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Collaborative Governance and Delivery of Primary Healthcare in Nigeria: A Policy Recommendation

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Abstract

Collaborative governance has emerged as a pivotal strategy in addressing complex public service delivery challenges, especially within health systems in developing countries like Nigeria. Despite notable efforts such as the Midwives Service Scheme and the Saving One Million Lives Programme, implementation has often been undermined by poor stakeholder alignment and political interference. This paper explores the role of collaborative governance as an effective approach to improving PHC delivery in Nigeria. Using the contingency model of Collaborative governance, the paper examines the collaborative arrangement for implementing some of the federal government-initiated programmes for improving the health outcomes of Nigerians. Document analysis was used to collect and analyse data. The findings indicate that power/resource imbalance between the federal, state and local governments, low incentive of state governments to implement these programmes, a pre-history of conflict between the federal and state governments, the limited capacity of federal agencies to mandate implementation at sub-national levels and departure from programme goals are the main issues. The paper concludes that a shift toward effective collaborative governance is not only necessary but also urgent to achieve universal health coverage for Nigerians.

Keywords: *Collaborative governance, Primary healthcare, Policy, Conflict, Trust building*

1. INTRODUCTION

Effective governance is essential to achieving sustainable development, equitable service delivery, and improved public health outcomes. In the context of Nigeria—a nation marked by immense diversity, vast geography, and complex socio-political structures—the delivery of primary healthcare (PHC) services poses significant challenges. These include fragmented service provision, inadequate infrastructure, workforce shortages, and inconsistencies in policy implementation (Croke & Ogbuoji, 2023). Addressing these multifaceted issues requires

innovative governance models that transcend traditional bureaucratic frameworks. One such model is collaborative governance, which emphasises multi-stakeholder engagement, shared responsibility, and joint decision-making among government agencies, civil society, private actors, and community representatives (Maduka et al, 2023).Collaborative governance refers to structured processes through which public agencies engage non-governmental stakeholders in a collective effort to formulate and implement policies and deliver public services (Adedeji, 2021). Unlike top-down approaches, collaborative governance is inclusive, participatory, and rooted in mutual trust and accountability. It is particularly suited to contexts like Nigeria's, where healthcare delivery spans multiple tiers of government—federal, state, and local—and is influenced by a mosaic of local cultures, institutions, and development partners.

In the Nigerian healthcare landscape, the importance of primary healthcare cannot be overstated. As the foundational tier of the health system, PHC is designed to provide essential health services close to where people live and work (WHO, 2019). It includes preventive, promotive, curative, and rehabilitative services that are vital for improving population health and reducing the burden on secondary and tertiary care facilities. Despite its centrality, PHC in Nigeria has suffered from years of underinvestment, policy discontinuity, and weak coordination among actors. The result has been suboptimal service delivery, especially in rural and underserved areas.

Against this backdrop, the application of collaborative governance principles presents a compelling strategy to revitalise PHC in Nigeria. It offers the potential to harness the strengths and resources of diverse stakeholders—including federal and state ministries of health, local government authorities, donor agencies, traditional institutions, community-based organisations, and the private sector—in addressing systemic bottlenecks. Collaborative governance facilitates dialogue, enhances accountability, and fosters innovation by leveraging local knowledge and shared ownership of health interventions.

This approach is increasingly being recognised in national and global health discourse, particularly in light of Nigeria's efforts to achieve Universal Health Coverage (UHC) and the health-related targets of the Sustainable Development Goals (SDGs) (Florini & Pauli, 2018). For collaborative governance to be effective in the Nigerian PHC context, however, it must be supported by enabling policies, clear institutional mandates, capacity-building initiatives, and mechanisms for monitoring and evaluating impact.

This paper, therefore, seeks to explore the theoretical underpinnings, challenges and policy recommendations for implementing collaborative governance in the delivery of primary healthcare in Nigeria. It aims to assess how inclusive governance structures can contribute to more responsive, equitable, and sustainable healthcare systems, and to identify lessons and strategies for scaling collaborative practices across the country.

