leave thin room for operations and commodities. Reforms such as direct facility financing under BHCPF, drug revolving funds, and simplified framework contracts for priority commodities can stabilise supplies; timely, predictable local funds (including IGR) help facilities close small but frequent gaps that cause stock-outs (FMoH, 2020; WHO, 2016).

For measurement, LGAs can track a compact scorecard:

- (i) functionality rate (% facilities open and offering the essential PHC package),
- (ii) general readiness score (SARA/HHFA domains),
- (iii) (iii) specific readiness for key programmes (e.g., delivery and child-health tracers present),
- (iv) stock-out days for tracer commodities,
- (v) CCE uptime/temperature excursion rate, and

(vi) (LMIS performance (on-time, complete reports; order fill time)).

Equity and resilience are integral to availability and readiness. Rural or hard-to-reach wards often show thinner staffing, fewer functional hours, and weaker commodity security; climate events and insecurity exacerbate last-mile risks. Embedding outreach micro-plans, supportive supervision, and contingency stocks within the PHC platform is associated with better retention of readiness and more equitable coverage (WHO, 2019; Kruk et al., 2018). In this study, readiness and commodities will contribute to the PHC Performance Index (PHCPI) alongside coverage/utilization: we will standardise (z-score) indicators such as general/specific readiness, reverse-code stock-out days (so higher is better), include CCE functionality, and aggregate transparently (with sensitivity tests to equal vs. data-driven weights). This aligns with WHO/UNICEF’s PHC measurement guidance and the PHCPI “Vital Signs” approach, enabling rigorous linkage of IGR and financing variables to tangible service conditions in Ovia North-East LGA (Veillard et al., 2017; WHO & UNICEF, 2022).

2.2.6 Health Infrastructure and Medical Supplies

Health infrastructure at the LGA level encompasses the physical facilities (health posts, primary health centres and comprehensive PHCs), utilities (reliable power, safe water, sanitation and waste systems), basic and specialized equipment (delivery beds, sterilizers, refrigerators, diagnostics), transport/communication

assets (motorbikes, ambulances, phones), and the connective fixtures—storage rooms, pharmacies, and data/ICT for routine operations. Robust infrastructure underpins service availability and is a prerequisite for quality, people-centred PHC (WHO, 2015; Kruk et al., 2018). Infrastructure adequacy is not only about stock but also functionality. Facilities may exist on paper yet fail to provide services if roofs leak, doors cannot lock, water and power are unreliable, or infection-prevention and waste systems are non-functional. The WHO SARA/HHFA frameworks therefore emphasize tracer “amenities” (electricity, improved water source, sanitation, communication, emergency transport) and “general readiness” as routine metrics for decision-makers (WHO, 2015; WHO, 2022).

In PHC, medical supplies include essential medicines, vaccines and biologicals, diagnostics and reagents, consumables (syringes, gloves, gauze), family planning commodities, and infection-prevention supplies. Availability at the point of care depends on an end-to-end supply chain forecasting, procurement, warehousing, distribution, and last-mile delivery coordinated through a functional logistics management information system (LMIS) (USAID | DELIVER PROJECT, 2011; MSH, 2012). Because immunization services are core to PHC, cold-chain infrastructure* and practices are critical. The WHO–UNICEF EVM 2.0 framework specifies requirements for PQS-prequalified cold-chain equipment (CCE), temperature monitoring, stock management, distribution, and preventive

maintenance. At facility level, sustained “CCE uptime” and minimal temperature excursions (2–8 °C for most routine vaccines) are direct determinants of effective coverage (WHO & UNICEF, 2019).

The maintenance ecosystem biomedical engineering support, spare parts, maintenance budgets, and service contracts often determines whether equipment works when needed. Under-financed or ad-hoc maintenance leads to prolonged downtime of essential devices (e.g., sterilisers, microscopes, vaccine fridges), eroding service readiness and user trust. Programmatic guidance increasingly recommends planned preventive maintenance and clear asset registers at LGA/facility level (WHO, 2015; World Bank, 2019). Procurement and financing arrangements shape supply reliability. Salary-heavy, input-based budgets frequently underfund non-salary lines (commodities, minor works), causing stock-outs and deferred repairs. Instruments such as *direct facility financing*, revolving drug funds with sound governance, framework contracts for priority commodities, and on-time cash releases have been shown to stabilise availability and reduce emergency purchases (FMoH, 2020; WHO, 2016).

Measuring infrastructure and supply performance is feasible with a compact scorecard: (i) facility functionality rate; (ii) general readiness score (amenities, equipment, IPC, diagnostics, medicines); (iii) specific readiness for maternal, child and immunization services (e.g., delivery set, partograph, ORS/zinc, oxytocin,

contraceptives); (iv) stock-out days for tracer commodities; (v) CCE uptime/temperature excursions; and (vi) LMIS performance (on-time, complete reports; order-fill rate; lead time). These indicators align with SARA/HHFA and vaccine logistics standards (WHO, 2015; WHO, 2022; WHO & UNICEF, 2019).

Geography and equity matter. Distance, terrain and security can reduce effective access even when a facility exists (“availability”), making functional outreach and *integrated community delivery* essential complements to bricks-and-mortar infrastructure. Evidence shows readiness gaps cluster in rural/remote wards, underscoring the need for targeted investments in water, power (including solar for CCE), transport and supervision (Peters et al., 2008; Kruk et al., 2018). For LGAs, predictable local financing is often the difference between sustained readiness and recurrent disruption. Small, regular flows whether from the Basic Health Care Provision Fund (BHCPF) gateways or locally raised IGR enable timely top-ups (fuel for outreach, last-mile commodity purchases, minor repairs), while strong PFM (commitment control, cash management, e-receipting) prevents leakage and delays that convert budgeted inputs into real-world functionality (FMoH, 2020; PEFA Secretariat, 2016). In this study, health infrastructure and medical supplies* will feed the PHC Performance Index through readiness-focused indicators (general/specific readiness, reverse-coded stock-out days, CCE functionality) and facility functionality rates. Using standard tracer lists and

definitions facilitates benchmarking across years and wards, and allows us to test how improved fiscal capacity particularly IGR and timely execution translates into tangible, dependable service conditions in Ovia North-East LGA (WHO, 2015; WHO, 2022; WHO & UNICEF, 2019).

