A SCOPING ASSESSMENT OF

Women's Health Advocacy in Nigeria

MAY 2024

POLICY INNOVATION CENTRE

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Acronyms

AAH	Action Against Hunger
ACF	Advocacy Coalition Framework
AIDS	Acquired Immune Deficiency Syndrome
AHFGGO	Avenir Health, Futures Group Global Outreach
ANC	AnteNatal Care
AYFS	Adolescent and Youth Friendly Services
AYP	Adolescents and Young People
BMGF	Bill and Melinda Gates Foundation
CBOs	Community-Based Organisations
CCW	Co-Creation Workshop
CDC	Centre for Disease Control
CHAI	Child Health Advocacy Initiative
CHEW	Community Health Extension Workers
CHIPS	Community Health Influencers, Promoters and Services
CSM	Collaborative Stakeholder Management
CSRM	Collaborative Stakeholder Relationship Management
CSO	Civil society organizations
CS-SUNN	Civil Society Scaling Up Nutrition in Nigeria
DET	Department of Education and Training
DFATD	Department of Foreign Affairs, Trade and Development
DFID	Department for International Development
DMPA	Depot Medroxyprogesterone Acetate
DMPA-SC	Depot Medroxyprogesterone Acetate – Sub-Cutaneous
DOLISA	Department of Labour, Invalids and Social Affairs
EC	Educar Consumidores
ECD	Early Child Development
ENCC	Essential Newborn Care Course
FHANI	Family Health Advocates Nigeria Initiative
FCDO	Foreign Commonwealth & Development Office
FCT	Federal Capital Territory
FHI-360	Family Health International
FMoH	Federal Ministry of Health
FOMWAN	Federation of Muslim Women Association of Nigeria
FP	Foundation's priorities
FP	Family Planning
FSSAI	Food Safety and Standards Authority of India
GAV	Global Affairs Canada
GBV	Gender Based Violence
GHAI	Global Health Advocacy Incubator
GHON	Grass-root Health Organization of Nigeria
GPMNCH	Global Partnership for Maternal, Newborn and Child Health
HIV	Human Immunodeficiency Viruses
HPP	Health Policy Project
HWC	Health Wellness Center
ICCM	Integrated Community Case Management of Childhood Illness
ICMR	Indian Council of Medical Research
IDEF	Integrated DEFinition Methods
IMCI	Integrated Management of Childhood Illness

INMCH	Integrated Neonatal, Maternal and Child Health
IUD	Intra-uterine devices
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
JWHA	Joint Women's Health Advocacy
KADCHMA	Kaduna State Contributory Health Management Board
KADMAM	Kaduna Maternal Accountability Mechanism
KANMAF	Kano State Mutual Accountability Framework
KANSLAM	Kano State Leadership and Accountability Mechanism
KASACA	Kano State AIDS Control Agency
KII	Key Informant Interview
KMC	Kangaroo Mother Care
KSECCOH	Kano State Emirate Council Committee of Health
KSHCH	Kano State House Committee on Health,
LAFIYA	Saving Lives Through Family Planning
LACSOP	Lagos State Civil Society Open Partnership
LASAM	Lagos State Accountability Mechanism
LASAM4CMNAH	Lagos Accountability Mechanism for Maternal, Newborn, Child and Adolescent Health Coalition
LAWG	Lagos Advocacy Working Group
LGA	Local Government Area
NAPHS	National Action Plan for Health Security
NASS	National Assembly
NCH	National Council on Health
NCHP	National Child Health Policy
NCD	Non-Communicable Diseases
NDHS	Nigeria Demographic and Health Survey
NGBNC	National Guideline for Basic Newborn Care
NGCNC	National Guideline for Comprehensive Newborn Care
NGO	Non-governmental Organisation
NGSTPLI	National Guidelines on Safe Termination of Pregnancy for Legal Indications
NH-IUD	National Hormonal Intrauterine Device
NiENAP	Nigeria Every Newborn Action Plan
NMPDSRG	National Maternal and Perinatal Death Surveillance and Response Guideline
NPIIMAM	National Programme on Immunization, Integrated Management of Acute Malnutrition
NPC	National Population Commission
NPHDAYPN	National Policy on the Health and Development of Adolescents and Young People in Nigeria
NPHESP	National Public Health Emergency Strategic Plan
NPHP	National Reproductive Health Policy
NPMIYCN	National Policy on Maternal, Infant and Young Child Nutrition
NPHSE	National Private Health Sector Engagement
NPPPPH	National Policy on Public Private Partnership for Health
NQPS)	National Quality Policy and Strategy
NSFEOF	National Strategic Framework for the Elimination of Obstetric Fistula
NSNM	Nigerian Society of Neonatal Medicine.
NISONM	Nigerian Society of Neonatal Medicine
MDAs	Ministries, Departments and Agencies
MCH	Mean Corpuscular Hemoglobin
MICS	Multiple Indicator Cluster Survey
MNCH	Maternal, Newborn and Child Health

MNH	Maternal and Neonatal Health
MMR	Maternal Mortality Ratio
MOLISA	Ministry of Labour, Invalids and Social Affairs
MPB	Ministry of Planning and Budgeting
MPDSRG	Maternal and Perinatal Death Surveillance and Response Guideline
MPDSR	Maternal & Perinatal Death Surveillance
MSDs	Multi-stakeholder Dialogues
MSF	Medicine San Frontiers
MSM	Men who Sleep with Men
MSP	Minimum Service Package
MSS	Midwives Service Scheme
MRL	Muslim Religious Leaders
MWA	Ministry of Women Affairs
MWAN	Medical Women Association of Nigeria
OCP	Oral Contraceptive Pills
OGP	Open Government Partnership
OQA	Obstetric Quality Assurance
PAC	Post-Abortion care
PACFaH	Partnership for Advocacy in Child and Family Health
PAN	Paediatric Association of Nigeria
PG	Population Groups
PHOs	Poly Hydrogenated Oils
PHO	Partially Hydrogenated Oils
PHCUOR	Primary Health Care Under One Roof
PHC	Primary Health Care
PHCB	Primary Health Care Borad
PPMV	Proprietary and Patent Medicine Vendors
PSA	Public Service Announcement
PSHAN	Private Sector Health Alliance of Nigeria
RI/RFPD	Rotary International
RMNCH	Reproductive, Maternal, Newborn and Child Health
RTSL	Resolve to Save Lives
SDG	Sustainable Development Goals
SDP	Service Delivery Points
SIC	Superintendent of Industry and Commerce
SOGON	Society of Obstetricians and Gynecologists of Nigeria
SURE-P	Subsidy Reinvestment and Empowerment Program
TA Connect	Technical Advice Connect
TB	Tuberculosis
TECCH	Traditional Emirate Council Committee on Health
TSTS	Task Shifting and Task Sharing
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
WB	World Bank,
WDC	Ward Development Committees
WH	Women's Health
WHD	World Hypertension Day
WHO	World Health Organization
WOWICAN	Women's Wing of Christian Association of Nigeria
WRAN	White Ribbon Alliance for Safe Motherhood Nigeria

Executive Summary

The Problem

Women's health outcomes in Nigeria remain amongst the poorest in the world[1] and currently there is very little to suggest that the Sustainable Development Goal (SDG) 3 (to ensure healthy lives and promote well-being for all at all ages)[2] target can be met by 2030. According to the World Health Organisation, a Nigerian woman has a 1 in 22 lifetime risk of dying from pregnancy related causes compared to most developed countries where the lifetime risk is 1 in 4900. As of 2020, Nigeria's maternal mortality ratio (MMR) was 1047 deaths per 100,000 live births despite a 6.6% decline from 2019, making it one of the highest in the African Region. Infection, haemorrhage, obstructed labour, anaemia, unsafe abortion, and hypertensive disorders of pregnancy remain the top drivers. This is complicated by poor access to healthcare facilities and the underutilization of low-cost, effective, and efficient reproductive healthcare services. The leading contributory factors include inadequate human resources for health (aggravated by the recent "Japa syndrome"), delay in seeking care, inadequate equipment, lack of ambulance transportation, and delay in referral services, among others. Nigerian women and girls make up 50.6% of the total population, and the estimated life expectancy at birth is 48.4 years. According to the 2018 NDHS report, in Nigeria, the unmet need for family planning (FP) is 19%, while the prevalence rate of modern contraceptive use is 12% among amongst women who are currently married. The report also showed that in Nigeria, the adolescent birth rate, defined by the number of live births to women aged 15-19 years, was 106 per 1,000 women. The fertility rate was highest in the northwest (6.6 children per woman) and lowest in the southwest (3.9 children per woman). The goal of the scoping assessment was to explore the feasibility and opportunities for joint advocacy and collective action in the women's health space in Nigeria, to facilitate strategic investments.

Policies and Past Interventions

Gaps in women's health, specifically in family planning (FP) and maternal, newborn, and child health (MNCH) in Nigeria, have necessitated programmatic and policy interventions by government and development partners. Although interventions including health advocacy efforts have yielded some results in the improvement of funding and adoption of policies, there are limitations to impact and scale. Limited funding, political alignment, bureaucratic inertia, poor contextual relevance and a siloed approach to advocacy are some factors that have limited the effectiveness and long-term impact of past advocacy efforts. Improving women's health outcomes requires an enabling policy environment, the design of evidence

based programs and the sustained delivery of high quality maternal, newborn and child health (MNCH) interventions. Nigeria's Health Sector Renewal Strategy (2023 – 2026) stipulates a sector-wide approach that 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 with relevant stakeholders, advocacy for policy change, allocation of resources, and establishment of monitoring and evaluation mechanisms at all levels.

Scoping Methodology

We utilized a mixed methods approach to explore the context of women's health and advocacy platforms and provided evidence-driven strategies for the delivery and support of a vibrant women's health joint advocacy in Nigeria. A total of 567 participants (survey=442; KII = 52; MSD = 75; CCW = 48) were drawn from the government, the INGO/NGO, the private sector, communities, faith-based organisations and professional associations in Lagos, Kano, Kaduna and the national level.

Adopting perspectives from two theoretical frameworks – advocacy strategy framework and advocacy coalition frameworks – we reviewed the literature; engaged, surveyed and interviewed stakeholders; and then supported them in the co-creation of contextually relevant, acceptable and practicable recommendations for women's health advocacy coalition typologies in Nigeria. We synthesized evidence from a literature review, key informant interviews and stakeholder dialogues to identify existing joint advocacy typologies. We then applied behavioural insight principles and a multi-layered human-centered design approach to co-create an ideal joint advocacy typology.