2. LITEATURE REVIEW

2.1 Conceptualising Collaborative Governance and Primary Health Care

Many politicians have talked about the need for government agencies to work together better and connect more with citizens and other groups. This is seen as a way to solve tough policy issues and improve how public services are delivered. Working together on policy-making has also been suggested as a way to close the growing gap between governments and the people they serve, helping to fix some of the common problems in Western democracies in recent decades. The idea of collaborative governance has attracted a lot of interest from researchers in public administration. It has become a popular topic in studies of policy, public management, and democracy. But as more people have started using terms like coordination, cooperation, joined-up governance, network governance (Robinson, 2006), and interactive governance (Michels, 2011), the conversation has become somewhat unclear and scattered, rather than forming one clear and unified message. Batory and Svensson (2019), in their analysis, pointed out that academic articles describe collaborative governance in different ways, focusing on at least five key areas: the divide between public and private (or government and non-government) actors; the role of individual actors or groups (agency); how organisations are involved; where and how it fits into the policy process; and the values or assumptions behind it. This paper offers some definitions of Collaborative Governance based on these key areas.

Ansell and Gash (2008) provided a relatively narrow definition, which specifically includes the involvement of non-government actors. They defined Collaborative Governance as "a governing arrangement where public agencies directly engage non-state stakeholders" (Ansell & Gash, 2008). This means that cooperation only within government bodies is not considered part of collaborative governance. According to Ansell and Gash, this focus should not be seen as controversial, since the idea of "governance" has become popular partly because it mixes roles between the public and private sectors (Stoker, 1998). Their definition also highlights that government agencies take the lead in reaching out to non-government groups. As a result, situations where non-government actors start the contact—such as advocacy or lobbying—are not included. The definition also leaves out cases where the government only seeks input without shared decision-making, like in simple consultations.

The definitions by Emerson et al. (2012) and Agranoff and McGuire (2003) do not specify which type of actor leads collaborative efforts. Emerson et al. (2012) describe collaborative governance as decision-making processes and structures that bring together stakeholders from different sectors and levels to achieve a public goal that could not be reached otherwise. Similarly, Agranoff and McGuire (2003) highlight how difficult it is to solve certain problems without cooperation. They define collaborative management as a process used to address issues that single organisations cannot solve on their own, or at least not easily. Bingham et al. (2005) and Bingham and O'Leary (2015) focus on the connection between the public and private sectors.

They combine the ideas of collaborative public management and participatory governance to explain the growing number of public policy processes that involve collaboration, often with positive results. In summary, collaborative governance involves the process of engaging multiple stakeholders from the public and private sectors with the intent of delivering public goods and services to the citizens (Adedeji, 2021)

Dr. Alma Ata, a Soviet public health expert, and her colleagues in the Declaration of Alma Ata in 1978 defined primary health care as essential health care based on practical, scientifically sound, and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination (Alma Ata, 1978). According to the Alma Ata Conference, primary healthcare is as necessary as medical care, always given to all persons and families at a cost that the community and the country can afford, with their complete cooperation and acceptable means. Primary healthcare constitutes the largest and most significant portion of a nation's health maintenance system and is essential.

It addresses every aspect of the community at the local level, intending to provide healthcare for people from birth to death; primary healthcare provides comprehensive care, encourages healthy lifestyles through health education, treats and prevents infectious and non-infectious diseases, manages public health, and provides all patients with palliative and rehabilitation care. The development and prosperity of individual nations and the survival of all humans depend on primary healthcare. Nigeria's basic healthcare system is the most important, unique, and essential part of the nation's three-tiered healthcare system, according to the World Health Organisation (WHO, 2018).

Primary health care is an approach to health and well-being considering the requirements, preferences, and unique characteristics of each individual, family, and community (WHO, 2019). In primary healthcare, the government's primary healthcare centres serve rural and suburban populations, while secondary and tertiary health facilities serve urban populations. The goal is to create a system of healthcare that is purposeful, methodical, and affordable while also guaranteeing quality healthcare services for both poor and majority citizens. No matter one's social or economic standing, everyone is directed to the primary healthcare system, which is intended to be affordable and the first line of care.

2.2 Theoretical Framework: Contingency Model of Collaborative Governance

The purpose of theory in research is to guide inquiry and provide explanations for the factors influencing particular events or outcomes. The contingency model of collaborative governance, developed by Ansell and Gash (2008), was created to identify key variables that contribute to successful collaboration. Their model outlines four main variables: starting conditions,

institutional design, facilitative leadership, and the collaborative process. Each of these components includes sub-variables that may either support or obstruct effective collaboration. According to the authors, the collaborative process is central to the model, while the remaining variables act as catalysts for its success. The following sections elaborate on each of these variables.