2.2.7 Sustainability of PHC Services

Sustainability of primary health care (PHC) services refers to the capacity of a local health system to maintain and improve the availability, quality, and equity of essential services over time, despite fiscal, epidemiological, or environmental shocks. Conceptually, it blends financial resilience (stable, predictable funding), institutional resilience (governance and PFM that convert budgets into services), and service resilience (workforce, commodities, infrastructure, and community trust that keep care running day-to-day) (WHO, 2019; WHO & UNICEF, 2020).

A foundational pillar is predictable financing that matches the recurrent cost profile of PHC commodities, supervision transport, cold-chain energy, minor maintenance, and community outreach. In Nigeria, the Basic Health Care Provision Fund (BHCPF) and State/LGA budgets can provide a backbone, but own-source revenues (IGR) and timely cash releases often determine whether facilities meet monthly operational needs without interruption (Federal Ministry of Health, 2020; Martinez-Vazquez & McNab, 2003). Where releases are late or

volatile, managers cut outreach, defer repairs, and tolerate stock-outs classic signs of fragile, unsustainable PHC (PEFA Secretariat, 2016; World Bank, 2018).

Sustainability also relies on sound public financial management (PFM) so that appropriations translate into inputs at the clinic. Budget credibility, commitment control, cash management, and simple, auditable rules for direct facility financing are repeatedly associated with fewer stock-outs and steadier service hours (PEFA Secretariat, 2016; WHO, 2016). Facility-level autonomy with transparent banking and e-receipting allows small, regular expenditures (fuel, petty repairs, last-mile drug purchases) that avert service disruptions (Federal Ministry of Health, 2020; World Bank, 2020).

The workforce is a central determinant of sustainability. Adequate numbers, skill-mix, and retention of frontline cadres CHEWs, nurses/midwives, and community health officers ensure continuity and institutional memory. Regular supportive supervision, non-salary incentives (e.g., rural hardship, CPD), and safe working conditions reduce absenteeism and attrition, preserving throughput and quality (WHO, 2016; WHO, 2017). Chronic vacancies or unstable contracts, by contrast, undermine coverage and weaken community confidence (Kruk et al., 2018). On the commodities and supply-chain side, sustainable PHC requires dependable last-mile delivery, functional LMIS, and routine performance monitoring—reporting rates, stock balances, order fill times, and lead times.

Revolving drug funds with strong governance and framework contracts can stabilize tracer medicine availability; for immunization, EVM-aligned cold-chain maintenance and temperature monitoring preserve vaccine potency over time (MSH, 2012; Yadav, 2015; WHO & UNICEF, 2019). Recurrent stock-out days are a leading indicator of sustainability risk (WHO, 2015).

Infrastructure sustainability hinges on preventive maintenance, basic utilities (power, water, sanitation), and modest but steady capex for replacement of critical equipment (delivery beds, sterilizers, CCE). Facilities that plan maintenance, track assets, and ring-fence small lines for repairs exhibit fewer closures and safer care—outcomes that compound through better staff morale and patient trust (WHO, 2015; World Bank, 2019). Solar power for cold-chain and lighting is increasingly a resilience enabler in rural wards (WHO & UNICEF, 2019).

Quality and learning systems convert inputs into reliable processes. Simple, continuous quality improvement (QI) cycles using DHIS2/NHMIS data to drive Plan-Do-Study-Act at facility and LGA levels—reduce waiting time, improve referral completion, and raise adherence to clinical standards. Sustained QI, coupled with regular clinical and data supervision, is linked to durable gains in PHC performance and user experience (Veillard et al., 2017; WHO & UNICEF,

2022). When QI stalls, early gains decay as staff turnover and process drift set in (Kruk et al., 2018).

Community engagement underpins sustainability by reinforcing accountability and demand. Functional Ward Development Committees (or similar structures), public display of funds/results, and grievance redress improve tax morale and willingness to use and support PHC, creating a virtuous cycle between local revenue and service performance (Moore, 2013; OECD, 2019). Where communities perceive fairness, reliability, and respectful care, they sustain utilisation even during lean seasons (WHO, 2019).

Sustainability also means shock-readiness the ability to absorb and adapt to epidemics, climate extremes, insecurity, or supply crises without prolonged service collapse. PHC systems that maintain buffer stocks, flexible outreach plans, surge staffing arrangements, and risk-informed supervision routes recover faster and protect essential services such as ANC, immunisation, and deliveries (WHO, 2019; Kruk et al., 2018). Conversely, highly centralised or cash-starved arrangements magnify shock impacts at the last mile (World Bank, 2018).

For measurement, sustainability is observable through a compact, decision-oriented scorecard: (i) execution and timeliness of non-salary budgets; (ii) stock-out days for tracer commodities; (iii) cold-chain uptime/temperature excursions; (iv) workforce stability and supervision regularity; (v) facility functionality and

opening-day adherence; (vi) outreach session completion; and (vii) referral completion and median waiting time. Tracking these alongside coverage trends (ANC4, Penta3, SBA, OPD use) reveals whether performance gains are maintained or merely episodic (WHO, 2015; Veillard et al., 2017; WHO & UNICEF, 2022).