Results

We found that across all Foundation priority states (and national level), there was evidence of interest, and past or current actions, in joint advocacy for women's health; approximately 92.3% of the participants reported that their organizations advocated for women's health. However, a significant proportion of advocacy efforts were siloed; 32.8% reported that they implemented alone, while 59.5% implemented as a partnership/consortium /coalition. Furthermore, the majority of advocacy efforts appear to be targeted at demand generation; approximately 93% of the participants reported that their advocacy efforts are focused on awareness creation. Across all states, there are advocacy efforts focused on strategies to increase awareness of FP-RMNCAH and social welfare services (child protection, adoption, psychological and counselling support for GBV, and economic skills development). Much of the awareness-raising, or demand creation effort, was via radio, television and even social media, with radio being the favoured approach is the North of Nigeria. Across all states, regarding advocacy efforts, there are significant evidence of past and existing collaboration and coalition building among partner NGOs, especially CSOs and or CBOs. Each state has three or more typologies of joint advocacy coalitions comprised of CSOs, state governments, faith-based organizations, media, professional associations, academia, local and international NGOs, implementing programs ranging from FP-MNCH, GBV, child protection, and nutrition to child adoption. The most common factor put forward as a challenge to joint advocacy was lack of funding. Second, respondents were unanimous on the role of government (all arms and at all levels - federal, state and local), religious and cultural leaders as key feasibility factors for women's health joint advocacy in Nigeria.

The findings suggest that the participants surveyed had sufficient work experience to understand the gaps and opportunities for advancing WH joint advocacy; 80.5% had worked for greater than 4 years in the WH advocacy space. There is a critical shortage of advocates with requisite skills, and technical capacity gaps exist across all study locations. Approximately 39% of the respondents were from

professions that are not health-related, and there was no indication that they had acquired additional health certifications that would position them better as women's health advocates. Regarding advocacy capacity, there were geographic differences - the incidence of poor communication skills was higher in Kano (79.8%) and Kaduna (67.5%) than in Lagos (36.3%) and national (62.1%). Successful engagement of these actors would go a long way in helping to shift knowledge, attitudes and behaviours regarding women's health, allowing for the creation of an efficient, effective and functional joint advocacy coalition for women's health in Nigeria. In addition, already existing, highly functional, women-led, structures were identified that can be leveraged in implementing women's health joint advocacy typologies that work. Where technical capacity for advocacy is lacking in these structures, capacity can be built through the provision of programmatic technical support from collaborating partners, with the end goals of sustainability and ownership. Finally, we found that advocates for women's health are open to the idea of technological solutions aimed at improving the functionality and efficiency of joint coalition advocacy efforts.

Recommendations

CSOs

- To develop and adopt a clear implementation plan that addresses issues of project phase to ensure continuity, a monitoring and evaluation plan (results-based framework should be prioritized).
- Contextually relevant approaches to women's health advocacy should be adopted.
- Outline roles and responsibilities of key actors.
- Should be set up and managed stakeholder relationship management platform (dashboard) for all women's health advocacy stakeholders.
- Pilot evidence-based initiative activities, adapt and learn.
- Develop and test the mentoring curriculum, the mentoring network's framework and protocols.
- Ensuring consensus building, capacity and systems strengthening activities for coalition members to address major barriers to effective women's health joint advocacy and ensure resilience against opposition and adverse events
- Coalition efforts for women's health should be aligned with the current sector wide approach of the government.
- Ensure the integration of GESI principles while ensuring a women-led approach and diversity (including male and social inclusion).

Government

- Political commitment to women's health.
- Policy champions at the national level
- Alignment of government priorities to evidence
- Enabling policy environment
- Host and an provide enabling environment for stakeholder relationship management platforms.
- Develop a clear charter (or memorandum of understanding), ensuring

integration of the GESI principles.

- Participatory institutional dialogue at different levels within the ecosystem should be led to design and co-create a strategic plan and roadmap that reflects a phased approach to institutional and systems change.
- Family health departments should be established, and the national health promotion policy, and other relevant policies should be established at the sub-national level for better coordination of women's health joint advocacy.
- Collaborate with the Nigeria Universities Commission to institutionalize first-degree courses in health promotion.
- Framing women's health programs reflects cultural sensitivity and larger development goals. Adopt a human-centered approach to advocacy.

Donors

- The adequacy, sustainability, coverage, and flexibility of funding for women's health advocacy should be prioritized.
- Explore more collaborative opportunities to scale impacts
- Use evidence to inform investments
- Ensure inclusion and transparency
- The situational analysis/stakeholder and network mapping of participating coalitions should be ensured prior to implementation.
- Support set up of family health departments and domesticate the national health promotion policy, and other relevant policies, at sub-national levels for better coordination of women's health joint advocacy.

Conclusions

There is a consensus that advocacy coalitions are impactful for facilitating collective action in the advancement of women's health. To ensure that advocacy programs are successful, it is important to deploy contextually relevant approaches that build strongly aligned coalitions, strengthen capacities, mobilize effective multi-sectoral partnerships, engage powerful allies in government and leverage sustainable funding models for subnational and national level impact. There is strong evidence that designing joint advocacy programs and interventions in Nigeria may require a hybrid of the government-led multi-sectoral and CSO-led advocacy coalition typologies described in this review. Such a coalition must be fully aligned with the sector wide approach to health programming of the Nigerian government to ensure sustainability and ownership.

1. Background

1.1 Introduction

Women's health (WH) outcomes in Nigeria remain amongst the poorest in the world[1] and currently there is very little to suggest that Sustainable Development Goal (SDG) [3] (to ensure healthy lives and promote well-being for all at all ages)[2] targets can be met by 2030. Women's health needs are complex and multifaceted. Advocacy provides a platform for stakeholders to draw attention to important issues and engage policymakers in evidence-based policy change, resource mobilization and social change. Gaps in women's health, specifically in family planning (FP) and maternal, newborn, and child health (MNCH) in Nigeria have necessitated programmatic and policy interventions by government and development partners. These interventions include: the National Strategic Health Development Plan II (NSHDP II), the National Health Insurance Scheme (NHIS), the National Family Planning Program, and the Safe Motherhood Initiative. Despite these interventions, women continue to bear a disproportionate burden of morbidity and mortality. Although interventions including health advocacy efforts have yielded some results in the improvement of funding and adoption of policies, there are limitations for impact and scale. Limited funding, poor political alignment, bureaucratic inertia, poor contextual relevance and a siloed approach to advocacy have limited effectiveness and long-term impact of past advocacy efforts. Improving women's health outcomes requires an enabling policy environment, the design of evidence-based programs of evidence based programs[3] and sustained delivery of high-quality Maternal, Newborn and Child Health (MNCH) interventions.[4]

Although some large-scale projects that sought to advance advocacy for WH issues, such as the Partnership for Advocacy in Child and Family Health (PacFaH) and the Health Policy Project recorded success, there are gaps related to long term sustainability. Advocacy projects mobilize collective action from interest groups, technical working groups, and coalitions such as the Association for the Advancement of Family Planning (AAFP); long term impact is a major challenge due to a lack of post funding sustainability plans, a lack of integration and a lack of sustained political will.

The recent communique issued by the Federal Ministry of Health and Social Welfare at the end of the 64th National Council on Health held in November 2023 was centered on building resilient and inclusive health systems to improve population health outcomes including women's health.[6] Recommendations were made for the adoption and implementation of maternal, infant and young child nutrition training courses at state and LGA levels.[6] Nigeria's Health Sector Renewal Strategy (2023 – 2026)[7] stipulates a sector-wide approach that 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 with relevant stakeholders, advocacy for policy change, allocation of resources, and establishment of monitoring and evaluation mechanisms at all levels.[7]

This scoping assessment seeks to provide answers to core questions on women's health advocacy in Nigeria, with a focus on FP and MNCH advocacy. To improve women's health, it is important to understand the Current health advocacy efforts, the results they have yielded, and the mechanisms of effectiveness and policy windows that can be leveraged. The scoping assessment also explored lessons to be drawn from regional and global advocacy efforts to understand operational modalities, best practices, and sustainability models. The lessons learned guided the design of plausible models of women's health joint advocacy and collective action.

1.2 Scoping assessment goals

The goal of the scoping assessment was to explore the feasibility and opportunities for joint advocacy and collective action in the women's health space in Nigeria to facilitate strategic investments.

1.3 Scoping assessment objectives

To capture evidence, program and policy gaps, lessons learned, and oppurtunities from Nigeria around bringing diverse advocates/advocacy sectors for joint advocacy under common goals (and applicable lessons from beyond Nigeria)

To identify opportunities for WH advocacy in Nigeria, and specific foundation priority FP, MNCH areas, tactics, policy and funding goals where joint advocacy would have a unique value add or benefit on accelerating progression the foundation strategic priorities.

To map existing relevant mechanisms/platforms working groups and communities of practice for WH advocacy. Synthesize evidence to understand the dynamics of advocacy (structure, processes, engagements, and success stories), integration of gender equality and social inclusion principles, lessons learned for the future of women's health policy advocacy coordination in Nigeria.

To identify key recommendations for foundation investment, including a strategic approach, structure, tactics, and partners for the WH Advocacy pillar, Propose alternative options if an advocacy hubs isn't identified as the best option for achieving foundation priorities

1.4 Theoretical underpinnings

Effective advocacy requires careful planning and the mapping of key actors, interest groups, political interests and opposition arguments. The policy process can be understood through different perspectives, Including incrementalism, the multiple streams framework, the advocacy coalition framework and punctuated equilibrium.[8] This review adopts the advocacy coalition framework of Sabatier (1988) which explains that policies emerge and change through the activities of policy subsystems.[9] A policy subsystem is the interaction of actors from different institutions who are interested an issues such as women's health and are defined by policy topics, territorial scope and the actors who influence the affairs of the subsystems directly or indirectly. These actors are organized into coalitions that employ strategies to influence decision-makers and policy outcomes. Opposition coalitions may exist to push back efforts by one coalition. As there are advocacy coalitions that work on the side of government, there may be opposition advocacy coalitions with alternative insights and criticisms.[10] The compromise resulting from the activities of opposing coalitions[8] (which often leads to policy middle grounds) and external events may result in policy change and consequently interventions.[9] The framework holds that public policies are similar to belief systems, with value priorities and assumptions on how to achieve the priorities.[9]

A major tool employed by coalitions to influence policymaking is advocacy. Advocacy itself has been defined variably. In one definition, advocacy is seen as "action to increase awareness of health issues, including issues that receive insufficient attention; to change behavior in the interest of public health; and to foster collaboration and greater coherence between non-State actors where joint action is needed."[11] It is a combination of actions aimed at gaining political commitment, public support, social acceptance, and systems support for a particular policy or intervention.[12] In advocacy, actors apply information and resources such as funds, effort, and votes, to bring about change in the system to influence people's lives.[13] For advocacy to have a far-reaching impact, advocates need to promote strategies for effective

policy change or interventions at both the local and national levels in multilevel political systems. In addition, they need to create an enabling environment for community health and well-being through media, legislation or community engagement efforts.[14] Health policy advocacy involves representing vulnerable populations, community development, activism and policy reform.[15] When successful, advocacy that influences public policy improves individual and community health, which reduces health disparities. Advocacies of this nature serve as a guide for health policy goals and drive the passing of priority legislation. Health policy advocacy also secures necessary funding for the implementation of new policies enacted for the good of society.[16]

In addition, we utilized the advocacy strategy framework to explore the diverse mechanisms of change, non-linear interaction of actors in the advocacy process, project strategies, interim outcomes and impact of advocacy interventions.