2.3 Starting Conditions

Ansell and Gash emphasise that the circumstances preceding collaboration significantly influence whether stakeholders will cooperate effectively. Prior to initiating a collaborative process, certain critical factors must be assessed:

- **Power/Resource Imbalances**: Disparities in resources or organisational capacity among stakeholders can impede equal participation. When some stakeholders possess significantly more power or resources, the process risks being dominated by the stronger party, leading to distrust and weak commitment (Gray, 1989; Warner, 2006). To address this, Ansell and Gash (2008) recommend a strong commitment to strategies that empower and represent weaker or disadvantaged stakeholders.
- **Incentives to Collaborate**: Although participation in collaborative processes is typically voluntary—even if legally mandated-it is essential to understand what motivates stakeholders to engage. Brown (2002) asserts that when stakeholders see a link between their participation and tangible policy outcomes, their incentive to participate increases. Building strong incentives into the process is therefore crucial.
- **Pre-history of Conflict or Cooperation**: The history of interaction among stakeholders can either facilitate or hinder collaboration (Andranovich, 1995; Margerum, 2002). A background of antagonism may result in low trust, reduced commitment, manipulation, and dishonest communication. Conversely, a history of cooperation is more likely to foster trust and commitment.

Facilitative Leadership

Given the involvement of multiple stakeholders, effective leadership is necessary to sustain a spirit of collaboration (Reilly, 2001). Vangen and Huxham (2003) highlight that true leadership involves embracing, empowering, and engaging all relevant stakeholders to keep the process moving forward. To do this effectively, leaders must possess the skills to:

- Promote broad and active participation,
- Ensure inclusive influence and control,
- Facilitate productive group dynamics, and
- Expand the scope of the collaborative process (Lasker & Weiss, 2001).

Institutional Design

This variable concerns the structures, protocols, and ground rules that govern collaboration. Institutional design also determines which stakeholders are included or excluded. Chrislip and

Larson (1994) argue that successful collaboration requires the inclusion of all stakeholders who are directly impacted by the issue at hand. Excluding certain parties, especially those considered "troublesome", can jeopardise the entire process. A well-structured institutional design must rest on clearly defined rules and procedural transparency (Geoghegan & Renard, 2002; Imperial, 2005; Wiessner & Sexton, 2005), which in turn builds trust and encourages stakeholder commitment.

2.4 The Collaborative Process

Ansell and Gash conceptualise collaboration as a cyclical, rather than linear, process, where each stage can reinforce the others. They identify five key stages:

Face-to-Face Dialogue

This allows stakeholders to dismantle stereotypes and communication barriers, facilitating mutual gains (Bentrup, 2001). It also helps build trust, mutual respect, shared understanding, and commitment (Gilliam et al., 2003; Schneider et al., 2003). While essential, face-to-face dialogue alone cannot guarantee successful collaboration.

Trust Building

Building trust is especially critical when stakeholders have a history of conflict, though it may be difficult to achieve (Murdock, Wiessner & Sexton, 2005).

Commitment to the Process

The degree of commitment among stakeholders is pivotal for the success of collaboration (Gunton & Deg, 2003). Ensuring "buy-in" from participants is key, even when collaboration is mandated by law.

Shared Understanding

Stakeholders must reach a mutual understanding of their goals at some stage. This includes agreement on problem definitions and necessary information for problem-solving.

Intermediate Outcomes

These are short-term, tangible results that can reinforce trust and commitment, creating a virtuous cycle (Vangen & Huxham, 2003).

Ansell and Gash's model seeks to clarify the conditions under which collaboration can achieve desired policy outcomes. By considering the starting conditions, institutional design, facilitative leadership, and the collaborative process, this framework provides a comprehensive guide for fostering effective stakeholder cooperation.

3. METHODOLOGY

The paper examines the delivery of Primary Healthcare within the premise of Collaborative Governance in order to ascertain its present state and recommend policy options for improvement. To interrogate the subject, the paper adopted a qualitative approach, which offers in-depth insight into issues under investigation. Oranga and Matere (2023) noted that "the essence of qualitative research/data is to establish patterns and themes that do not require quantification". Consequently, document analysis was used to collect and analyse data from secondary sources comprising journal articles, official publications and research reports. The aim of document analysis is to "uncover meaning, gain understanding, develop empirical knowledge and draw conclusions from the documents under study" (Oranga & Matere, 2023, p. 7).Thus, fulfilling the essence of the paper, which is to identify patterns and provide a deeper understanding of the issues surrounding Collaborative Governance and the delivery of Primary Healthcare in Nigeria.