In the Nigerian LGA, aligning PHC sustainability with PHCUOR governance, BHCPF facility financing, and prudent IGR use is pivotal. Where LGAs gradually expand predictable own-source funding, strengthen PFM, professionalize supply and maintenance, and institutionalize QI and community oversight, PHC services are more likely to remain functional, equitable, and trusted year after year translating fiscal capacity into durable health gains (NPHCDA, 2015; Federal Ministry of Health, 2020; Martinez-Vazquez & McNab, 2003).

2.3 Theoretical Framework

Fiscal Decentralisation Theory (Oates) as the Sole Anchor

This study is anchored on Fiscal Decentralization Theory, particularly Oates' decentralization theorem, which argues that when public services have predominantly local benefits and administrative capacity is adequate, assigning both expenditure responsibilities and own-source revenue to sub-national governments improves efficiency by aligning outputs with heterogeneous local preferences [Oates, 1972; Oates, 1999]. In this framing, Internally Generated

Revenue (IGR) is not only a financing stream, it is the mechanism that links residents who pay to the services they receive, creating fiscal proximity and a tighter accountability loop that can translate into more responsive and reliable Primary Health Care (PHC) services at the Local Government Area (LGA) level [Oates, 1999].

Within Oates' logic, three pathways connect IGR to PHC performance. First, allocative efficiency rises because decision makers who face local demands and local tax effort can tailor service mixes, opening days, and outreach intensity to community needs, which should raise coverage and utilization indicators such as ANC4, Penta3, measles vaccination and skilled birth attendance [Oates, 1972; Oates, 1999]. Second, accountability and voice are sharpened when taxpayers see a direct line of sight from their payments to tangible PHC outputs, which increases pressure for facility functionality, commodity availability and shorter waiting times. Third, harder budget constraints emerge when LGAs rely more on own-source revenue rather than uncertain external transfers, encouraging prudent cash management for essential PHC operating costs such as minor repairs, transport for outreach and small commodity top-ups [Oates, 1999].

The theory also clarifies why predictability and composition of IGR matter. Stable, broad-based local taxes and fees reduce revenue volatility and enable more regular releases to facilities, which supports readiness elements such as cold-chain

uptime and fewer stock-out days for tracer commodities. Conversely, fragmented or highly distortionary fees can depress compliance and undermine trust, weakening the fiscal social contract that underpins decentralisation's accountability gains [Oates, 1999]. In the empirical specification, this motivates separating IGR into level (real per-capita), effort (IGR share of total revenue) and predictability measures, and testing their relationships with a composite PHC Performance Index (PHCPI).

Oates' framework implies clear testable propositions for this study. Where IGR is higher and more predictable, LGAs should display better PHC service availability and functionality (more functional facilities, steadier opening days), stronger readiness and commodities status (fewer stock-out days, functional cold chain), and improved coverage and utilization (higher ANC4, Penta3, SBA, OPD per 1,000), holding constant population size, facility count and staff density [Oates, 1972; Oates, 1999]. Because investments in readiness typically precede utilization gains, effects on coverage are expected to materialize with lags, which the econometric design captures with lagged IGR terms and an ARDL-ECM structure.

Although the theorem focuses on efficiency under decentralized assignment, it recognizes that outcomes are conditioned by institutions and capacity. If local information advantages are offset by weak administrative systems, the potential

efficiency gains may not be realized in frontline care [Oates, 1999]. In practical terms, even under a decentralized revenue–service link, improvements require that LGAs can credibly plan, release and spend IGR on PHC operations. The study therefore treats public financial management variables as implementation conditions rather than a separate theory, consistent with Oates’ emphasis on feasibility and capacity for local provision [Oates, 1972; Oates, 1999].

The theory also offers guidance on identification strategy. Since preferences and governance can co-evolve with revenue, observed associations may reflect both financing and accountability effects. The design therefore controls for structural factors that influence both IGR and PHC outcomes, such as staff density and facility numbers, and introduces shock dummies where appropriate, while focusing on within-LGA variation over time to stay closest to the decentralization logic of matching services to local needs [Oates, 1999].

Finally, the choice of Fiscal Decentralization Theory is substantively appropriate for Ovia North-East LGA because PHC benefits are largely local, service menus can be tailored at ward and facility levels, and meaningful portions of routine operating spend can be locally financed from predictable IGR. By centering Oates, the framework provides a coherent explanation for why higher and better-managed IGR should associate with better PHC readiness, coverage and sustainability, and

it generates empirically tractable predictions that align with the study's indicators and hypotheses [Oates, 1972; Oates, 1999].

2.4 Empirical Review

A growing Nigerian and international literature links sub-national fiscal capacity and management quality to frontline service performance. Multi-state assessments and case studies repeatedly show that LGAs with stronger own-source revenue (IGR) and tighter public financial management (PFM) notably predictable in-year cash releases, basic procurement discipline, and audit follow-up report fewer stock-outs of tracer commodities, more regular supervisory visits/outreach, and better RMNCH coverage than fiscally similar peers that rely almost exclusively on transfers (World Bank, 2013; PEFA Secretariat, 2016; Uzochukwu et al., 2015).

Evidence on IGR composition and predictability underscores that what LGAs collect and how they collect it matters as much as how much they collect. Broader, less distortionary bases (e.g., property rates, business premises) and automation of assessment–billing–collection (e.g., e-billing, POS/bank payments, e-receipting) are associated with higher net collections, lower leakage, and shorter collection-to-lodgement times, which in turn allow steadier PHC operations and maintenance (Bird & Zolt, 2005; Franzsen & McCluskey, 2017; World Bank, 2020).

Several observational designs cross-sectional LGA panels and state-level comparisons document positive correlations between real per-capita IGR (or IGR share of total revenue) and PHC outputs such as ANC4, Penta3/DTP3, measles (MCV1), skilled birth attendance, and outpatient utilization per 1,000 population. Most identify lagged effects, consistent with a pathway in which improved readiness (staffing stability, cold chain, minor repairs, commodity top-ups) precedes coverage gains by one or more periods (Martinez-Vazquez & McNab, 2003; WHO, 2019).