Figure 1: Advocacy strategy framework

The framework analyses the main actors that the policy advocacy strategy targets and the changes (awareness, political will and action) that result from the application of these strategies. The framework defines the main actors required to advance the policy goal, the positioning of the policy issues and approaches for community organization, coalition building and coordinated action. Shared ideology, that is policy-relevant values and beliefs, is the primary driver of joint advocacy within policy subsystems. Often, policy champions strategically avoid actors perceived to hold values and beliefs that are incongruent with their core values and beliefs.[17,18]

We analysed different advocacy models in Nigeria and regionally to understand what works and in which context. The theoretical frameworks applied in this review guided recommendations for strategy options to consider for WH advocacy coalitions in Nigeria. To facilitate recommendations on a nuanced, targeted and sustainable model, we analysed critical success factors at the national and subnational levels.

2. Methodology

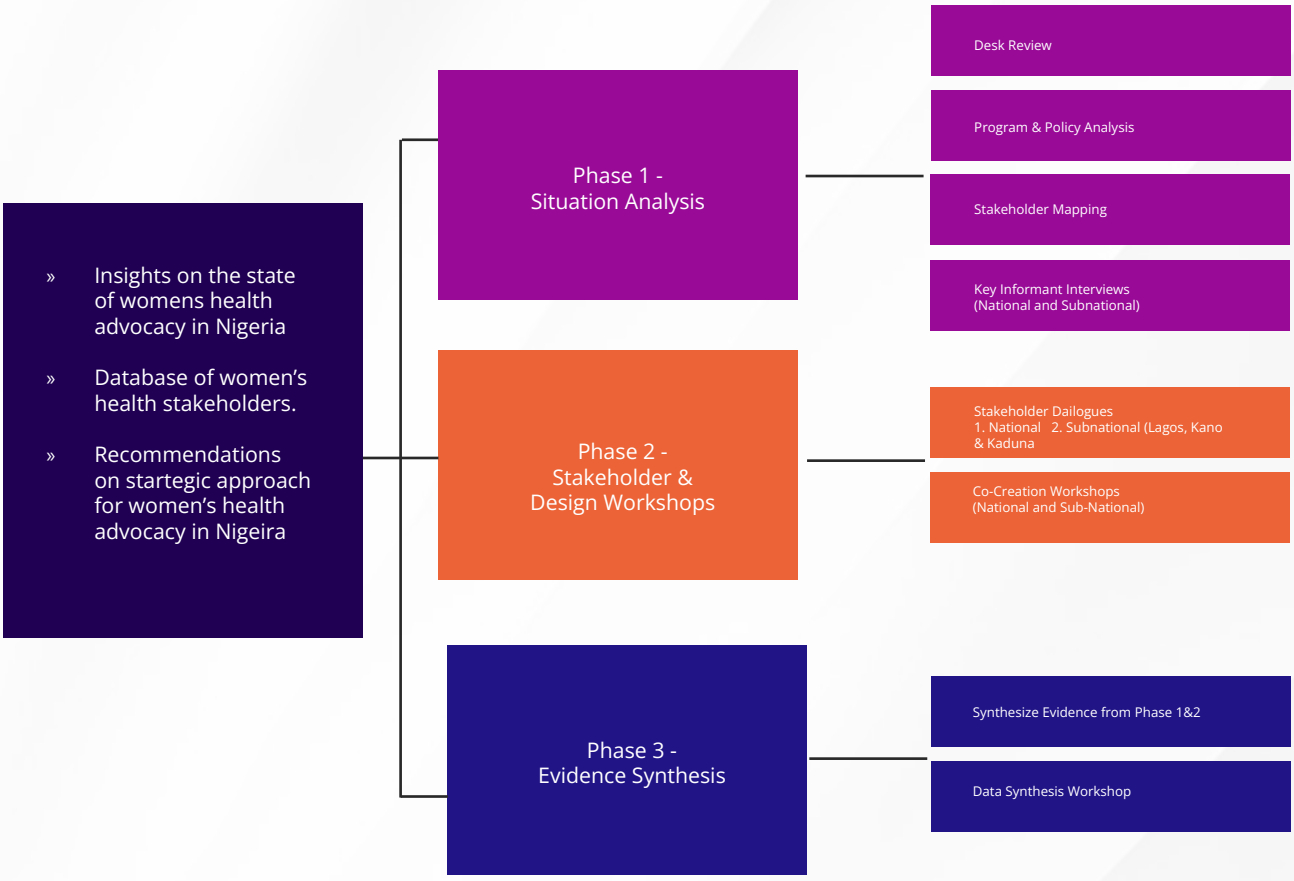
2.1 Study area

The scoping assessment was conducted in three of the Foundation's priority states (Kano, Kaduna, and Lagos) and National. Lagos State is in the south-western part of the country while Kano and Kaduna are in the north-western part of Nigeria. The National comprised the ministries, departments, agencies, professional associations, media, private sector, and national and international non-governmental organizations working in or supporting women's health advocacy.

2.2 Study design

We utilized a mixed methods approach to explore the context of women's health and advocacy platforms and provided evidence-driven strategies for the delivery and support of a vibrant women's health joint advocacy in Nigeria. The scoping was conducted in three-phases. Phase one involved an extensive literature review documenting the landscape and context of women's health in Nigeria. Stakeholder mapping was conducted to identify and document key stakeholders and experts involved in women's health joint advocacy efforts at the national and subnational levels. Key informant interviews and short surveys were conducted to further elicit information on the status, gaps, and opportunities for advancing women's health priorities. Phase two involved a stakeholder consultative approach, comprising phased multi-stakeholder dialogues (MSDs) and co-creation workshops, based on human-centred design principles, with relevant stakeholders. In phase three, we synthesized evidence from phases one and two and the output was used to develop important insights and recommendations for advancing women's health joint advocacy and collective action in Nigeria.

Figure 2: Study design



2.3 Scoping participants

A total of 567 stakeholders were engaged across three states and the national throughout the phases of the scoping review.

The scoping participants were drawn from government, the INGO/NGO, the private sector, communities, faith-based organisations and professional associations in Lagos, Kano, Kaduna and national level.

Figure 3 below shows a breakdown of the participants in relation to the goal of the engagement.

Figure 3: Cross section of the scoping participants

Of the total number of participants, 45.2% were from the public sector, while 32.4% not-for-profit actors. The private sector, faith-based, and professional associations accounted for 4.9%, 5.2%, and 4.4%, respectively.

Co-creation was conducted centrally in Abuja, drawing participants from all the states and national level, comprising a two-day human-cantered design and behavioural science approach.

Table 1: Breakdown of stakeholders engaged by state and by sector

Sector	Lagos			Kaduna			Kano			National			CCW
	Sur	KII	SD	Sur	KII	SD	Sur	KII	SD	Sur	KII	SD	
Govt	49	3	5	58	6	7	84	7	8	48	2	9	18
NGO / CSO	44	4	3	37	5	5	29	7	1	49	5	5	25
Private Sector	0	0	0	19	0	1	3	2	0	3	0	0	1
Faith Based	0	1	7	0	2	8	0	2	3	0	2	8	0
Prof Assoc	9	1	0	4	0	2	3	0	0	3	3	0	2
Media	0	0	1	0	0	0	0	0	0	0	0	0	1
Donor	0	0	0	0	0	0	0	0	0	0	0	0	1
Total	102	9	16	118	13	23	119	19	12	103	12	22	48

2.4 Data collection methods

Desk reviews

Guided by the advocacy coalition and advocacy strategy frameworks, this review explored existing initiatives, policies and programs developed in response to women's health advocacy efforts. We conducted a policy analysis to examine the differential effects of national and subnational policies on women's health and the extent to which policies address health inequities across diverse populations of women. We explored policy advocacy pathways that facilitated the policy development process to understand what works in relation to policy advocacy, the gaps, opportunities, and sustainability. This review further examined the social and political context in which women's health policies are developed, implemented, and experienced. The best practices for women's health advocacy were explored, focusing on gender transformative insights and gender-inclusive solutions for future policy response. We documented lessons regarding what works (and what does not work) within the Nigerian context and used the evidence in designing sustainable joint advocacy models.

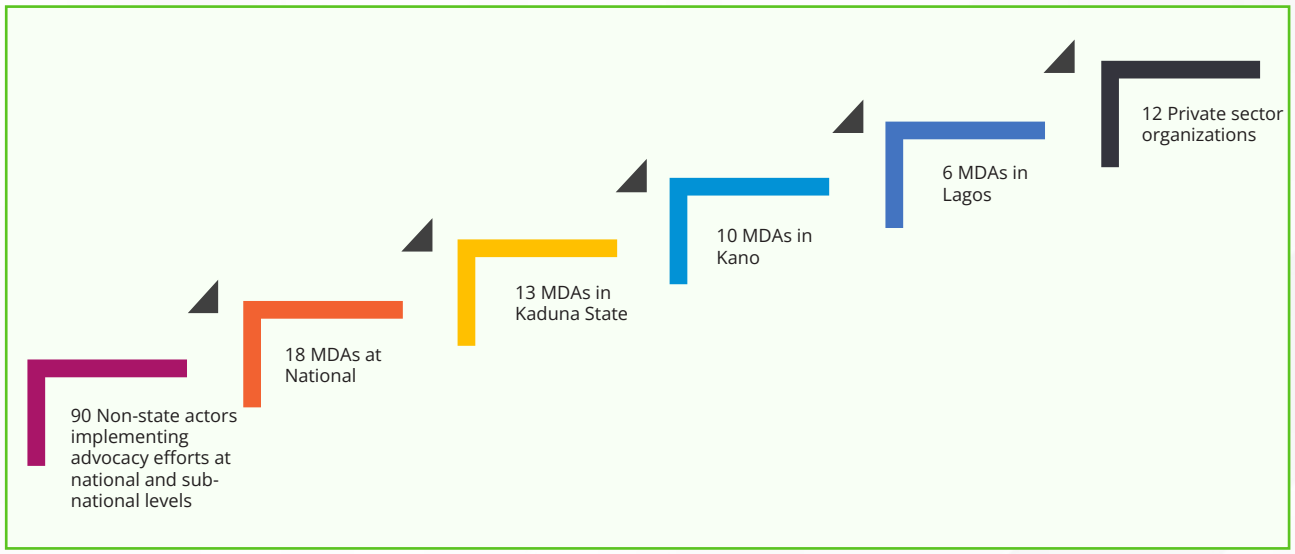
Stakeholder engagement and mapping

Multipronged comprehensive stakeholder mapping was conducted to identify all ecosystem actors working in the women's health advocacy space in Nigeria. Using a snowballing approach, we conducted a systematic, multi-level stakeholder engagement to map women's health advocacy partners, including national and international non-governmental organizations, community-based organizations, and government stakeholders at national and sub-national levels.

The map culminated in a stakeholder relationship management virtual dashboard that serves as a directory and advocacy tool for women's health in Nigeria. It provides a real time interactive platform and analytics for existing and future women's health stakeholders. In designing the dashboard, privacy, security, scalability and interactivity were prioritized.

Webpage - ***https://www.womenshealthnigeria.com/***

Figure 4: Stakeholders map



Survey

We conducted a brief survey to capture structured information on women's health-focused platforms, initiatives and organizations. The survey provided information on interventions, leadership structures, diversity, operational models, implementation challenges, collaboration opportunities, capacity gaps (including gender mainstreaming, stakeholder engagement, and fundraising), and government systems strengthening efforts.