4. RESULTS

Nigeria created the National Basic Health Services Scheme (NBHSS) between 1975 and 1980, the cornerstone of the primary health care (PHC) paradigm. The program's primary goals were to provide health facilities, train medical professionals, including the community, foster transversal cooperation, and employ local technologies to deliver healthcare (Obionu, 2007; Mike, 2010; Fatusi, 2015). Primary health care (PHC) was first implemented in fifty-two local government districts in 1985, following the model of the Alma-Ata Declaration. A complete national health policy centred on PHC was presented in 1988. The 1988 primary health care program prioritised free childhood vaccinations, exclusive breastfeeding, mandatory maternal death reporting, preventive medicine, and local government health care (Uneke et al., 2010; Aregbeshola & Khan, 2017).

Nigeria founded the National Primary Health Care Development Agency (NPHCDA) to maintain and advance the primary health care agenda in 1992 (Fatusi, 2015; Lambo, 2015). Since then, other initiatives and policies have been enacted to facilitate and improve the health outcomes of Nigerians through Primary healthcare. Some of the notable initiatives and programmes of the federal government are the Saving of One Million Lives (SOML), Maternal, Neonatal and Child Health (MNCH), Midwives Service Scheme (MSS), National Health Act, 2014, Integrated Maternal, Neonatal and Child Health (IMNCH), Subsidy Reinvestment and Empowerment Programme for Maternal and Child Health (SURE-P MCH)(Dada, 2023; Croke & Ogbuoji, 2023). All these had a collaborative approach to it, and the Primary Health Centre (PHC) was the focal health facility for their implementation. An overview of each initiative is given below:

Saving One Million Lives and Saving One Million Lives Programme for Results

In 2012, Nigeria's Federal Government initiated the Saving One Million Lives (SOML) program to improve maternal, newborn, and child health (MNCH) indicators. The program began in 13 states, focusing on technical assistance for data generation and policy development. In 2015, the SOML program was restructured into the Saving One Million Lives Programme for Results (SOML-PforR) with a $500 million World Bank credit. This new approach focused on results-based financing to enhance health sector governance and transparency. The SOML-PforR focused on six key pillars to improve MNCH, including maternal health, immunisation, and nutrition. The program established specific indicators to measure progress and incentivise state performance. The indicators are:

i. Children under the age of five vaccinated with the Pentavalent vaccine 3
ii. Children under the age of five sleeping under Insecticide-Treated Nets
iii. Women of reproductive age using Modern Contraceptives
iv. Pregnant women delivered by Skilled health workers
v. HIV Counselling and testing during antenatal care, and
vi. Vitamin A coverage among children six months and five years

In addition, States were allowed to design programs to improve their health indicators. Likewise, the programme aimed to increase the utilisation and quality of high-impact health interventions. The program was guided by a Program Implementation Manual (PIM) detailing operational guidelines, financial management, and monitoring. A structured governance framework was established to oversee implementation and ensure accountability. SOML-PforR utilised a transparent financial management system, with funds managed through the Central Bank of Nigeria. States received seed funds and were incentivised based on performance improvements. An initial seed fund of $1.5 million was disbursed to each state, and a total of $378,999,955 was disbursed, representing 76% of the allocated funds. (Adewole & Adeyi, 2022)

Integrated Maternal, Newborn and Child Health

The Integrated Maternal, Newborn, and Child Health (IMNCH) programme was initiated by the Federal Ministry of Health in March 2007 to enhance the well-being of mothers, newborns, and children. It incorporates a comprehensive range of interventions delivered across a continuum of care, all aimed at improving health outcomes for these vulnerable groups. According to the World Health Organization (WHO, 2016), the IMNCH programme focuses on overcoming delays in maternal, newborn, and child healthcare by promoting better household and care-seeking behaviours, empowering communities to foster a supportive environment, and strengthening the quality of healthcare services at both the local and district (LGA) levels.

Maternal, newborn, and child health are key indicators of a nation's healthcare system and reflect the overall level of societal development. The Integrated Maternal, Newborn, and Child Health programme aims to enhance maternal and child health by pursuing a set of clearly defined

objectives. According to the Federal Ministry of Health (2012), these objectives include: improving the quality of healthcare services, ensuring the availability of essential medical supplies, strengthening the capacity to deliver MNCH services, enhancing management capabilities, securing adequate funding, reinforcing supervision and monitoring mechanisms, fostering and sustaining partnerships, and ultimately ensuring better maternal health outcomes.