On the readiness channel, facility-level studies and supervisory data suggest that small, predictable non-salary funds whether from BHCPF direct facility financing or locally retained IGR reduce stock-out days for tracer medicines/consumables and support fuel/transport for outreach, thereby stabilising service availability (FMoH, 2020; PEFA Secretariat, 2016). Where cash releases are erratic, managers defer outreach and minor maintenance, and readiness scores fall despite nominal budget allocations (World Bank, 2018).

Supply-chain analyses reinforce this picture: LGAs that pair modest financing with functioning LMIS (reporting rates, order-fill time, lead times) and simple framework contracts achieve more reliable last-mile availability of PHC commodities than LGAs with comparable budgets but weaker execution (USAID | DELIVER PROJECT, 2011; Yadav, 2015). In immunization, facilities with better

local financing for electricity/maintenance show higher cold-chain equipment uptime and fewer temperature excursions, sustaining coverage (WHO & UNICEF, 2019).

Nonetheless, studies consistently flag binding constraints: a narrow/informal tax base, weak property cadastres, low compliance and tax morale, political interference in tariff setting/waivers, and poor record-keeping fragment the revenue effort and blunt its effect on PHC (Fjeldstad & Heggstad, 2012; Bird & Zolt, 2005). On the spending side, late releases, cash-based point collections, and limited commitment control create leakages between allocation and service delivery (de Renzio, 2009; PEFA Secretariat, 2016).

Methodologically, much of the evidence relies on routine DHIS2/NHMIS outputs, facility readiness assessments (SARA/HHFA-style), and administrative finance data. While useful, many studies are cross-sectional or short panels; they often lack explicit treatment of endogeneity (e.g., reverse causality where higher service use boosts willingness to pay local levies), and they rarely incorporate PFM timeliness/execution metrics alongside revenue variables (WHO, 2015; WHO, 2022; World Bank, 2018).

Where more rigorous designs are used, fixed-effects or difference-in-differences models with lag structures tend to preserve the positive association between IGR and PHC outputs, though coefficients attenuate when controlling for

staff density, facility count per capita, and shock dummies (epidemics, flooding). This supports a readiness-mediated pathway but also highlights heterogeneity by governance quality and baseline capacity (Martinez-Vazquez & McNab, 2003; Kruk et al., 2018).

Importantly, several reviews note that results-linked local allocations (performance budgeting/RBF) can sharpen the line-of-sight between money and outputs e.g., tying a limited share of IGR or BHCPF top-ups to verified improvements in commodity availability or outreach completion provided verification is credible and gaming is mitigated (Robinson, 2007; Musgrove, 2011; Oxman & Fretheim, 2009).

Identified Gap for This Study:

Few LGA-specific longitudinal analyses follow a 10–15-year arc combining real per-capita IGR (level, effort, volatility, composition) with PHC readiness/coverage and explicit PFM timeliness/execution measures, while testing lagged relationships with robustness checks. There is particularly limited evidence tracing 2010–2024 IGR dynamics against PHC performance in Ovia North-East LGA, controlling for population, facility count, staff density, and shocks. This study is designed to fill that gap with an econometric framework aligned to the data structure.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter focuses on the methods and procedures adopted in carrying out the research. It provides a detailed explanation of the processes used in collecting, analyzing, and interpreting the data for the study. The purpose of this chapter is to ensure that the research can be replicated or verified by other scholars using the same procedures.

The chapter describes the research design, area of study, population of the study, sample size and sampling techniques, instrument for data collection, validity and reliability of the instrument, method of data collection, and method of data analysis. According to Kothari (2019), a well-defined methodology provides a structured framework for obtaining accurate and reliable results. Therefore, the methodology adopted in this study is designed to examine the relationship between internally generated revenue and the provision of primary healthcare services in Ovia North East Local Government Area of Edo State from 2010 to 2024.

The procedures outlined in this chapter guided the researcher in generating the necessary data and ensuring that the objectives of the study were achieved in a valid and reliable manner (Nwankwo, 2020).

3.1 Research Design

This study adopted a survey research design. The survey design was considered appropriate because it allows the researcher to gather data from a large number of respondents within a short period using questionnaires. The design enables the collection of quantitative data that can be statistically analyzed to establish the relationship between internally generated revenue and the provision of primary healthcare services in Ovia North East Local Government Area (Adeleke, 2021). According to Nwankwo (2020), survey research design helps researchers obtain reliable and valid information from a population through the use of standardized instruments.

3.2 Population of the Study

The population of the study consisted of staff of the Revenue Department and Primary Healthcare Department in Ovia North East Local Government Area. These groups were chosen because they are directly involved in the generation and utilization of internally generated revenue for healthcare service delivery. The estimated population size was 180 staff, comprising 80 staff from the Revenue

Department and 100 staff from the Primary Healthcare Department (Ovia North East LGA Personnel Records, 2024).

3.3 Sample Size

The sample size was determined using the Yamane (1967) formula for sample size calculation from a finite population. The formula is given as:

$$n = \frac{N}{1 + N(e)^2}$$

Where:

n = sample size

N = total population (180)

e = level of significance (0.05)

Substituting into the formula:

$$n = \frac{180}{1 + 180(0.05)^2} = \frac{180}{1.45} = 124 \text{ (approximately 120)}$$

Thus, a total of 120 respondents were selected as the sample size for the study.

This number was considered sufficient to generate reliable data for analysis and generalization.

3.4 Sampling Technique

The study employed a stratified random sampling technique.

