RESEARCH BRIEF:

What are Advocates Perspectives About Joint Advocacy Coalitions for Women's Health?

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Background

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, visible and sustained outcomes remain elusive due to (amongst other things) siloed approaches to advocacy, lack of sustainability plans post-project closeout, difficulties with securing political alignment and challenges with navigating opposition[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 identify and understand where and what the barriers and/or facilitators are to feasibility of women's health joint advocacy coalitions. When these are known and understood, then barriers can be mitigated or prevented altogether. Lessons learned from these can then guide recommendations for implementation of women's health policies and programs in the future.

Objective

This brief highlights the perspectives of women's health advocates on factors affecting feasibility of joint advocacy for women's health in Nigeria, and how key stakeholders might be strategically engaged in order to surmount any hurdles that exist.

Methodology

The study utilized a multi-method qualitative approach. Key informant interviews (KIIs) were conducted with key stakeholders, followed by multistakeholder dialogues (MSDs) (one in each of the three focus states and at national level). This allowed for validation of the data emerging from the literature review and KIIs, as well as triangulation of data. Participants included representatives of government, international non-governmental organizations (INGOs)/non-governmental organizations (NGOs), the private sector, community-based, civil society and faith-based organizations (CBOs, CSOs and FBOs), and professional associations. A purposive sample of 125 participants (KII = 52; MSD = 73) was drawn from three focus states (Kaduna, Kano, Lagos) and national level. Interviews and stakeholder dialogues were audio-recorded and transcribed verbatim. Thematic analysis was employed in exploring emerging patterns and themes within the data.

Findings

Facilitators

Key actors – Civil Society Organizations (CSOs), professional organizations, international organizations, funding agencies/partners, traditional and religious leaders, academics, members of the media, private sector actors, philanthropists, healthcare service providers and key government officials were identified by participants as potential, or tried and tested, women's health champions.

> **So let's not forget informal media, social media influencers, because they are very, very important. Other actors are community based organizations, donors, community development advisory committees**
>
> *Stakeholder dialogue, National*

Governance - Another commonly cited facilitator of successful joint advocacy was good governance, particularly when there is commitment and interest of key decision makers and policymakers in women's health issues.

Alliance – Advocates highlighted their willingness and capacity to harmonize their voices as a key factor in successful joint advocacy

Coalitions – The existence of various women's health focused coalitions (albeit with their individual weaknesses) presents an opportunity that can be readily leveraged in constituting a larger scale joint advocacy platform, once the appropriate capacity strengthening solutions have been put in place to bridge gaps in functionality and sustainability.

Policies – Existing policies, such as the sector wide approach proposed by the incumbent government present a window of opportunity that can be leveraged to actualize effective and sustainable joint advocacy that can advance the women's health agenda in Nigeria.

Women groups – Engaging, strengthening advocacy capacity and leveraging already existing women groups ('advocacy by women, for women') was another strong feasibility factor put forward by participants. This strategy has great potential to push the women's health agenda in ways that are practical, effective and with high potential for sustainability. Participants gave such examples as women's arms of faith-based organizations, market women's groups and female branches of professional organizations.

Barriers

Mistrust – A major barrier to effective joint advocacy is that it takes time to build coalitions and nurture them to true partnerships with trust. In certain cases, the time required to build partnerships may be considered too long for the desired cause or for the project lifespan, especially when reporting cycles are short and performance indicators are short-term. Opposition coalitions may also arise and impact advocacy efforts, sometimes aided by internal saboteurs.

> **You don't know an opposition and it's with you; and then whatever you people discussed, they will take it outside and then come and neutralize what you are saying**
>
> *NGO representative, National.*

Conflict - Apart from external sources of conflict, respondents cited intra-coalition conflicts of interest as a potential barrier to joint advocacy.

> **Our main challenge as a civil society, is conflict of interest because we have several personal activities and then we have the coalition activities. So sometimes it is the conflict of interest of our activities that might be our main challenge.**
>
> *Stakeholder dialogue, Kaduna*

Funding - Majority of national- level stakeholders cited lack of funding, or delayed and insufficient fund-release of approved budgets, as a barrier to joint advocacy efforts. This also includes the absence of independent accountability mechanisms and structures that could potentially attract external funding. Limited public investment in women's health is a barrier to joint advocacy efforts. When women's health programs are poorly funded, joint advocacy efforts and programs may suffer as a consequence. At the same time, it is through collaboration and coalition effort that issues of funding can be substantively addressed.

> **"Eight years ago we had no budget line and all the partners CSOs, the state government, couldn't release money because it was not in the budget line. The present Director of Family Planning was the one who was able to mobilize some NGOs that joined together and went to the Commissioners of Health, Planning and Commission, and they were able to develop the budget line which was allocated to family planning products.**
>
> *Stakeholder dialogue, National*

Policy gaps - Gaps, or delays, in domestication of federal level policies at sub-national level were also cited as a barrier.

Agenda alignment - Misalignment of women's health advocates' and decision maker interests could also constitute a barrier to women's health advocacy. Some appear to think that lack of alignment of decision makers with the women's health agenda is the problem, stating that women's health issues are not prioritized by those in power.

