RESEARCH BRIEF:

Coalitions for Women's Health Advocacy in Nigeria: What Works?

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Background

Women's health needs are complex and multifaceted. Advocacy provides a platform for stakeholders to draw attention to important issues and engage policymakers towards evidence-based policy change, resource mobilization and social change[1]. Advocacy projects mobilize collective action from interest groups, technical working groups, and coalitions[2,3,4]. However, long term impact and sustainability is a major challenge due to lack of post-project closeout sustainability plans, lack of integration of key policies and practices and lack of sustained political will[5,6,7,8]. Nigeria's Health Sector Renewal Strategy (2023 – 2026)[9] stipulates a sector-wide approach which includes multi-stakeholder, multilevel platforms for dialogue, resource mobilization, allocation and accountability for results, as well as strengthened citizen and civil society engagement. This strategy may provide a window of opportunity for collaboration and collective action in the form of highly effective joint advocacy coalitions for women's health. To achieve this, it is important to first of all identify and understand the features of women's health advocacy coalitions that currently exist, their structure, functionality, strengths and weaknesses, as well as important metrics for success. Lessons learned from these can then guide the design of viable typologies for women's health joint advocacy coalitions.

Objective

This brief highlights the existing typologies of women's health joint advocacy coalitions in Nigeria, their inherent strengths and weaknesses (and how these can be addressed) and proffers recommendations for what works, given the Nigerian context.

Methodology

The study utilized a multi-method approach guided by two theoretical frameworks – advocacy strategy and advocacy coalition frameworks. A review of literature was done to identify existing joint advocacy typologies, followed by key informant interviews (KIIs) and Multi-Stakeholder Dialogues (MSDs) with stakeholders in women's health advocacy. The co-creation workshop (CCW) that followed synthesized evidence from KIIs, MSDs and literature review. Via a design-thinking approach, participants were supported to co-create contextually relevant, and feasible recommendations for women's health advocacy coalition typologies in Nigeria. A purposive sample of 175 participants (KII = 52; MSD = 73; CCW = 48) was drawn to include representatives of government, International Non-Governmental Organizations (INGOs) and Non-Governmental Organizations (NGOs), the private sector, Community-based, Civil Society and Faith-based Organizations (CBOs, CSOs and FBOs), and professional associations. KIIs and MSDs were audio-recorded and transcribed verbatim. A Thematic analysis was used in exploring emerging patterns and themes within the data.

Findings

Overview of Literature

Five typologies of joint advocacy initiatives were identified from the literature:

» ***The "CSOs/NGO-led" comprising a coalition of organizations (community-based, local and international organizations, private sector, academia, media, activists, etc.).***

» ***The "Government-led multi-sectoral" coalitions which include the government, academia, media, CSOs, communities, private sector, media, implementing partners, religious and traditional rulers. This typology has strong convening power and usually has its secretariat domesticated with the government.***

» ***The "Government embedded" model in which a partner or funder may second staff to a government agency for knowledge transfer and better alignment. The secretariat may be set up at the government agency.***

» ***The "Private Sector-led" model wherein a group of private sector organizations form a coalition to support advocacy processes. In this model, the government may provide direction and coordination of the coalition activities. This process may also lead to basket funding initiatives for advocacy purposes.***

» ***The "Community-led" model where community gatekeepers are the drivers of change, holding the government and other actors accountable.***

Findings from KIIs and MSDs

From the KIIs and MSDs, we were able to identify four main typologies:

1. The Government-Led Multi-Sectoral Coalition

Better known as RMNCAEH +N TWG (i.e., Reproductive, Maternal, Newborn, Child, Adolescent, Elder Health and Nutrition Technical Working Group), this typology exists at national level and in each of the focus states. It is a government-led, multi-stakeholder partnership involving private sector, academia, national and international NGOs, government, professional associations, legislative, media, communities, etc. At the national level, this typology has four subcommittees (Advocacy, Resource Mobilization & Communication; Leadership, Coordination & Partnership; Accountability, Data & Knowledge management; and Quality Technical Delivery). Subnational level RMNCAEH TWGs do not necessarily have the same number of sub-committees as the national level TWG, the number of subcommittees varying from state to state. Across states and national, membership of sub-committees is voluntary, determined largely by members' preferences.