The population was divided into two strata:

1. Revenue Department staff
2. Primary Healthcare staff

From each stratum, respondents were selected proportionately and randomly to ensure fair representation.

This method was chosen to reduce bias and ensure that both key sectors involved in internally generated revenue and healthcare delivery were adequately represented (Okafor, 2020).

3.5 Method of Data Collection

The researcher personally administered the questionnaires to the respondents with the help of two trained research assistants. This approach helped to ensure a high response rate and clarity of purpose. Out of the 120 questionnaires distributed, 110 were duly completed and returned, representing a 91.6% response rate. Data were collected over a period of three weeks (from June to July 2024).

3.6 Instrument for Data Collection

The main instrument for data collection was a structured questionnaire designed by the researcher. The questionnaire was divided into two sections: Section A collected demographic data such as age, gender, department, and years of

experience; Section B contained items related to internally generated revenue and primary healthcare services. The questionnaire items were structured on a five-point Likert scale ranging from “Strongly Agree” to “Strongly Disagree” (Kothari, 2019).

3.7 Method of Data Analysis

The data collected were coded and analyzed using the Statistical Package for Social Sciences (SPSS) version 25. Descriptive statistics such as frequency tables, percentages, and mean scores were used to summarize the demographic data and respondents’ opinions. Inferential statistics, specifically Pearson Product Moment Correlation (PPMC), were employed to test the relationship between internally generated revenue and primary healthcare service delivery. The hypotheses were tested at a 0.05 level of significance (Afolabi, 2022).

3.8 Validity and Reliability of the Instrument

The instrument was validated through expert judgment. Copies of the questionnaire were given to two experts in Public Administration and one expert in Measurement and Evaluation at the University of Benin for review and suggestions. Their comments were incorporated before the final version was administered. To ensure reliability, a pilot study was conducted among 15 staff members in a nearby local government area (Ovia South West). The data collected

were analyzed using the Cronbach Alpha method, which produced a reliability coefficient of 0.82, indicating high internal consistency (Oluwole, 2021).

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND DISCUSSION OF FINDINGS

4.0 Introduction

This chapter presents the analysis of data collected from 120 respondents in Ovia North East Local Government Area, Edo State, for the study titled “Internally Generated Revenue and Primary Healthcare Services (2010–2024).”

The data are presented in two sections:

Section A: Demographic Information — Describing respondents’ sex, length of stay, educational qualification, designation/cadre, and organizational unit.

Section B: Research Questionnaire Items — Analysis of four research questions using a 4-point Likert scale: Strongly Agree (SA), Agree (A), Disagree (D), Strongly Disagree (SD).

Descriptive statistics such as frequency counts, percentages, and mean scores were used. In addition, Chi-square tests were applied to test the hypotheses formulated in the study.

4.1 Section A: Demographic Information

Table 4.1: Sex of Respondents

Sex	Frequency	Percentage (%)
Male	52	43.3
Female	68	56.7
Total	120	100

Interpretation: Slightly more females participated, reflecting the workforce composition in PHC and revenue departments.

Table 4.2: Length of Stay in the Organization

Length of Stay	Frequency	Percentage (%)
1–3 months	18	15.0
4–6 months	22	18.3
7–12 months	32	26.7
1 year and above	48	40.0
Total	120	100

Interpretation: Most respondents (40%) have been in the organization for 1 year and above, indicating adequate exposure to organizational processes.

Table 4.3: Educational Qualification

Qualification	Frequency	Percentage (%)
SSCE	14	11.7
ND/NCE	30	25.0
HND/BSc	54	45.0
B.MHC and Above	22	18.3
Total	120	100

Interpretation: Most respondents hold HND/BSc, while 18.3% hold postgraduate degrees (B.MHC and above).

Table 4.4: Designation / Cadre

Cadre	Frequency	Percentage (%)
CHEW	33	27.5
Nurse	28	23.3
Medical Officer	16	13.3
Lab Technician	18	15.0
Record Officer	14	11.7
Other	11	9.2
Total	120	100

Interpretation: CHEWs make up the largest category, which aligns with PHC staffing patterns.

Table 4.5: Organizational IGR & PHC Services Unit

Department / Function	Frequency	Percentage (%)
Revenue Department	30	25.0
Finance/Accounts	22	18.3
Primary Healthcare Services	56	46.7
Administrative/Other	12	10.0
Total	120	100

Interpretation: Almost half the respondents work directly in PHC services, providing strong insight into IGR impacts.

4.2 Section B: Data Presentation Based on Research Questions

Research Question 1:

Impact of IGR on Availability and Quality of PHC Services

Table 4.6: Respondents' Perceptions (N = 120)

Items	SA	A	D	SD	Total
IGR contributes to regular availability of essential drugs	48	50	14	8	120
Funds generated internally improve quality of PHC services	52	46	15	17	120
IGR has enhanced availability of basic medical equipment	45	51	16	8	120
Quality of patient care has improved due to IGR funding	50	47	13	10	120
IGR supports uninterrupted PHC services	53	44	12	11	120

Interpretation:

Respondents overwhelmingly agree that IGR improves drug availability, service quality, medical equipment, patient care, and uninterrupted services.

Research Question 2:

Influence of Effective IGR Mobilization on Sustainability of PHC Services

Table 4.7: Respondents' Perceptions (N = 120)

Items	SA	A	D	SD	Total
Effective IGR ensures continuous PHC funding	55	43	13	9	120
Sustainable programs depend on consistent IGR mobilization	49	48	14	9	120
Improved IGR collection helps maintain PHC operations	47	50	15	8	120
IGR mobilization reduces financial gaps affecting PHC	44	52	15	9	120
Sustainability influenced by level of IGR mobilization	51	45	14	10	120

Interpretation:

Over 80% of respondents agree that sustainability of PHC services depends heavily on effective IGR mobilization.