The participants included representatives of civil society organizations (CSOs), state-level and federal-level staff of ministries of health and primary health care board (PHCB), representatives of non-governmental organizations (NGOs), professional associations, the private sector, health care service providers, religious leaders from the two major religions in Nigeria (Islam and Christianity), representatives of people living with disability (vulnerable populations), and community-level ward heads.

2.5 Data analysis

We analysed the qualitative data with NViVo 12 and the survey with SPSS version 23. Guided by constructs derived from the Advocacy Strategy Framework, we examined the qualitative data for insights into women's health advocacy efforts centred on the following five broad themes:

1. Awareness creation strategies – These strategies include activities such as public awareness campaigns and programs aimed at sensitizing and educating decision makers, key influencers and the public, via public demonstrations, rallies, parades, presentations, town hall meetings, public polling and various accountability mechanisms.

2. The outcomes of joint advocacy - including:

- Collaboration among partners
- Coalition/Advocacy capacity building
- Successful mobilization of key voices
- Policy change, Legislation or Regulatory feedback
-

3. Gender Equity and Social Inclusion (GESI) - which includes evidence of awareness, consideration and action regarding opportunities for the integration of the GESI in advocacy efforts for FP and MNCH, as well as evidence indicating barriers to/challenges of GESI integration.

4. Key factors influencing the feasibility of joint advocacy for FP+MNCH - These are factors that either advance or inhibit women's health advocacy. They include national and subnational MDAs, private sector NGOs, enabling laws and policies, religious teachings/ doctrines, cultural norms, availability of necessary funding etc.

5. Lessons learned from the implementation of past programs and policies - refer to missed opportunities for joint advocacy and suggestions for future advocacy strategies, and viable entry points that can be leveraged for women's health joint advocacy.

2.6 Ethical considerations

Ethical approval was obtained from the National and State Health Research Ethics Committee. In addition, social clearance was obtained to conduct research within each of the three states. Informed consent was obtained from all participants and the study procedure ensured privacy and confidentiality at all levels with the full right to participate or decline participation without consequences. All researchers received training on the ethical conduct of research and risk mitigation.

3. Results

3.1 Evidence from the Literature

3.1.1 Policy and Program Response for FP and MNCH in Nigeria

3.1.1.1 Women's Health Profile in Nigeria

The highest attainable standard of health is the fundamental right of every human being, regardless of gender, religion, political beliefs, the economic or social situation. This right is applicable to WH needs, defined by six major indicators as described in Table 2.[19,20] In 2023, Nigerian women and girls constituted 50.6% of the total population, with life expectancy at birth estimated at approximately 54.6 years.[21] According to the 2021 multiple indicator cluster survey (MICS) only approximately 43% of women aged 15-24 years are literate and the proportion of women aged 15-49 years with at least one live birth is 25.3%.[19]

Table 2: Six major indicators of women's health needs

Maternal Health

This includes maternal mortality ratio, prenatal care coverage, skilled birth attendance, postnatal care coverage, and usage of family planning services).

Child Health

Including infant and child mortality rates, vaccine coverage, and the prevalence of childhood illnesses such as diarrhea and acute respiratory infections.

Reproductive Health

This includes contraceptive prevalence, unmet need for family planning, fertility rates, and age at first marriage

Sexual Health

Prevalence of sexually transmitted infections, knowledge of HIV/AIDS prevention methods, and use of HIV testing and counselling services)

Nutrition

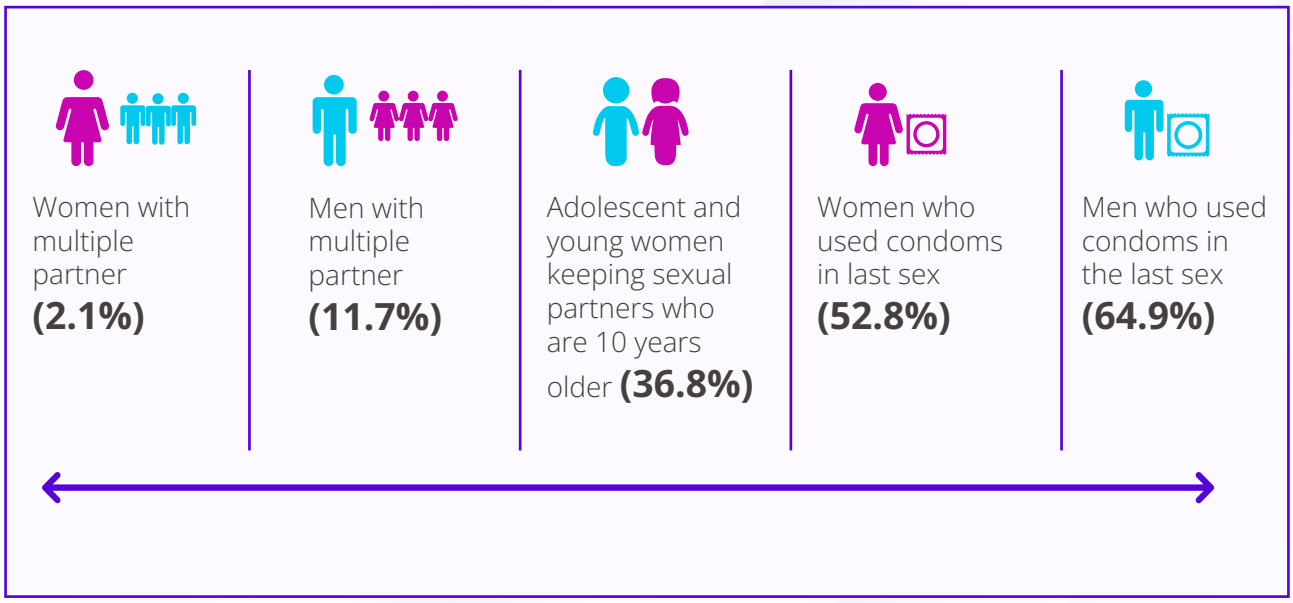
Including maternal and child nutritional status, anaemia prevalence, and breastfeeding behavior

Gender-Based Violence

Experience of violence including physical, sexual, economic, & emotional/ psychological, help-seeking by victims of GBV, child/forced marriage & female genital mutilation.

The sexual health indices among men and women aged 15-49 years show that men are more likely to have multiple sexual relationships than women (Figure 5). Compared to men, women are more likely to have sex with a partner 10 or more years older and less likely to use a condom at the sex.[19,22]

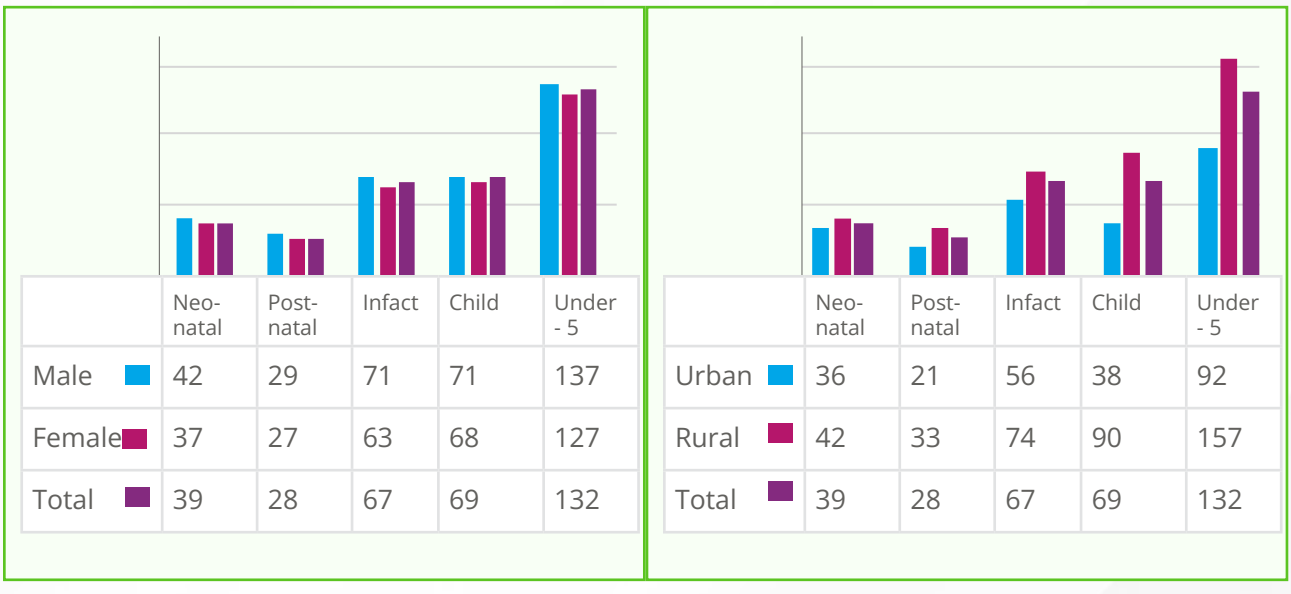
Figure 5: Reproductive health indicators



3.1.1.2 Nigeria's MNCH Profile

In Nigeria, under-five and maternal mortality are attributable to poverty – highest in the lowest and second lowest wealth quintiles. Under-five mortality rate is 132 deaths per 1,000 live births, which is greater in the rural areas than in urban areas. Fig. 6 shows the gender and geographic differentials in early childhood mortality.

Figure 6: Under-five mortality rate (5-yr period)



	Neo-natal	Post-natal	Infact	Child	Under - 5
Male	42	29	71	71	137
Female	37	27	63	68	127
Total	39	28	67	69	132

	Neo-natal	Post-natal	Infact	Child	Under - 5
Urban	36	21	56	38	92
Rural	42	33	74	90	157
Total	39	28	67	69	132

Nigeria's reproductive and maternal health indicators continue to worsen, making it difficult for the country to reach health-related SDGs. Women have 54.5 years estimated of life expectancy at birth.

The 2018 demographic and health surveys indicate that Nigeria's maternal mortality ratio (MMR) was 512 deaths per 100,000 live births despite a 6.6% decline since 2013. As of 2020, Nigeria's maternal mortality ratio (MMR) was 1047 deaths per 100,000 live births despite a 6.6% decline from 2019, making it one of the highest in the African region. Only approximately 70% accessed antenatal care at least once by a skilled provider.