> **"When those committees were carved out, we asked people to choose whatever committee [they] wanted to belong to. So there and then, nobody forced anybody to be the chair, they leave it open.**
>
> *Stakeholder dialogue, National*

At national level, the leadership of the RMNCAEH TWG is statutorily the Honorable Minister of Health and Social Services, while at state level it varies; for example, in Lagos and Kaduna, the RMNCAEH TWG is led by the Permanent Secretary of the State Ministry for health, while in Kano it is chaired by the Director for Health and Disease control. Due to the structure of this coalition typology, succession is based on appointment to the office. The implication is that the leadership and functioning of the coalition, at both national and subnational levels, is affected by transfers, retirements, transitions in power and political appointments.

The Director, Department of Family Health, Federal Ministry of Health (FMoH), acts as deputy to the Honorable minister on the national level RMNCAEH core TWG, and as such, the RMNCAEH TWG is domiciled in the Department of Family Health; this is not necessarily always the case at subnational level, since not all states have departments of family health established yet. With regard to tenure, the sub-committees are usually supposed to have fixed terms of two years. The national RMNCAEH+N core TWG is supposed to meet twice a year, but lack of consistency in meetings has rendered it non-functional.

> **So, it's not really consistent... we have not had consistent meetings**
>
> *Stakeholder dialogue, National*

Unlike the case with the national level RMNCAEH, the subnational RMNCAEH TWGs are reportedly quite functional although lack of funding was cited as the reason for non-functionality in one of the states. With regard to RMNCAEH TWG subcommittees, the national level RMNCAEH advocacy subcommittee has not fared better than its umbrella body in terms of functionality; although the policy stipulates quarterly meetings, it has also not been able to meet regularly as stipulated. However, at subnational level, most advocacy subcommittees are reportedly functional, with the exception of a state with non-functional leadership due to poor commitment.

> **Probably at a time we fixed for the meeting, there are actually issues of the director not being around**
>
> *Stakeholder dialogue, National*

2. The Hybrid or Mixed Leadership Coalition

Across all states, hybrid/mixed leadership typologies were identified (though not previously identified in the literature); examples include Family Health Advocates Nigeria Initiative (FHANI) in Kaduna state and the Open Government Partnership (OGP) and Kaduna State Maternal Accountability Mechanism (KANSLAM) in Kano state. As the name suggests, in this typology leadership is shared and the coalition is usually co-chaired. In KANSLAM, for example, there is both a CSO representative co-chair and a government representative co-chair. This structure allows for easier engagement with the government and ready access to key government staff, structures and resources.

3. The CSO/NGO-Led Coalition

A CSO-led typology was reported.. Examples of this typology include: the Kaduna State Maternal

Accountability Mechanism (KADMAM); Lagos Accountability Mechanism for Maternal Newborn, Child Maternal Neonatal and Adolescent Health (LASAM4CMNAH), aka Lagos State Accountability Mechanism (LASAM). LASAM, KADMAM and KANSLAM came about as a program sustainability effort of the MamaYe project. However, although KANSLAM started off as a CSO-led coalition, implementation nuances led to its operationalization as a hybrid typology. Other examples of CSO-led coalitions include the Lagos State Advocacy Working Group (LAWG) and the Lagos State Civil Society Open Partnership (LACSOP); The Lagos Civil Society Participation for Development (LACSOP) offers a platform for all advocacy groups to jointly promote women's health policies and programs. LACSOP is made up of more than 400 organizations, including NGOs, trade unions, FBOs, CBOs, social movements, etc., committed to strengthening democracy and good governance and it promotes ownership of advocacy efforts and outcomes through collaboration with the different arms of government, Ministries, Departments and Agencies (MDAs) as well as the media.

In the CSO-led typology, leadership positions are typically determined by election and there is usually a two-year tenure for elected leaders. The CSO-led coalitions tend to be highly functional and provide accountability and regulatory feedback oversight to the state's policy and decision makers. CSO-led coalitions work by collating evidence through government-domiciled monitoring and evaluation structures. In addition, they hold key decision makers in government accountable to either implement or enforce already existing policies and approved budgets, or demand that they address gaps in service delivery, health workforce, or quality of care. In this typology, the government plays a supportive role.