Midwives Service Scheme

In 2009, the Federal Government of Nigeria launched the Midwives Service Scheme (MSS) to address critical shortages in healthcare personnel and expand access to skilled birth attendants, particularly in rural areas. The scheme was implemented through the National Primary Health Care Development Agency (NPHCDA), the federal body responsible for guiding primary healthcare policy at the sub-national level.

The MSS aimed to boost the availability and utilisation of essential maternal and child health services, including antenatal care, postnatal care, routine immunization, and other primary healthcare services. Recognizing Nigeria's federal structure—where state governments set their own health priorities—the MSS was designed as a collaborative effort involving all three tiers of government: federal, state, and local. Roles and responsibilities for each level were detailed in a memorandum of understanding (MOU), signed by all parties within each jurisdiction.

Midwives for the scheme were recruited by the federal government and deployed to selected rural primary healthcare facilities after receiving relevant training. The programme drew from a diverse pool, including retired midwives who were still fit to work, unemployed midwives, and recent graduates from schools of midwifery across the country. For retired midwives, participation in the MSS provided an added incentive, as they received compensation for their services in addition to their existing pension benefits.

To guarantee the availability of round-the-clock obstetric services in MSS primary healthcare (PHC) facilities, midwives were deployed in teams of four to each site. In addition, pairs of Community Health Extension Workers (CHEWs) were assigned to each facility to assist the midwives and lead community mobilisation efforts. To strengthen community involvement, the government supported the establishment of community health committees in areas hosting MSS facilities. These committees served as a link between the health facilities and the local population.

Each participating local government area (LGA) had four MSS facilities, all strategically connected to a secondary healthcare facility (general hospital) for managing referrals and providing higher-level care when needed (Okpani & Abimbola, 2016).

Subsidy Reinvestment and Empowerment Programme

The Subsidy Reinvestment and Empowerment Programme (SURE-P) is built on two core pillars: a social safety net initiative aimed at improving the quality of life for Nigerians, and infrastructure and human resource development projects designed to stimulate economic growth and reduce poverty. The Maternal and Child Health (MCH) component of SURE-P is specifically geared toward reducing maternal and newborn morbidity and mortality in Nigeria. It seeks to align the country with the targets of the 4th and 5th Millennium Development Goals (MDGs), drawing on successful strategies from the earlier Midwives Service Scheme (MSS).The SURE-P MCH project presents a strategic opportunity to expand access to essential maternal and child health services through a comprehensive continuum of care for pregnant women and their newborns.

The SURE-P Maternal and Child Health (SURE-P MCH) project consists of two key components. The first focuses on strengthening the supply of healthcare services by enhancing both infrastructure and human resources at the primary healthcare level. This includes renovating selected primary health centres (PHCs), providing essential equipment and medicines, and increasing the number of trained healthcare personnel—such as midwives, community health extension workers (CHEWs), and village health workers (VHWs)—to ensure effective service delivery. The second component targets demand creation, aiming to boost the utilization of maternal and child health services at PHCs. This is primarily achieved through Conditional Cash Transfers (CCTs), which provide financial incentives to pregnant women who meet specific responsibilities, thereby encouraging regular attendance and engagement with healthcare services throughout pregnancy and childbirth.

In identifying 1,000 health facilities across Nigeria as SURE-P MCH centres, the project was structured in two phases. Each designated facility was to undergo renovation and be equipped with essential medical tools to support the supply-side objectives of the programme. During the first phase, 500 health facilities were designated as SURE-P MCH centres in October 2012. In the second phase, an additional 500 facilities were added in November 2013. The distribution of these facilities was strategically based on regional maternal and child mortality rates—priority was given to areas with the highest need, with the Northeast receiving the most coverage due to its high mortality rates, while the Southwest received the least, reflecting its comparatively lower rates (EpiAFRIC, 2015).