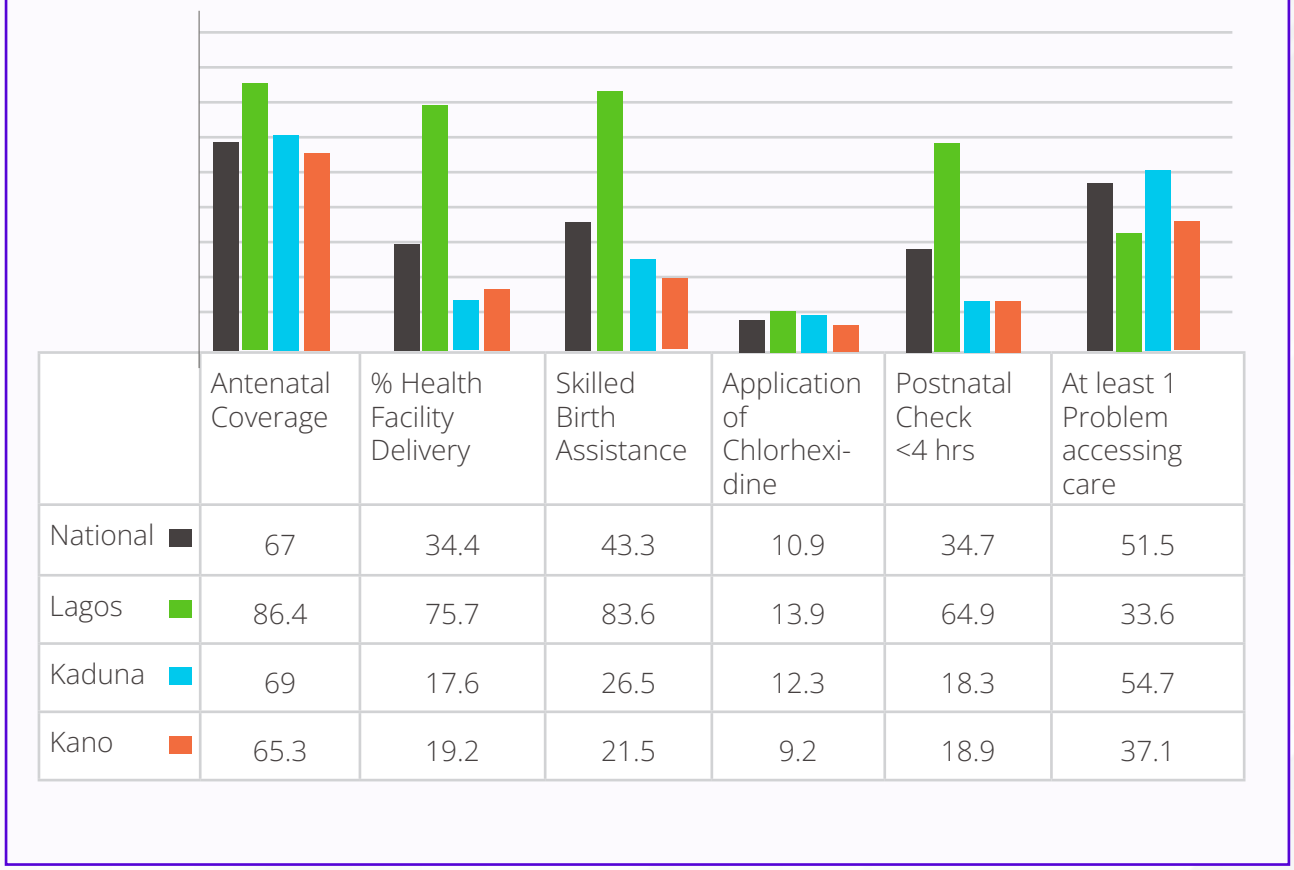
Hemorrhage, obstructed labor, anaemia, unsafe abortion and hypertensive disorders of pregnancy remain the top drivers, complicated by poor access to healthcare facilities, inadequate human resources for health, delays in seeking care, inadequate equipment and delays in referral services. Women's education continues to play a role in increasing maternal mortality.

The adolescent birth rate, defined by the number of live births to women aged 15-19 years, was 106 per 1,000 women, according to NDHS 2018. On average, Nigerian women have, 0.5 more children than they want, and 8% of current pregnancies are untimed, while 3% are unwanted.20 Nigeria's predominant fertility and mortality patterns have resulted in a young population structure, where more than 40% of the current population are children under the age of 15 years.

The fertility rate is highest in the northwest (6.6 children per woman) and lowest in the southwest (3.9 children per woman).[20] A recent study on fertility in Africa by region revealed a pooled total fertility of 5.4 children per woman,[50] similar to the total fertility in Nigeria (5.3 children per woman).

There is a wide gap in antenatal care coverage for women - only approximately 70% of women antenatal care at least once by a skilled provider, and a smaller proportion of women complete at least four antenatal visits (Figure 7). Institutional delivery (defined by delivery in a health facility) and delivery attended by skilled birth attendants remain low.[20] These statistics show a high loss to follow-up and suggest that women who drop out of antenatal care visits may patronize faith-based service providers and traditional birth attendants, or deliver at home.[51,52,53] Women face myriads of problems accessing care, including getting permission to go for treatment, finance, distance to the facility, and not wanting to visit the facility alone. These challenges highlight the dire need for joint advocacy to scale up access to FP and ANC services.

Figure 7: MNCH indicators

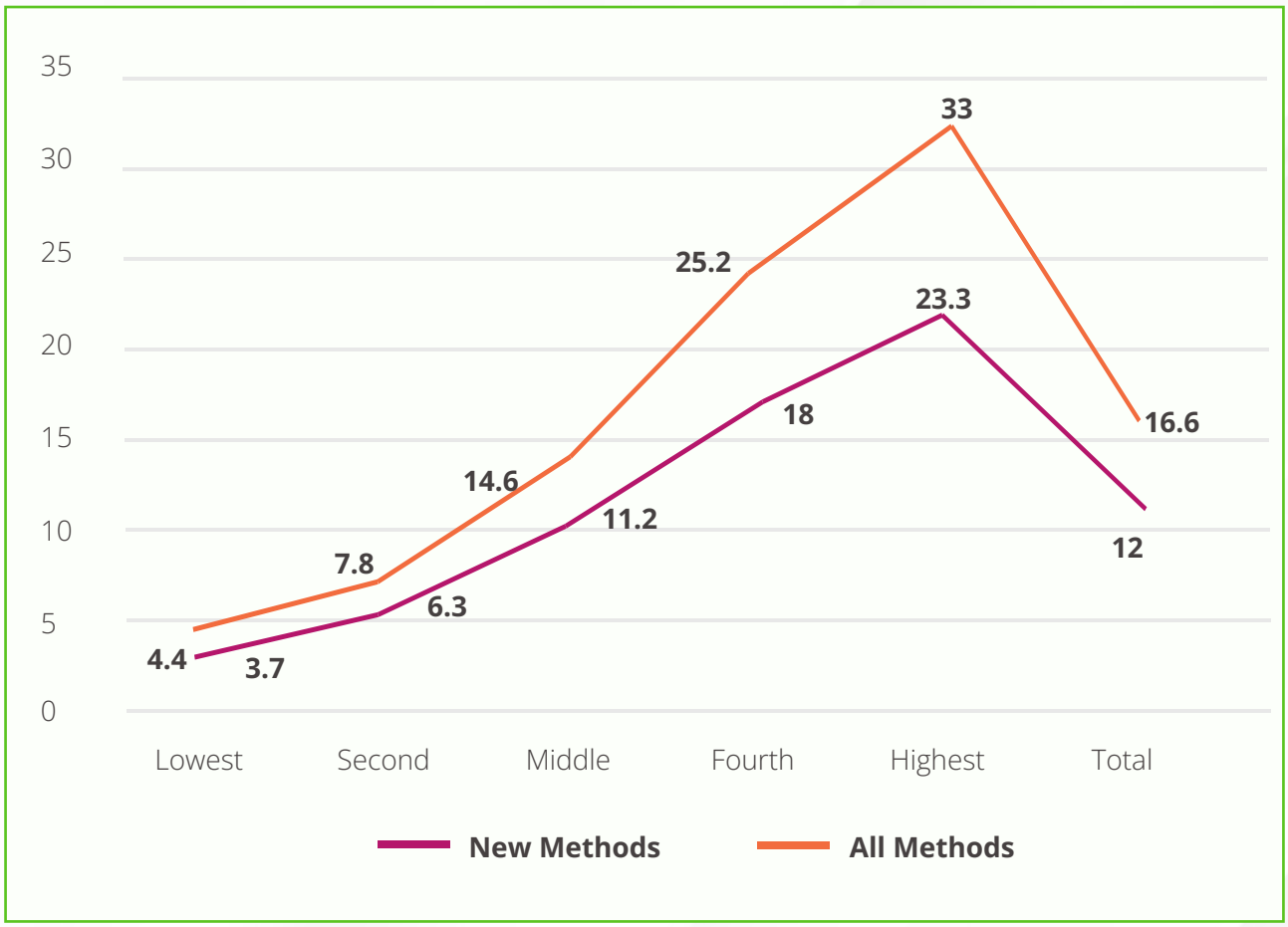


	Antenatal Coverage	% Health Facility Delivery	Skilled Birth Assistance	Application of Chlorhexi-dine	Postnatal Check <4 hrs	At least 1 Problem accessing care
National	67	34.4	43.3	10.9	34.7	51.5
Lagos	86.4	75.7	83.6	13.9	64.9	33.6
Kaduna	69	17.6	26.5	12.3	18.3	54.7
Kano	65.3	19.2	21.5	9.2	18.9	37.1

3.1.1.3 Nigeria's Family Planning Profile

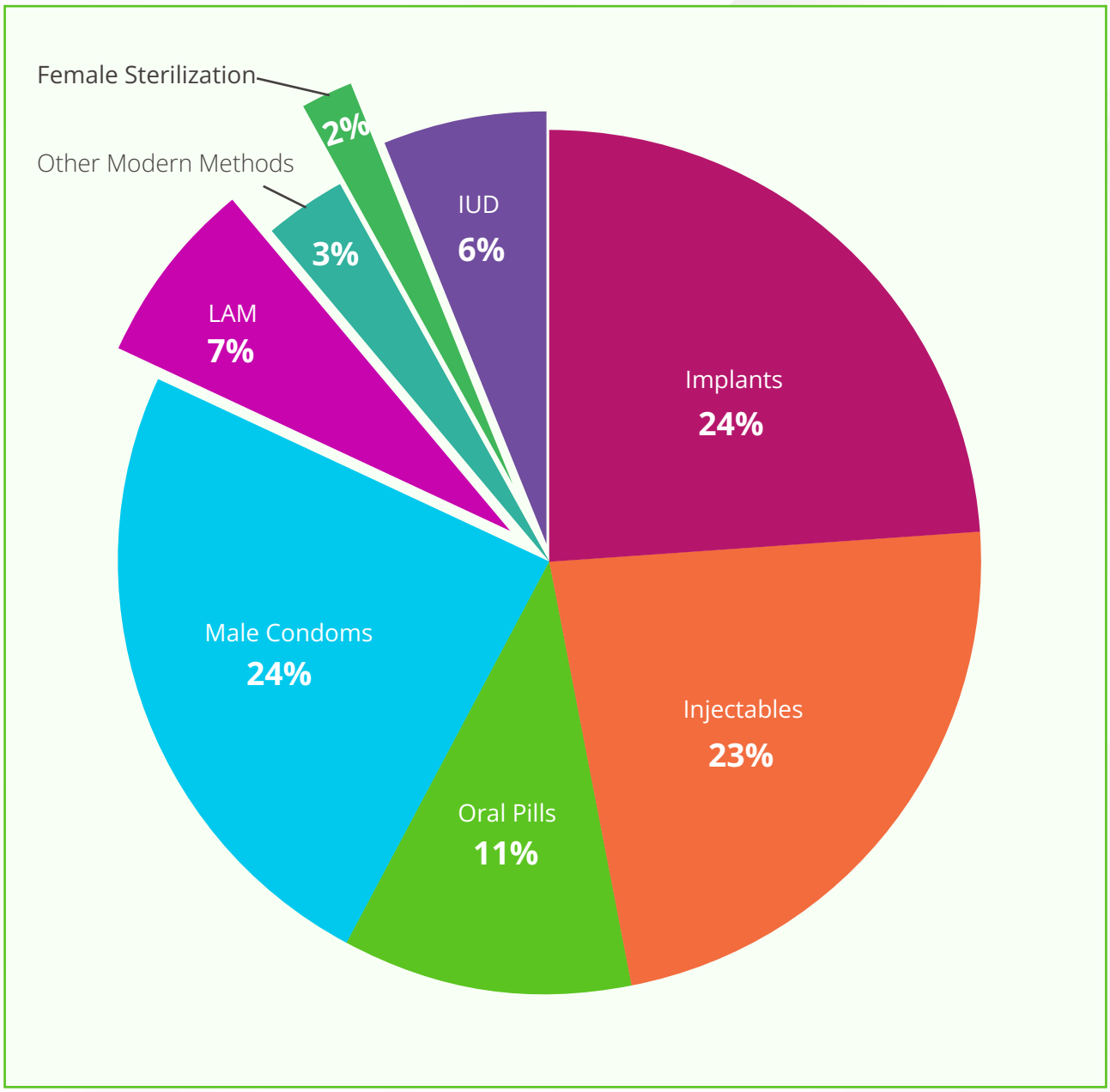
Nigeria's family planning (FP) profile remains sub-optimal (Figure 8). Although there has been an increase in the use of modern contraceptive methods since 2012, findings from the 2018 NDHS indicate that only 47% of the potential demand for FP was met.[20] The total unmet need was 19%, with geographic differentials (that is, greater unmet needs in urban locations than in rural areas across all regions of the country). The unmet needs were also highest among the poorest wealth quintile, relative to wealthier population groups.[20]