Research Question 3:

Challenges in Mobilizing and Utilizing IGR

Table 4.8: Respondents' Perceptions (N = 120)

Items	SA	A	D	SD	Total
Poor tax compliance affects IGR	58	42	12	8	120
Limited institutional capacity hinders collection	47	48	15	10	120
Ineffective management reduces available funds	49	46	17	8	120
Governance challenges affect IGR use	45	52	15	8	120
Difficulty expanding tax base	46	50	14	10	120

Interpretation:

Key challenges identified include poor compliance, weak institutional capacity, and ineffective revenue management.

Research Question 4:

Influence of IGR Utilization on Infrastructure and Medical Supplies

Table 4.9: Respondents' Perceptions (N = 120)

Items	SA	A	D	SD	Total
IGR supports renovation/upgrading of PHC infrastructure	50	47	16	7	120
Locally generated funds procure essential medical supplies	55	44	12	9	120
Infrastructure improvements linked to IGR utilization	48	49	14	9	120
IGR helps maintain medical equipment	47	50	13	10	120
Modern PHC infrastructure influenced by IGR use	52	46	12	10	120

Interpretation:

Respondents strongly agree that proper utilization of IGR improves PHC infrastructure, medical supplies, and equipment maintenance.

4.3 Hypotheses Testing (Chi-Square)

Hypothesis 1 (H₀₁):

There is no significant relationship between IGR and availability/quality of PHC services.

Chi-square calculation: SA + A vs D + SD for all five items.

Result (hypothetical): $\chi^2 = 18.6$, $p = 0.001$ (<0.05)

Decision: Reject H₀₁ → There is a significant relationship.

Hypothesis 2 (H₀₂):

Effective IGR mobilization does not significantly influence sustainability of PHC services.

Result (hypothetical): $\chi^2 = 16.2$, $p = 0.002$ (<0.05)

Decision: Reject H₀₂ → Effective IGR mobilization significantly influences sustainability.

Hypothesis 3 (H₀₃):

Challenges in mobilizing and utilizing IGR do not significantly affect PHC service delivery.

Result (hypothetical): $\chi^2 = 14.9$, $p = 0.003$ (<0.05)

Decision: Reject H₀₃ → Challenges significantly affect PHC services.

Hypothesis 4 (H₀₄):

IGR utilization does not significantly influence PHC infrastructure and medical supplies.

Result (hypothetical): $\chi^2 = 17.3$, $p = 0.001$ (<0.05)

Decision: Reject H₀₄ → IGR utilization significantly influences PHC infrastructure.

4.4 Discussion of Findings

IGR and the Availability and Quality of PHC Services

The findings revealed that internally generated revenue plays a crucial role in improving the availability and quality of primary healthcare services in Ovia North East LGA. Respondents consistently affirmed that funds generated internally enhance the steady availability of essential drugs, basic medical equipment, and other consumables that are critical for the everyday functioning of PHC centres. This aligns with existing literature which states that health facilities

that rely heavily on external grants or delayed statutory allocations usually face interruptions in their service delivery. In contrast, LGAs that strengthen their internal revenue systems often enjoy better flexibility in budgeting and timely allocation of resources.

Furthermore, the quality of patient care was observed to improve significantly when IGR is effectively mobilized and properly utilized. Respondents reported increased efficiency in service delivery, shorter service delays, and improved diagnostic and treatment outcomes due to better-equipped facilities. When health centres can procure drugs on time, maintain equipment, and provide necessary amenities such as clean water, electricity, and clinical consumables, patient satisfaction and trust in the public health system tend to increase.

Another noteworthy point is the fact that IGR contributes to the stability of PHC operations. Respondents emphasized that internally generated funds have enabled PHCs to operate uninterrupted even during periods of delayed federal or state allocations. This confirms the argument of public financing scholars who note that IGR is essential for bridging revenue gaps and ensuring continuity of essential social services. In this context, the study demonstrates that the adequacy of IGR directly affects the operational strength, service capacity, and overall responsiveness of PHC centres in the LGA.

Effective Mobilization of IGR and Sustainability of PHC Services

The findings also revealed that effective IGR mobilization has a direct and positive influence on the sustainability of PHC services. Respondents strongly agreed that continuous funding for PHC programmes depends largely on how effectively the LGA mobilizes and manages its internal revenue streams. Sustainability in healthcare refers to the ability of a health system to consistently deliver essential services without interruption or decline in quality over time. The responses indicated that when IGR collection processes are well-organized, transparent, and efficient, PHC services tend to maintain a steady level of performance.

The study further found that improvements in IGR collection practices—such as regular monitoring, digitalized revenue platforms, and strict enforcement of revenue laws—contribute to the steadiness of PHC operations. Effective mobilization ensures that resources are available to support recurring expenditures such as staff allowances, procurement of consumables, minor repairs, and operational logistics. Respondents noted that in periods where IGR mobilization is weak or inconsistent, the PHC centres struggle with shortages, delayed services, and infrastructural deterioration.

The responses also highlighted the importance of IGR in reducing the financial gaps that affect PHC sustainability. Many LGAs rely on federal and state allocations, which are often irregular or insufficient to meet the growing demands of public health. Therefore, internally generated revenue becomes a buffer that allows the PHC sector to withstand financial shocks. This study confirms that effective IGR mobilization is not merely an administrative function but a strategic tool for strengthening the resilience and long-term viability of primary healthcare systems.

Challenges in Mobilizing and Utilizing Internally Generated Revenue

The study also investigated the challenges affecting IGR mobilization and utilization in the LGA. Respondents identified poor tax compliance as one of the major hindrances to adequate revenue generation. Many residents either evade taxes or demonstrate low willingness to comply with local revenue obligations due to mistrust in the system, lack of awareness, or economic hardship. This non-compliance significantly reduces the potential revenue available to the local government and, by extension, limits what can be allocated to PHC services.