> **"They [government staff who are members of KADMAM] only provide us with evidence information. That was why we picked them from different ministries, departments and agencies. So, any data we need, we touch base with [the MDA], and they provide it for us.**
>
> *KII, KADMAM representative Kaduna*

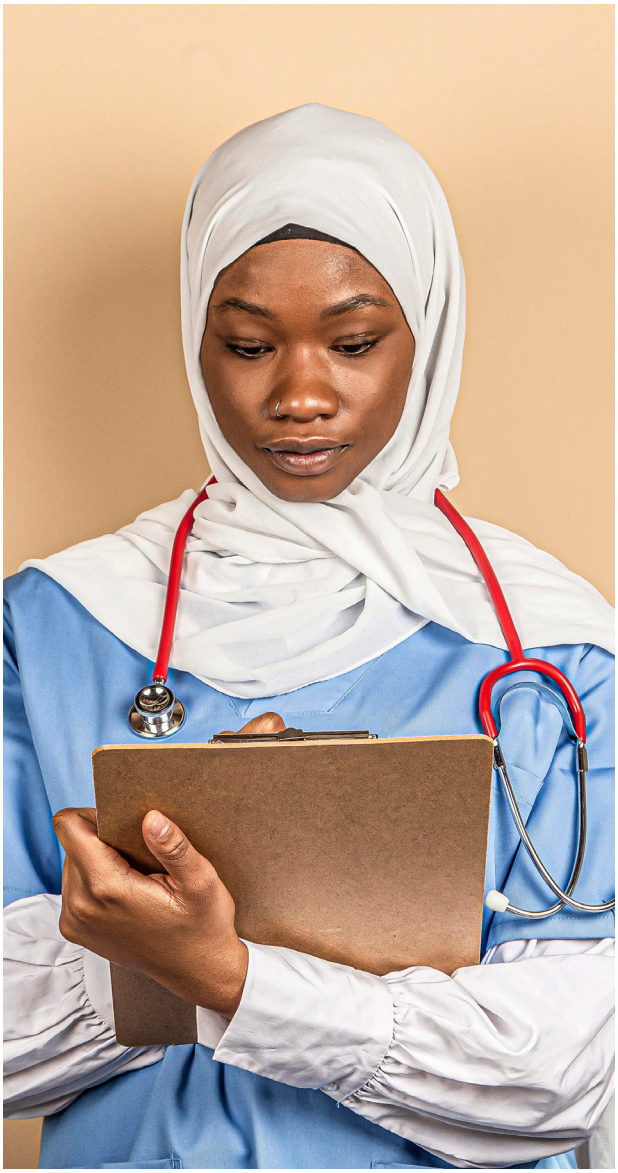
This typology typically is comprised of a multisectoral membership including representatives from the public sector, traditional and religious leaders, representatives of professional associations, media and civil society organizations.

Interestingly both LASAM and LASCOP (two CSO-led typologies in Lagos state) have representatives within the Lagos state government-led multisectoral typology – RMNCAEH TWG.

> **"LASAM is like the accountability mechanism sub-technical working group for RMNCAEH. They ensure accountability for RMNCAH, with a focus on CSOs and the press. They also feed into RMNCAEH. They function almost like a sub-technical working group of RMNCAEH, and the majority of us attend both meetings.**
>
> *Stakeholder dialogue, Lagos*

4. The Community-Led Coalition

The fourth typology identified was the community-led typology. Examples include the Ward Development Committees (WDCs) that exist in all the focal states, and the Kano State Emirate Council Committee on Health and Development (KSECCOH). Interestingly, while the KSSECOH has representatives of WDC among its membership, KSSECOH itself has representation within the government-led multisectoral coalition (RMNCAEH) in Kano. Membership of KSSECOH is quite diverse and includes several traditional and religious representatives, as well as government staff. The coalition is reportedly highly functional and tackles a broad range of issues that extend beyond health to include other areas of development. In Northern states like Kano where religious and cultural leaders are highly revered, this typology may have considerable potential in pushing women's health issues if coalition leadership can be strategically engaged, educated and incentivized through culturally sensitive and innovative approaches.