Figure 8: Met need for FP according to wealth quartile in Nigeria (adapted from NDHS2018)



The current method mix for FP in Nigeria include the use of intrauterine devices (IUDs), implants, injectables, oral contraceptive pills (OCPs), barriers, and natural and sterilization methods as shown in Figure 9. The FP2030 Annual Progress Report (2020-2021) shows that implants, injectables and male condoms are the most preferred methods.

Figure 9: Met need for FP according to wealth quartile in Nigeria (adapted from NDHS2018)



The 2021 Multiple Indicator Cluster Survey indicated a low contraceptive prevalence rate (21.7%) among women aged 15-49 years who are currently married or in a union or whose partner is using any method of contraceptives.[19] This indicates slow progress compared to the 17% prevalence rate documented in the 2018 NDHS.[20] Similarly, the prevalence rate of modern contraceptives was 18.2% among currently married women, which was slightly higher than the 2018 NDHS rate (12%).

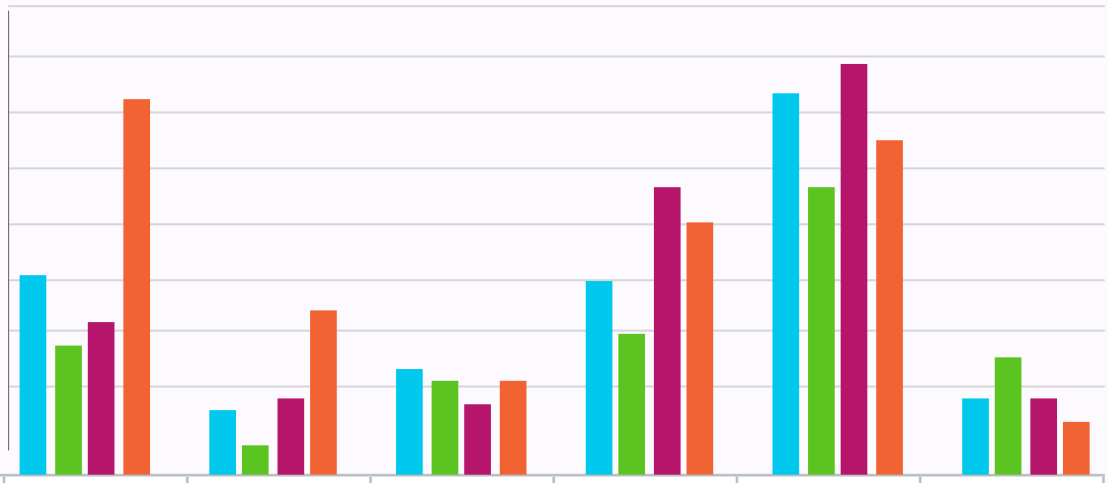
Among currently married women (or who are in a union), 39.9% have their needs for family planning satisfied with modern contraceptive methods.[20]

Among currently unmarried women or women who are not in any union, the contraceptive prevalence rate (any method) was reported to be 35.9% while the modern contraceptive prevalence was 32.5%.[20] The statistics are greater among currently unmarried women compared to currently married women.

Factors such as parity, fertility desire, mother's education, socio-economic status, marital status, place of residence, costs, religion, cultural norms, family size, male partner influence, and health provider behavior influence modern contraceptive use.[20,23,24,25]

Studies in other African countries such as Ethiopia, Ghana, and Kenya have reported similar findings.[26, 27,28,29] A close look at the priority areas (National, Kano, Kaduna, and Lagos) showed variable outcomes.[20] While Lagos had the highest modern contraceptive rate (36.6% for married women and 55.7% for unmarried women), Kano and Kaduna showed zero prevalence among unmarried women. The unmet needs in Kano and Kaduna remained greater than those in Lagos and National. A recent systematic review of twenty FP studies in Nigeria showed that FP uptake ranges from 10.4% to 66.8%, highlighting difficulties in accessing services and procurement processes as barriers[30] Disappointingly, high level knowledge about contraceptives[20] has not translated to high uptake. Figure 10 describes the FP profile in the focal states of this review (that is National, Kano, Kaduna and Lagos).

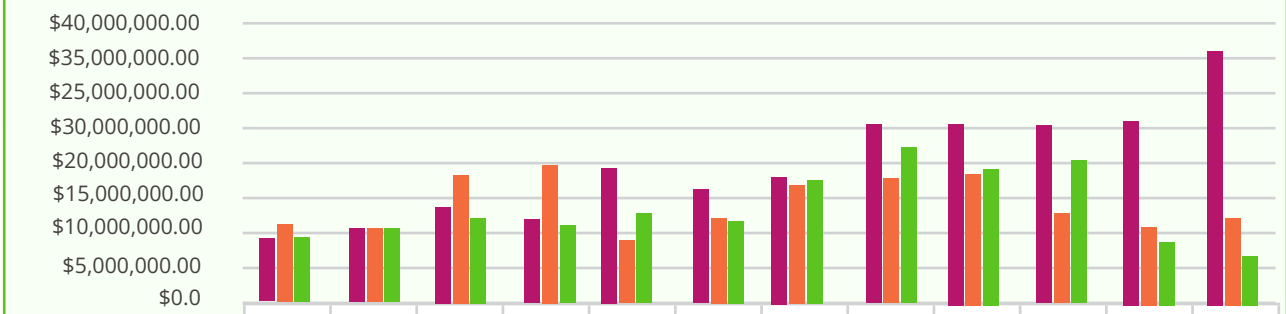
Figure 10: Family planning profile in the priority areas (National, Kano, Kaduna, and Lagos)



	Total demands for FP (All Methods)	Married women and sexually active unmarried currently using any modern method of FP	Unmet need for FP (Currently married)	% Deman dor modern FP satisfied with (currenlty married)	Decision making to use FP (joint husband & wife)	% Women not using FP but visited health facility in the past 12 months to discuss FP
National	35.5	12	18.9	33.9	66.3	13.9
Kano	22.8	5.6	16.5	24.7	50.9	20.6
Kaduna	27.2	13.7	12.3	50.6	71.4	13.4
Lagos	65.9	29	16.5	44.1	58.2	9.3

Over the years, FP services have been supported and funded by the Federal Government of Nigeria through the Federal Ministry of Health (FMoH) and development partners such as United Nations Populations Fund (UNFPA), The Foreign, Commonwealth and Development Office (FCDO), the Department of Foreign Affairs, Trade and Development /Global Affairs Canada (DFATD/GAC) and the United States Agency for International Development (USAID) (Figure 11). Partners contributed 80% a or more to the basket funds for FP/RH commodities.

Figure 5: Trends in funding requirement, pledge and disbursement in Nigeria.[31]



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Funding Requirement	$8,853	$10,861	$14,63	$11,889	$19,754	$15,353	$17,855	$26,270	$26,270	$25,982	$26,510	$35,360
Pledged	$10,595	$10,712	$19,001	$20,142	$7,4977	$12,018	$15,026	$17,126	$18,834	$13,231	$11,353	$12,462
Disbursement	$8,853	$10,861	$11,902	$10,744	$13,263	$11,901	$17,138	$22,443	$19,763	$20,637	$8,314	$7,873

To ensure sustainable financing for FP commodities/services in Nigeria and to reduce donor dependency,[31] especially in the face of dwindling foreign aid, it is imperative to increase domestic financing for FP commodities and services.

FP provision (excluding commodity costs) seems to fall to the state and the funds required to transport commodities and consumables to service delivery points (SDPs) are not available. Lagos State officially disbursed funds directly for FP services, but this was still insufficient to meet the required needs. Thus, states lacking donor funded projects are severely limited in providing FP services and commodities through the public health system. This will ultimately affect the financing of FP for Local Government Areas (LGAs) which depend on budgets released by states and are responsible for managing primary health centers (PHCs).

The provision of additional funding for FP at the provision of levels will be a critical part of expanding access to, and use of, contraception across Nigeria. This can be achieved by implementing the FP2030 commitment to "improve financing for FP by leveraging both existing and additional innovative domestic mechanism", which will improve financing for FP by ensuring the allocation of at least 1% of the annual national and state budgets to health. The National Guidelines for State-Funded Procurement of Family Planning Commodities stipulate that 7% of the total cost for the procurement of FP commodities should be allocated for last-mile distribution.

3.1.2 Family Planning Programs and Policies in Nigeria

The FMoH has made substantial efforts to create an enabling policy environment for FP through the development of several FP specific policies, guidelines, and protocols, comprising:

- National Policy on Free Family Planning Commodities (2011)
- National Guidelines for State funded Procurement of Family Planning Commodities
- Basic Healthcare Provision Fund
- Nigeria Family Planning Blueprint (2020 – 2024)
- National Guidelines on Self-Care for Sexual Reproductive and Maternal Health (2020)

- National Hormonal Intrauterine Device (H-IUD) Introduction and Scale-up Plan (2021 – 2024)

There are clear linkages between FP and maternal mortality through a reduction in the number of high-risk and high-parity births and unwanted pregnancies that could have resulted in unsafe abortions.[30] Evidence from the 2018 NDHS shows a decline in the pregnancy-related mortality ratio and a slight increase in contraceptive prevalence rate compared to previous years.[20] However, pregnancy related mortality ratio remains high (512 deaths per 100,000 live births).[20] There are global debates that FP programs are linked to human capital development as enshrined in the sustainable development goals.[32,33,34,35,36]

3.1.2.1 FP 2020 and FP 2030

In July 2012, many countries convened for the London Summit on Family Planning in pursuit of the goal of ensuring that an additional 120 million women and girls in the 69 poorest countries in the world have access to effective family planning information and services by the year 2020.[35] Family planning stakeholders at the summit, including the government of Nigeria, donors, civil society and the private sector, committed to tackling issues affecting women's reproductive health.