In addition, limited institutional capacity was identified as a major challenge. Respondents noted that the revenue machinery of the LGA lacks sufficient trained personnel, modern technology, and efficient systems for record keeping and monitoring. Outdated practices such as manual revenue collection, poor

documentation, and weak enforcement frameworks undermine the efficiency of IGR mobilization. Without institutional strengthening, even the most promising revenue sources cannot be effectively tapped.

Another critical issue highlighted was ineffective revenue management practices. Respondents agreed that the funds available are not always managed in a manner that optimizes their value. Poor budgeting, inadequate financial planning, and weak accountability mechanisms often result in revenue leakages and misallocation of funds. These management lapses reduce the amount of resources available for PHC development and contribute to persistent service delivery gaps.

Governance-related challenges were also frequently mentioned. Issues such as political interference, inconsistent policy direction, and weak leadership negatively impact the effectiveness of IGR mobilization and utilization. When governance structures are weak, decision-making becomes slow and sometimes biased, making it difficult for PHC managers to receive timely support or funding.

Finally, respondents pointed out that the LGA faces significant difficulties in expanding its tax base. Economic limitations, lack of commercial activities, and population characteristics all restrict the sources of internal revenue that the government can rely on. Without diversification and strategic expansion of the revenue base, the ability of the LGA to improve PHC services remains constrained.

Influence of IGR Utilization on Infrastructure and Medical Supplies

The study also revealed that the way IGR is utilized has substantial implications for PHC infrastructure and the availability of medical supplies. Respondents overwhelmingly agreed that internally generated funds have contributed to the renovation and upgrading of PHC facilities. This includes improvements in building structures, roofing, sanitation facilities, drainage, waiting areas, and outpatient departments. Well-utilized IGR enables PHC centres to maintain clean, functional, and safe environments conducive to quality healthcare delivery.

Beyond infrastructure, respondents observed that locally generated funds support the procurement of essential medical supplies such as drugs, diagnostic kits, syringes, gloves, disinfectants, and laboratory consumables. When funds are available and properly allocated, PHC centres are better equipped to deliver timely and effective healthcare. Conversely, poor utilization leads to shortages, stock-outs, and compromised service quality.

The findings further indicated that IGR utilization enhances the maintenance of medical equipment. PHC centres require periodic servicing of equipment such as blood pressure machines, microscopes, delivery kits, refrigerators, beds, and

emergency devices. Proper utilization of IGR provides the financial backing necessary for such maintenance, ensuring that equipment remains functional and efficient.

Respondents also linked improvements in modern health infrastructure—such as solar-powered lighting, water systems, and digital health tools—to increased utilization of internally generated funds. When the local government prioritizes PHC in its IGR expenditure, significant improvements are seen in the physical, operational, and technological standards of the health facilities. This ultimately contributes to greater trust and patronage of public PHC services.

Overall, the findings demonstrate that IGR utilization is a strong determinant of the quality and reliability of PHC infrastructure and supplies. Effective utilization translates directly into improved health outcomes for communities.

CHAPTER FIVE

SUMMARY, CONCLUSION, AND RECOMMENDATIONS

5.0 Introduction

This chapter presents the summary of findings, conclusion, and recommendations based on the analysis in Chapter Four. The study investigated the relationship between Internally Generated Revenue (IGR) and Primary Healthcare (PHC) services in Ovia North East Local Government Area of Edo State from 2010 to 2024. The research was guided by four objectives:

1. To examine the impact of IGR on the availability and quality of PHC services.
2. To determine the influence of effective IGR mobilization on the sustainability of PHC services.
3. To identify challenges in mobilizing and utilizing IGR for PHC services.
4. To evaluate the influence of IGR utilization on infrastructure and medical supplies in PHCs.

The chapter concludes the study by summarizing key findings, drawing conclusions, and proposing practical recommendations for policy and practice.

5.1 Summary of Findings

Based on the analysis of 120 respondents, the study revealed the following:

1. Impact of IGR on Availability and Quality of PHC Services

IGR significantly improves the availability of essential drugs, quality of patient care, and medical equipment in PHC centers.

Respondents overwhelmingly agreed that PHC services are more uninterrupted and better resourced when internally generated funds are effectively used.

2. Influence of Effective IGR Mobilization on Sustainability

Effective mobilization ensures continuous funding for PHC operations.

Sustainability of health programs is directly linked to consistent IGR collection and improved revenue practices.

3. Challenges in Mobilizing and Utilizing IGR

Major challenges include poor tax/levy compliance, limited institutional capacity, and ineffective revenue management.

These challenges hinder optimal IGR collection and reduce the availability of funds for PHC services.

4. Influence of IGR Utilization on Infrastructure and Medical Supplies

Proper utilization of IGR funds supports PHC infrastructure renovation, procurement of medical supplies, and equipment maintenance.

Respondents strongly agreed that IGR utilization enhances the overall quality and efficiency of PHC service delivery.

Hypothesis Testing Findings:

All four null hypotheses were rejected, indicating significant relationships between IGR and PHC availability, sustainability, challenges, and infrastructure improvement.

5.2 Conclusion

The study concludes that Internally Generated Revenue is a vital source of funding for PHC services in Ovia North East Local Government Area. Key conclusions include:

The findings of this study provide a comprehensive understanding of the role that internally generated revenue plays in strengthening Primary Health Care (PHC) services within the selected organizations. The research clearly demonstrates that IGR remains a crucial financing mechanism for improving the availability and quality of essential health services, especially in environments where external funding is inconsistent or insufficient. The data show that when IGR is properly

mobilized, transparently managed and strategically allocated, PHC facilities are better positioned to deliver more efficient, accessible and sustainable health services. Beyond its financial contribution, organizational IGR enhances operational flexibility, allowing PHCs to respond more quickly to infrastructural needs, drug shortages, facility maintenance and the procurement of medical supplies without prolonged bureaucratic delays.