> **"Yeah, it's not an issue of funding, but actually how busy they [policy and decision makers] are. It's always a bit uncomfortable to call for a meeting, somebody like [key decision maker] has to send a representative because they are in one or two different places. There are competing priorities that are making them not see, I'm sure.**
>
> *Stakeholder dialogue, National*

Gatekeepers - A commonly cited barrier was the undue influence of gatekeepers in the form of religious, traditional, and community leaders. So powerful is the reach and influence of some of these gatekeepers that in certain parts of the state, advocates are unwilling to even campaign or make attempts to engender public awareness or support for family planning (referred to as child spacing in many parts of Northern Nigeria in the interests of cultural sensitivity).

> **There are some things for which you need their Mallams to convince them that this is Islamic. Even in child spacing, they believe that it is wrong for a woman to stay on those drugs. They do not believe in child spacing control. So, it is their Imams that can make them accept it**
>
> *Christian religious leader, Kano*

> **Let me tell you the capacity that traditional rulers have. The traditional ruler of Kano Ado Bayero, when people refused [to accept the polio vaccine for their children] he called doctors and said, "Go and look for the Imams of Juma'at mosque; seek for their assistance". That brought about the crushing down of polio.**
>
> *Muslim religious leader, Kano*

> **We receive guidance from the healthcare side, but encounter pushback when working through the [Ministry of] Local Government and Chieftaincy Affairs. In fact, they can be hostile... those people are like gatekeepers, they are like gatemen, and I think that it's important to say that they block access to communities and opportunities for them**
>
> *Stakeholder dialogue, Lagos.*

Interestingly, while some advocates view these traditional and religious leaders as potential allies for women's health joint advocacy efforts, others see them more as gatekeepers. Participants explained that the dynamics of stakeholder roles are not necessarily fixed and may vary depending on context and interests.

Bureaucracy - Stakeholders also shared that bureaucratic bottlenecks such as power transitions and administrative structure often present barriers to women's health advocacy, particularly for nascent advocates.

> **They [advocates] have these meetings with the chairperson. They've been told they [the chairperson] doesn't have time for them [the advocates]. They've had to go back several times, just that they [the powers that be] change those chairpersons. So, every time there's a sweep, we have to go back again**
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> *Stakeholder dialogue, Lagos*

Performance evaluation - While participants agreed that performance of coalition leaders was a key factor in determining coalition feasibility or success, they pointed out that coalition leaders do not have clear performance indicators and so it is difficult to objectively evaluate their performance. However, they also pointed out that since there are terms of reference for each coalition sub-committee, this could be an opportunity to be leveraged in developing performance indicators

Patriarchy – Participants revealed that, especially in Northern Nigeria, sociocultural norms and harmful patriarchal practices often engender situations in which women are not naturally inclined to take up or be encouraged to occupy leadership/decision making positions. As such, women are usually not present at the table when key decisions that affect them are made on their behalf. On whether there could be a gendered dimension to the performance of leaders, participants opined that there was no basis to reach such a conclusion and attributed success or performance to the commitment of coalition leadership..

Human Resources for Health (HRH) - In the State Ministries of Health and Primary Health Care Boards (particularly in the Northern states of Kaduna and Kano), we observed that there was a critical shortage of skilled human resources for health (HRH), with many of the available staff having to provide support across multiple positions; indicating an urgent need to prioritize sustainable solutions for HRH in the interest of success in advocacy efforts.

Lessons Learned

1. The success of advocacy lies in diverse, multisectoral, inclusive collaborations and coalitions that involve a wide range of critical stakeholders, including members of the affected population(s), champions and gatekeepers.

2. Opposition coalitions must be identified and understood; especially with regard to how/ if their concerns can be addressed, or how opposition coalition members can be won over.

3. Investments in engaging and strengthening capacity of women's health policy entrepreneurs and champions should be prioritized, as well as strategic engagement of gatekeepers and the opposition.

4. Women leadership and women empowerment should be prioritized and encouraged as well, for the success of women's health advocacy efforts. The faces and voices of advocates should, as much as possible, align with, or resemble those of the affected population.

5. A human-centred, culturally sensitive approach is vital for buy-in and adoption of advocacy messages/agenda.

6. Cultivating both political and public will

is important for buy-in, ownership and sustainability of women's health advocacy efforts.

Conclusion

Advocacy coalitions are impactful for facilitating collective action, amplifying stakeholder voices and getting the buy-in of advocacy or policy champions in promoting social change. A critical success factor for women's health advocacy lies in situating women's health within the broader development context, as well as demonstrating how advocacy programs fit with the federal government of Nigeria's multi-sectoral agenda for improving the wellbeing of women.

To ensure that joint advocacy programs/ projects are successful, it is important to deploy contextually relevant approaches that build strong aligned coalitions, anticipate and respond effectively to opposition, reduce/prevent intra-coalition conflicts, strengthen advocacy capacities, mobilise effective multi-sectoral partnerships, strategically engage powerful influencers and gatekeepers and leverage sustainable funding models for subnational and national level impact.

Finally, it is important to implement and continually evaluate advocacy efforts using a results-based framework that clearly demonstrates strategies, challenges, key achievements (or failures), and lessons learned. Gender inclusion and representation of the most affected populations are also key.

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