As an outcome of the commitment made, a global partnership, "Family Planning 2020" (FP 2020) was initiated to support the rights of women and girls to decide freely on matters relating to their reproductive health – whether, when, and how many children they want to have.

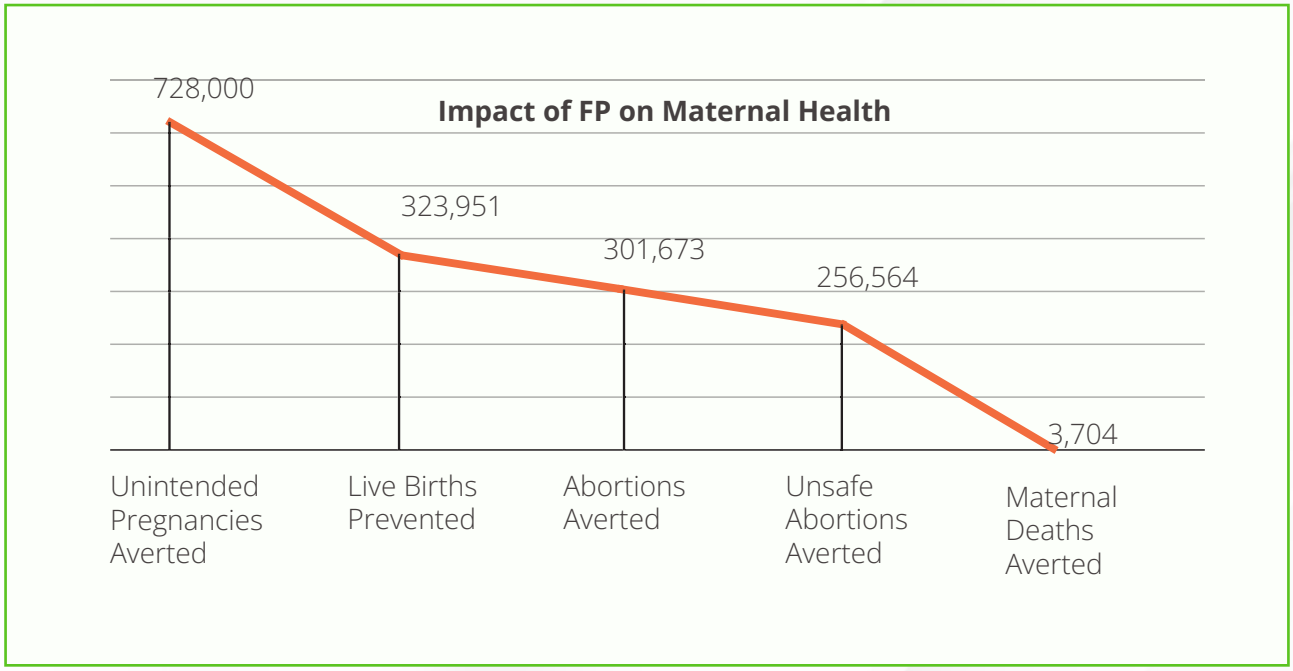
The FP2020 commitment extends to the lifesaving benefits of modern contraception and contributes to the achievement of the SDGs. It is a critical benchmark on the global path to universal access by 2030.[37] To fulfil its part of the goal of FP2020, the FMoH developed scale up plans spanning the 2014-2018 and 2020-2024 periods. Partnering with the private sector was a major requirement for achieving the goals of FP2020.[35]

In 2022, Nigeria launched the FP2030 policy. The policy has the goal of ensuring that by the end of 2030, every Nigerian, including adolescents, young people, populations affected by crisis and other vulnerable populations, will be able to make informed choices, have equitable and affordable access to quality family planning and participate as equals in societal development.[31]

In the FP2030 policy, FP is integrated into the drive for universal access to health services to ensure optimal health outcomes, achieve SDGs and make other economic gains in Nigeria. As Expected, the policy benefited from a partnership between the Ministry of Health and UNFPA Nigeria.[31] Funding for FP initiatives comes largely from foreign donors, with little government commitment.[32,33]

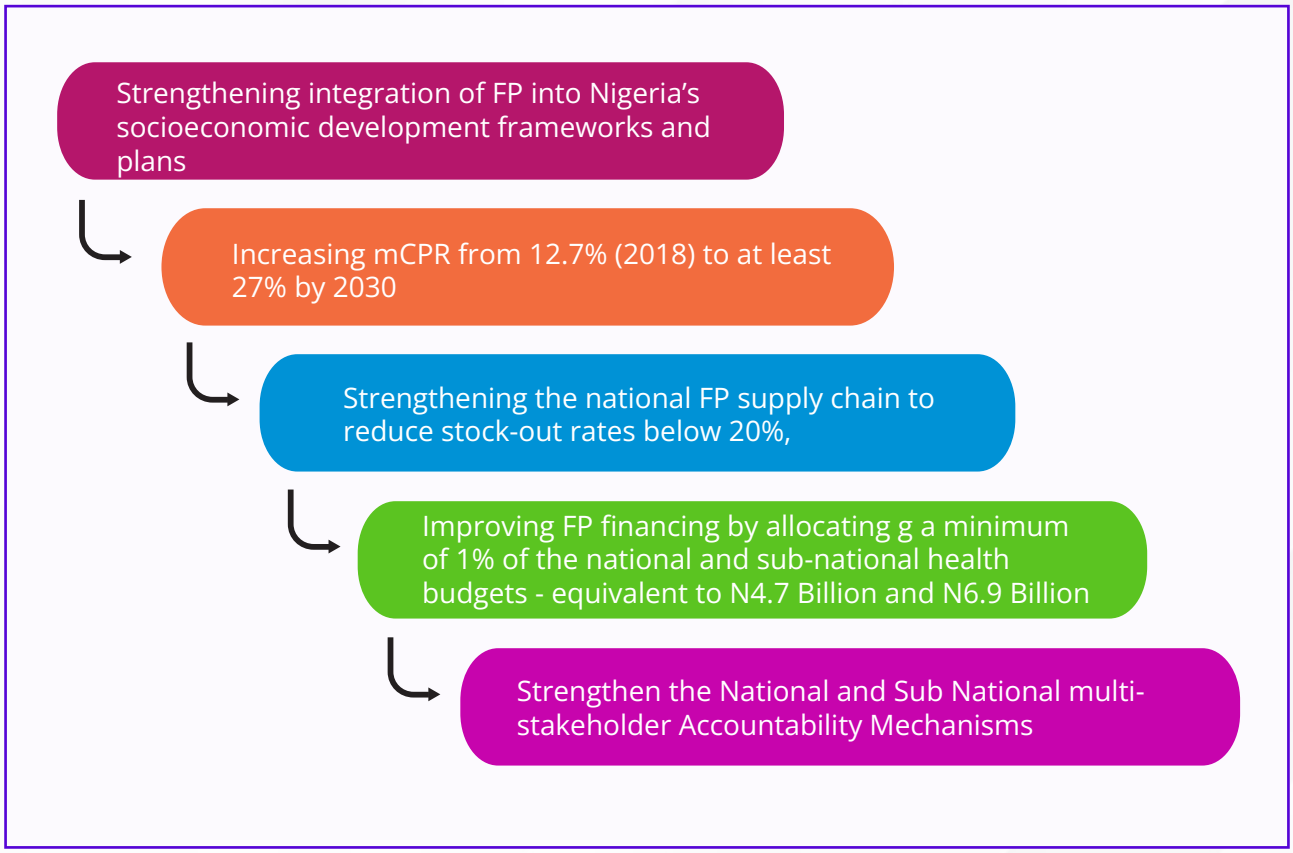
Consequently, the Nigerian government's development plan strives toward the SDGs with family planning at the center of the goals related to addressing inequalities, promoting gender equity, reducing poverty, and ensuring good health and well-being.[34,35] Thus, it is projected that between 2019 and 2023, investment in FP may save more than $40 million in total direct healthcare cost for maternal and child health, as described in Figure 12.[36]

Figure 12: Projected maternal and child health outcomes averted due to FP (2019 – 2023)



In line with the UNFPA FP initiative, Nigeria is currently implementing the FP2030 policy which aims to ensure an environment where every person can access quality FP information and services delivered through approaches that empower women and girls, affirm individual rights and leave no one behind.[37] The FP2030 policy has five thrusts as summarized in Fig. 13 which strongly suggests the need for joint advocacy and collective action which is believed to facilitate strategic investments.[38]

Figure 13: Nigerian FP20230 commitments



In addition to FP 2030 commitments, there have been other efforts, at different levels of government, to improve responsiveness to sustainable FP programs. However, evidence suggests that many sub-national governments in Nigeria are at different stages of compliance; ownership and sustainability of FP programs remain a challenge largely because many of the FP programs are donor driven.[39,40,41]

Beyond demand side challenges, health system factors (including cost, difficulty accessing services, and procurement difficulties)[25] call for efforts to integrate FP into PHC and health insurance schemes.

Since 2015, the federal government has consistently included the FP in the national budget. However, the USAID and UNFPA remain the two largest donors to FP programs in Nigeria; the Federal Capital Territory and 19 States receive support for FP program from the UNFPA, while the 36 states and the FCT receive assistance from USAID through partnerships with a few implementing partners and community-based organizations (Partnerships and Projects).[42]

3.1.2.2 The National Private Health Sector Engagement (NPHSE) Strategic Plan for Family Planning Services

There is sufficient evidence to show that the participation of private-for-profit and not-for-profit organizations including health providers, religious and other voluntary organizations, can contribute significantly to promoting universal access to health care. This is supported by the 2005 National Policy on Public Private Partnership for Health in Nigeria and aligns with the 2017 National Reproductive Health Policy. It reinforces the need to pursue effective partnerships and collaboration between various health actors. In 2021, the FMoH developed the National Private Health Sector Engagement Strategic Plan for FP Services with the following objectives:

i. Identify potential areas for public-private partnerships and private health sector engagement in FP service provision.
ii. This highlight the role of the government in effective engagement with the private sector which will lead to the achievement of Nigeria's FP2030 goal.
iii. Propose an investment plan for private sector engagement in FP service provision.

A major challenge with previous attempts at public-private collaboration in healthcare in Nigeria has been the lack of effective partnerships resulting in weak and ineffective coordination of the numerous stakeholders and active participants in the health sector.