			CSOs/NGO-led	Government-led Multi-sectoral	Government Embedded	Private Sector-led	Community-led
CLEAR PURPOSE AND VISON	32	53%	High 12	Med 8	Low 4	Low 4	Low 4
PARTNERSHIP AND OWNWERSHIP	48	80%	High 12	High 12	Med 8	Med 8	Med 8
ACCESS TO DECISON MAKERS & INFLUENCERS	40	67%	High 12	High 12	Med 8	Low 4	Low 4
SUSTAINABILITY	28	47%	High 12	Med 8	Low 4	Low 4	Low 4
RESOURCE MOBILIZATION	40	67%	High 12	Med 8	Low 4	High 12	Low 4
LEADERSHIP AND GOVERNANCE	48	80%	High 12	High 12	Med 8	High 12	Low 4
SKILLS COMPETENCE AND CAPACITY	33	73%	High 9	High 9	Med 6	Med 6	Low 3
RESEARCH EVIDENCE	26	58%	High 9	Med 6	Med 6	Med-Low 5	None 0
			86 95%	75 83%	48 53%	55 61%	31 34%

Scoring of Identified Typologies by Weighted Features

Findings From the Co-Creation Workshop

Scoring and weighting, of each of the five identified typologies identified in the literature, resulted in ranking of the typologies from highest (most viable) to lowest (least viable), with the CSO/NGO-led model ranking highest and the Government-led multisectoral ranking second. Sustainability was found to be a recurrent weakness of all five typologies. In co-creating ideas for improving the two top typologies, basket funding was strongly recommended (leveraging on prior experience in Kaduna and Kano States). The solutioning session emphasized that realigning political commitment with the coalition goals remains essential for sustaining future coalition models. There was a consensus to keep the coalition structure "loose" to avoid intra-coalition conflict. Additionally, there was consensus that both top typologies (CSO-led and government led) would require mentoring of coalition staff to ensure advocacy capacity strengthening.

Recommendations

Co-creation workshop participants highlighted certain coalition success metrics based on which the following recommendations are proffered for a viable, contextually relevant joint advocacy typology:

Ensure diverse representation	Multi-sectoral participation
Alliance	Advocates aligning or collaborating in greater numbers leads to amplification of their voices and yields greater results in a shorter space of time.
Gender Equality and Social Inclusion	Integration of Gender Equality and Social Inclusion (GESI) principles (allowing and encouraging women, marginalized and vulnerable populations to advocate for themselves and to take up positions of leadership in advocating for change)
Political Alignment	Alignment with government policies and strategies in order to foster ownership and seamless adoption at sub-national levels
Advocacy capacity strengthening	Investments in capacity strengthening of coalition teams, both pre-service as well as in service, in order to optimize Human Resources for Health
Accountability	Ensure accountability and transparency in order to generate public trust and buy-in and engender intra-coalition cohesion
Sustainability	A well laid out plan for funding, detailed in the coalition memorandum of understanding (MoU), that includes a sustainability plan for post-project funding (funding sources, commitments, timelines, disbursement plans, signatories, accounts, patterns of funding and transitions (if regressive funding will be employed) must all be clearly outlined and then implemented with fidelity to the MoU)
Policy implementation	Commitment to implement existing policies (national level policies must be adapted or adopted at the state level with the right enabling environment for successful implementation)
Culturally sensitive stakeholder engagement	Culturally sensitive and human-centered advocacy (investing in education counselling, and strategic engagement of influencers and gatekeepers of target populations is key).
Leverage existing women's groups.	Furthermore, women-led initiatives, and approaches that reduce hurdles/barriers to desired changes in behavior are also highly recommended.

Conclusion

Advocacy coalitions are impactful for facilitating collective action to amplify stakeholder voices and get the buy-in of advocacy or policy champions in promoting social change. There is strong evidence that designing an ideal joint advocacy coalition for women's health in Nigeria may require a hybrid of at least two of the different advocacy typologies described in this review. Finally, it is important to implement set-up of such a coalition using a results-based framework grounded in the evidence, while demonstrating how advocacy programs fit with the government of Nigeria's multi-sectoral agenda for improving the wellbeing of women.

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