Despite the lofty goals of these programmes, health outcomes in Nigeria are below expectations when compared with other Low and middle-income countries (LMICs) (Abubakar et al, 2022). Ogbuoji and Yamey (2019) observed that Nigeria is presently not on track to achieve key health Sustainable Development Goals (SDGs). This is as a result of the country's high under-5 and maternal deaths. Although significant progress has been made in certain spheres, several challenges remain (Saka et al, 2021). It has been observed that the country's health system is not

sufficient to meet the healthcare needs of Nigerians, particularly those residing in rural areas (Maduka et al, 2023). Other notable challenges affecting the health sector are the brain drain plaguing the country's medical profession, high out-of-pocket payment for medical services and the inability of the health insurance system to cover a large percentage of Nigerians (Meroyi, 2018). It is against this background that this paper interrogates the collaborative framework established to implement these programmes. Using the contingency model of collaborative governance, which prescribes certain conditions that would facilitate effective collaboration, this paper ascertains if the present collaboration in delivering primary healthcare is moving towards or away from the prescribed conditions.

Nigeria operates a federal structure, comprising the federal, state, and local governments. The country's healthcare system is also structured along this line. The federal government oversees tertiary healthcare, the state governments handle secondary healthcare, while the local governments have responsibility over primary healthcare (Adedeji, 2013). Notwithstanding, the federal and state governments play active roles in the delivery of primary healthcare as the local governments lack the financial capacity to manage it (Obembe, 2024).

The first variable of the contingency model is starting conditions which encapsulate power/resource imbalances, incentive to collaborate and pre-history of conflict or cooperation. While the collaborative framework involves multiple agencies from government, non-governmental organisations and development partners, these conditions manifest more in federal-state-local relations. For instance, fiscal administration in the country is highly centralised, making the state and local governments dependent on federal allocation. This dependence on federal allocation has negatively impacted the administrative capacity of local governments under whose jurisdiction fall primary healthcare services (Aregbesola & Khan, 2017). Thus, a power/resource imbalance exists between the federal, state and local governments. Likewise, an incentive to participate in federal government-initiated programmes appears weak. An example in this regard is this implementation of the National Health Sector Reform Programme at the subnational level. Nigeria experienced a high rate of maternal mortality and child morbidity, contributing significantly to the global burden. In response, the Federal Ministry of Health (FMoH), in collaboration with key development partners, undertook a major policy reform in 2007. This involved consolidating various fragmented maternal, newborn, and child health (MNCH) policies into a unified strategy aimed at reducing morbidity and mortality within the framework of the National Health Sector Reform Programme (2003–2007).

The resulting Integrated Maternal, Neonatal and Child Health (IMNCH) strategy was approved by the National Council on Health (NCH) for implementation at the subnational level. Between 2009 and 2019, three major initiatives served as key instruments for executing this strategy: the Midwives Service Scheme (MSS), the Subsidy Reinvestment and Empowerment Programme for Maternal and Child Health (SURE-PMCH), and the Saving One Million Lives Programme for

Results (SOML PfR) (Etiaba et al, 2023). Following the launch of the strategy, subnational governments were expected to assume ownership and implement interventions within their respective states and local government areas. However, an annual evaluation conducted in 2009 revealed that only 23 states had formally requested implementation support from the Federal Ministry of Health (FMoH, 2009). Etiaba et al (2023:7) observed that "states and LGAs adopted programmes by passively signing memoranda of understanding (MOUs) without adequate intent to implement". A pre-history of conflict is evident in Nigeria's sphere of intergovernmental relations, where state governments challenge the incursion of the federal government into their sphere of jurisdiction (Adedeji, 2018; Adedeji, 2021b). This pre-history of conflict creates a low level of trust (Adedeji, 2025).

Facilitative leadership is needed to sustain the collaborative process. This is to ensure broad and active participation. Nigeria's health policy landscape operates through a complex federalist system marked by layered decision-making authority. At the national level, the National Council on Health (NCH)—comprising state health commissioners under the leadership of the federal health minister—serves as the apex policy advisory body. However, real implementation power resides sub-nationally, where state governors function as the ultimate arbiters of health priorities. This governance dynamic creates inherent tensions. While the NCH formulates national health strategies, state legislatures enact localised health laws ratified by governors, effectively superseding federal recommendations (Eboreime et al., 2017). States exercise full autonomy in determining healthcare expenditures and interventions without federal oversight, leading to divergent policy trajectories across the country. For instance, in the Saving One Million Lives Programme for Results (SOML-PforR) programme, Adewole and Adeyi (2022) observed the poor funding of health and poor financial management at the State level as a serious challenge to the programme. This is despite the financial incentive package in the programme to motivate States. This shows that the ability of Federal agencies to provide leadership in collaborative arrangements with State agencies is limited.