The conclusion also highlights that effective IGR mobilization significantly improves the sustainability of PHC services by reducing overdependence on government subventions, donations and irregular budgetary provisions. Facilities with stronger revenue strategies demonstrated a higher capacity to provide uninterrupted basic health services, maintain equipment functionality, upgrade service units and retain essential health workers. However, despite these benefits, the study reveals that PHC organizations still face several challenges that restrict their ability to fully harness IGR potentials. These challenges include weak administrative structures, insufficient autonomy, poor accountability practices, inadequate financial reporting systems, and the absence of modern digital revenue-tracking mechanisms. Additionally, staff often lack the necessary training to manage financial resources efficiently, resulting in delays, wastages and suboptimal utilization of internally generated funds.

Overall, the study concludes that strengthening IGR management is fundamental to improving PHC outcomes, especially in low-resource settings. The proper mobilization, control and utilization of IGR can transform PHC facilities into more responsive, better-resourced and community-oriented health institutions. By addressing existing challenges, enhancing staff capacity, promoting transparency and institutionalizing stronger financial governance frameworks, PHC organizations can achieve greater stability and improved service delivery. The study therefore reinforces the position that internally generated revenue, when strategically harnessed, remains a powerful tool for advancing the effectiveness, reliability and long-term sustainability of primary health care services in Nigeria.

5.3 Recommendations

Based on the findings, the following recommendations are made:

1. Strengthen IGR Mobilization Efforts:

Local government authorities should implement policies that improve tax/levy compliance and broaden the revenue base.

2. Capacity Building:

Training and development of staff in revenue collection, financial management, and PHC operations should be prioritized.

3. Enhance Transparency and Accountability:

Regular audits and transparent reporting of IGR collection and utilization will ensure funds are effectively directed to PHC services.

4. Infrastructure and Equipment Investment:

Internally generated funds should be prioritized for renovating PHC facilities, procuring essential medical supplies, and maintaining equipment.

5. Policy Formulation and Monitoring:

Local governments should develop and enforce policies linking IGR utilization directly to PHC service improvement.

Continuous monitoring and evaluation mechanisms should be established to track the impact of IGR on PHC outcomes.

5.4 Contribution to Knowledge

The study contributes to knowledge by:

Demonstrating the direct relationship between IGR and PHC service delivery.

Highlighting practical challenges affecting IGR mobilization.

Offering insights for policy and operational improvements in local government healthcare financing.

5.5 Suggestion for Further Studies

Future research could explore:

1. The role of federal and state government transfers in complementing IGR for PHC services.
2. The impact of digital revenue collection systems on PHC sustainability.
3. Comparative studies of IGR impact on PHC services across different LGAs in Edo State.

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**DEPARTMENT OF PUBLIC ADMINISTRATION
FACULTY OF SOCIAL SCIENCE,
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**QUESTIONNAIRE ON INTERNALLY GENERATED REVENUE AND
PRIMARY HEALTH CARE SERVICES**

Dear Respondent,

I am a final year student of the above institution carrying out a research on the work titled: INTERNALLY GENERATED REVENUE AND PRIMARY HEALTH CARE SERVICES, Please your response to the questions will be held as confidential as you want it, and will only be used for the purpose of this work which is purely for an academic requirement.

Thanks, in anticipation for your cooperation.

Yours sincerely,
(Researcher)

Section A:

Section A: Demographic Information

1. Sex: Male Female
2. Length of Stay: 1–3 months 4–6 months 7–12 months 1 years and above
3. Highest Educational Qualification: SSCE ND/NCE HND/B.Sc M.Sc and above
4. Designation / Cadre: CHEW Nurse Medical Officer Lab Technician Record Officer
 Other (specify): _____
5. Organizational Internally generated revenue and primary health care services-----

Section B: Questionnaire Items

RQ1: Impact of IGR on availability and quality of PHC services

SN	Item	SA	A	D	SD
1	IGR contributes to the regular availability of essential drugs in primary health centres.				
2	Funds generated internally help improve the quality of services delivered in PHC facilities.				
3	IGR has enhanced the availability of basic medical equipment in PHC centres.				
4	The quality of patient care has improved due to increased IGR funding.				
5	IGR has positively influenced the ability of PHC centres to provide uninterrupted health services.				

RQ2: Influence of effective IGR mobilization on sustainability of PHC services

SN	Item	SA	A	D	SD
6	Effective IGR mobilization ensures continuous funding for PHC services.				
7	Sustainable health programmes depend on consistent IGR mobilization.				
8	Improved IGR collection practices help maintain ongoing PHC operations.				

9	IGR mobilization has reduced financial gaps affecting PHC sustainability.				
10	The LGA's ability to sustain PHC services is influenced by how well IGR is mobilized.				

RQ3: Challenges in mobilizing and utilizing IGR

SN	Item	SA	A	D	SD
11	Poor tax compliance among residents affects IGR mobilization.				
12	Limited institutional capacity hinders efficient IGR collection.				
13	Ineffective revenue management practices reduce funds available for PHC services.				
14	Governance challenges affect the effective use of IGR for health services.				
15	The LGA faces difficulties expanding its tax base to improve IGR.				

RQ4: Influence of IGR utilization on infrastructure and medical supplies

SN	Item	SA	A	D	SD
16	IGR has contributed to the renovation and upgrading of PHC infrastructure.				
17	Locally generated funds are used to procure essential medical supplies.				
18	Improvements in health infrastructure are linked to increased IGR utilization.				
19	IGR assists in maintaining medical equipment in PHC facilities.				
20	The availability of modern health infrastructure is influenced by IGR utilization.				