Furthermore, the structural misalignment between national policy aspirations and subnational implementation has significant consequences. As Okpani and Abimbola (2016) underscore, the absence of enforceable accountability mechanisms allows state-level political considerations to frequently override nationally agreed-upon health agendas. This fragmentation explains why Nigeria struggles with coherent health system performance despite well-articulated federal policies. This decentralised framework highlights the challenges of health governance in federal systems, where constitutional divisions of power can both enable localised responsiveness and hinder unified action on national health objectives.

Institutional design covers the rules and those allowed to participate in the collaborative process. Primary Healthcare (PHC) services in Nigeria operate within a web of overlapping institutional responsibilities that reveal both the strengths and challenges of decentralised health governance.

At the subnational level, Local Government Areas (LGAs) work alongside an extensive network of actors, including state health ministries, local government affairs ministries, and administrative bodies like the Local Government Service Commission and Civil Service Commission. This multi-stakeholder framework extends beyond government entities to incorporate critical partners such as faith-based organisations, NGOs, and international development agencies. Federal institutions like the National Primary Health Care Development Agency (NPHCDA), the Federal Ministry of Health, and the National Health Insurance Scheme (NHIS) complete this intricate ecosystem of PHC governance. However, this collaborative approach comes with significant structural challenges. As Wang and Hansen (2013) demonstrate, the system suffers from pronounced vertical and horizontal fragmentation - a phenomenon particularly evident in the disjointed management of human resources, financial flows, and material assets across these numerous stakeholders. The resulting governance complexity represents one of the most persistent obstacles to effective PHC delivery in Nigeria, as multiple decision-making centres struggle to align priorities and operational approaches. While this pluralistic system brings diverse resources and perspectives to primary healthcare, it simultaneously demands exceptional coordination mechanisms to overcome its inherent centrifugal tendencies.

The collaborative process is hampered by a lack of adequate consultation between the national and sub-national agencies. For instance, in the design of the Midwives Service Scheme (MSS) and Subsidy Reinvestment and Empowerment Programme for Maternal and Child Health (SURE-P MCH), sub-national stakeholders were not actively engaged at the early stages, and this undermined the success of implementation (Etiaba et al, 2023). To underscore this point, the authors quoted one of the State level interviewees who noted not been involved in the design of the MSS (Ibid: 6). In terms of intermediate outcomes, FMoH (2017), while evaluating the outcome of the SOML programme, noted that there wasa clear departure from programme targets and activities, resulting in less than expected outcomes. Similarly, Okeke et al (2017) observed the midwives' attrition under the MSS programme due to a lack of accommodation in the local government area. In terms of shared understanding, Etiaba et al (2023) observed an instance of states procuring equipment such as tricycle ambulances and generators—items that, while important, were not directly part of the SOML PfR components. With the constant power struggles and internal crisis such as the one observed by Adewole and Adeyi (2022), between State Primary Health Care Board and State Ministry of Health due to poor communication, shows a low level of trust among stakeholders. Etiaba et al (2023) noted that persistent top-down structures and power imbalances, which previously caused conflict and mistrust, undermined shared motivation and limited the capacity for joint action toward achieving programme goals.

5. CONCLUSION AND POLICY RECOMMENDATIONS

Nigeria's primary healthcare system has not met the expectations of citizens. The underperformance of the system is attributed to the ineffective collaborative framework for

implementing the various federal government initiatives. A policy recommendation of this paper is for a strengthening of the collaborative governance framework that promotes inclusive decision making, shared accountability and joint implementation between federal, state and local governments, civil society, traditional institutions and private sector actors. To achieve this, the paper recommends:

- Institutionalised multi-stakeholder governance platform comprising representatives from the three tiers of government, donor agencies, civil society, private sector, traditional rulers and community health advocates. The National Health Council may have to expand its membership to include some of the representatives mentioned or institutionalise a platform to engage them.
- Define and align roles through intergovernmental agreements by facilitating legally backed Memoranda of Understanding between all stakeholders involved in the governance, planning, financing and implementation. Responsibilities should be assigned based on competence and backed with financial capacity.
- Constant evaluation of the collaborative framework to resolve issues of disagreement among stakeholders.

The future of primary healthcare in Nigeria depends not just on increased investment or infrastructure but on how well institutions work together and how effectively citizens are engaged in health decision-making. A collaborative framework offers a sustainable pathway to re-engineer Nigeria's primary healthcare system into one that is inclusive, accountable and responsive.

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