The NPHSE Strategic Plan was therefore developed based on the need to create streamlined systems and structures aimed at building platforms for engagement. These platforms will also present avenues for sharing information, data and planning joint programs. It is therefore necessary to understand the operation of different players, their strengths and weaknesses, and based on such understanding, establish new relationships that will entail the act of learning, compromise, and understanding and shared responsibilities.[43]

3.1.2.3 Strategic Plan for DMPA-SC Introduction and Scale-Up (2018-2022)

Injectable contraceptives are increasingly popular in Nigeria due to their convenience, privacy, and effectiveness. In the past, the most common injectable contraceptive was depot medroxyprogesterone acetate (DMPA), which is administered intra-muscularly by a healthcare provider. More recently DMPA has been formulated as a subcutaneous injection that can be administered by paraprofessionals such as junior community health extension workers (CHEWs), community-based distributors, proprietary and patent medicine vendors (PPMVs), or even the clients themselves.[44,45] The Strategic Plan for DMPA-subcutaneous (DMPA-SC) Introduction and Scale-Up was therefore developed to expand access to this product. However, while the introduction and scale-up of the DMPA-SC created great potential for increasing mCPR, there were certain barriers that prevented access to it at the community level. For instance, under regulation, community health extension workers were not allowed to administer any

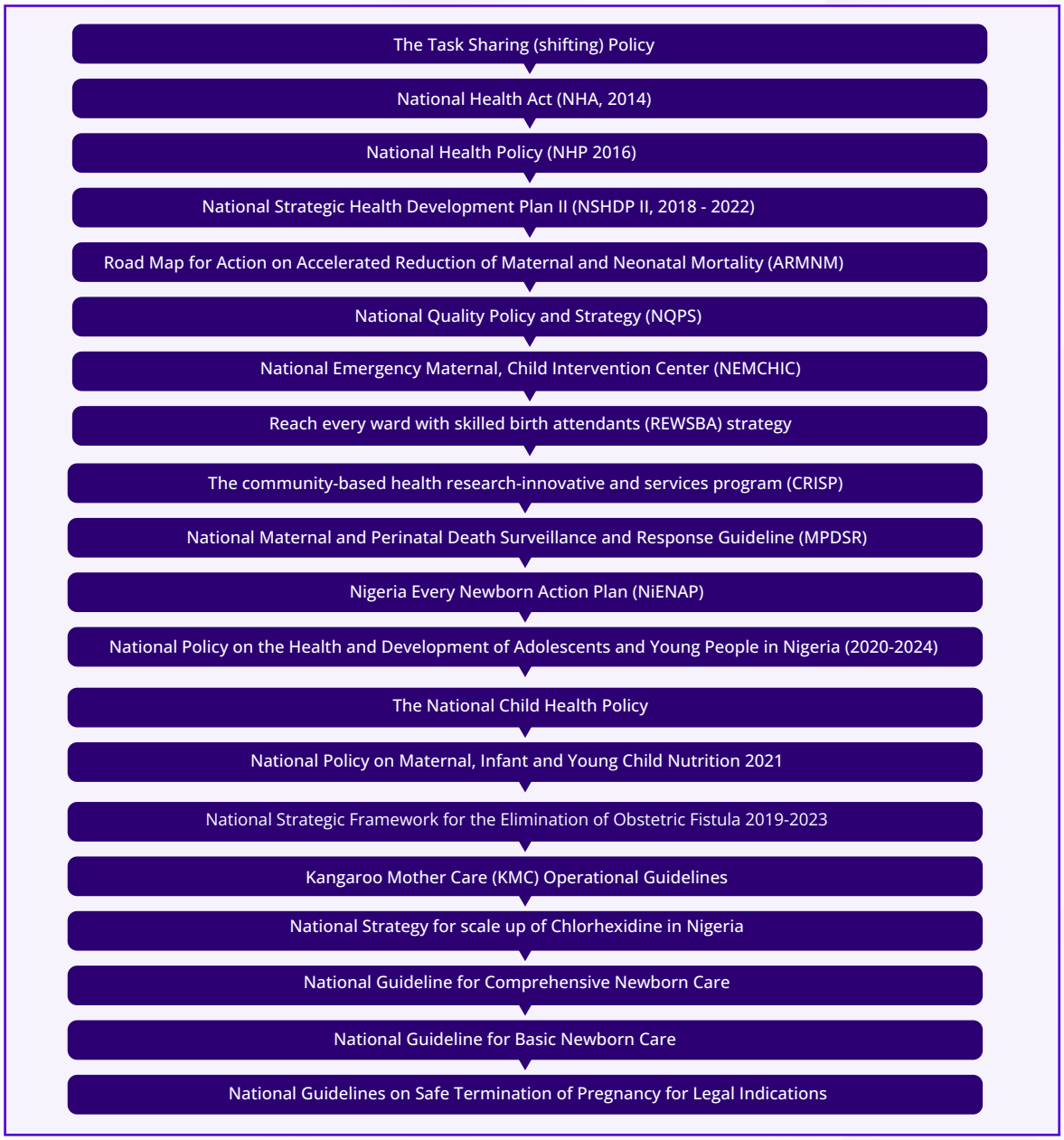
form of injectable. This challenge was also relevant to the private sector since pharmacies and PPMVs can not legally sell or inject DMPA-SC.

The Task Shifting and Task Sharing (TSTS) policy has been reviewed to allow all eligible providers across public and private sectors to be trained on DMPA-SC service provision, including counselling women on self-injection. Pharmacies and PPMVs will be able to legally stock and administer DMPA-SC and community health extension workers will administer injections.[43,45,47,48,49]

3.1.3 MNCH Programs and Policies in Nigeria

The list of MNCH policies and programs in Nigeria appears inexhaustible. In this review, a few of the policies and programs are summarized in Figure 14 with a view to understanding what roles advocacy efforts may have played in their appearance on the policy agenda of the government, potential advocacy allies, and the role of advocacy in their implementation.

Figure 14: Snapshot of the MNCH Programs and Policies



The Second National Strategic Health Development Plan (NSHDP II) prioritizes advocacy for policies on free ANC, skilled attendance at delivery, community mobilization and behaviour change communication for safe motherhood and the challenges of early marriages.56 This also includes advocacy for enabling legislation, policies and funding for reproductive health, family planning, and newborn and child health services.

Some of the policies described in Figure 14 aimed to mobilize political, financial, social, and health system commitments to reduce maternal and newborn mortality and increase the sense of urgency in government, community and religious leaders about the prevention of maternal and newborn deaths.

For example, the Road map for Action on Accelerated Reduction on Maternal and Neonatal Mortality seeks to increase advocacy for MNCH in Nigeria[57] National Policy on the Health and Development of Adolescents and Young People in Nigeria (2020-2024),[58] National Task Shifting and Task Sharing Policy,[59] and National Health Act 2014 etc., recommend several actions including increasing political commitment, investment, financial empowerment of women, investigation and learning from every maternal death, and engaging communities to change attitudes toward deaths which are viewed in some contexts as the will of God.

3.1.3.1 Nigeria's Health Sector Renewal (2023 – 2026)

Nigeria has launched a strategic vision for the health sector, spanning from 2023 to 2026. This strategic vision aims to save lives, reduce physical and financial burdens and ensure universal health coverage. This strategy has four major thrusts – **effective governance; efficient, equitable and quality health systems; unlocking value chains; and health security.**[7]

The new vision stipulates a sector-wide approach that encourages joint advocacy through "multi-stakeholder, multi-level platforms for dialogue, resource mobilization, allocation and accountability for results; improved government-partner coordination; and strengthened citizen and civil society engagement".7 One key feature of the sector-wide approach is that it will be government-led (that is, coalitions, committees and partnerships will be chaired by the ministries of health at federal and state levels).

This will include ensuring the performance management of critical aspects of primary health care reform and overarching grievance redress.

Nigeria's Health Sector Renewal Strategy 2023-2026 envisages a socially accountable health care system for a healthy and productive population. This implies a government- and citizen-led effort to ensure social accountability and the amplification of citizens' voice in the delivery of health services. It aims to amplify dialogue with citizen, CSO and community-based organizations (CBOs); creating space for CSO engagement through information sharing, media engagement; and citizens and CSOs engagement in the policy making process.[7] In other words, Nigeria's Health Sector Renewal Strategy is expected to prioritize joint advocacy for effective health service delivery in Nigeria.

3.1.3.2 Roadmap for the Accelerated Reduction of Maternal, Newborn Mortality in Nigeria

The FMoH commissioned a task force comprised of FMoH officials, relevant Ministries, Departments and Agencies (MDAs), State Ministries of Health, the Society for Gynecology and Obstetrics of Nigeria (SOGON), Pediatric Association of Nigeria (PAN), MNH experts and development partners, to identify effective context-specific interventions and programs for accelerated reduction of maternal and newborn deaths in Nigeria.57

The goal of the 2019 policy is to "mobilize political, financial, social, and health system commitment to reduce maternal and newborn mortality" and raise the sense of urgency in government, community and religious leaders about the prevention of maternal and

newborn deaths.[57]

The policy document emphasizes the actions (political, economic, social etc) needed to support the timely delivery of care in the country in general and especially in hard-to-reach parts of high-burden states – Jigawa, Katsina, Yobe, Sokoto, Kebbi, and Zamfara.[57] The policy seeks to increase advocacy for behavioral change at the community level to improve MNCH outcomes in Nigeria.

3.1.3.3 National Quality Policy and Strategy (NQPS)

In 2020, the National Quality Strategy for Reproductive, Maternal, Newborn and Child Health (RMNCH) was utilized to inform the initiation of the NQPS for advancing the goal of the Nigerian government in addressing the high burden of maternal and newborn morbidity and mortality. In 2022, The National Implementation Guide for Reproductive, Maternal, Newborn, Child, and Adolescent Health Quality of Care in Nigeria was developed to support the national vision of reducing maternal and newborn mortality, preventable deaths, and stillbirths, and improving the quality of care for children and young adolescents.[60]

3.1.3.4 National Maternal and Perinatal Death Surveillance and Response Guideline (MPDSR)

Reducing perinatal deaths relies on strengthening health systems through the development of a reliable surveillance system for tracking maternal and perinatal deaths.

The 2014 National Maternal and Perinatal Death Surveillance and Response Guideline was designed to ensure the investigation of every maternal death and review the lessons about how and why the death occurred. The review process was designed to create a safe environment in which all relevant parties can probe the events and circumstances that led to a woman's death to prevent the reoccurrence of such death in similar circumstances.[61]

The guidelines are a product of the collaborative efforts of the Ministry of Health and professional organizations such as the SOGON, PAN, the Nigerian Society of Neonatal Medicine (NISONM), and key advocates for RMNCH.[61] A recent study affirmed that the results of the MPDSR can translate to better maternal and child case management and a decrease in mortality if applied.[62]

Rotary International supported the implementation of the Nigerian Maternal & Perinatal Death Surveillance by introducing an e-platform database which helps to collect maternal and perinatal mortality data using the MPDSR guidelines. The project is complemented by Rotary's largest project on Quality Assurance in Obstetrics and Family Planning through close collaboration with the Nigerian FMoH. The generated hospital reports support gynaecologists and midwives in finding possible interventions.[63] The project is supported by a web-based databank, integrates approaches to obstetric quality assurance (OQA) and MPDSR. The digital system facilitates the remote collection and analysis of data on several scales – hospital, community, state and federal – facilitating the development of evidence-based responses. The OQA project is closely linked to the RFPD's mission to improve access to quality family planning services and to reduce the burden of high maternal and child mortality rates in Nigeria.[64] The eMPDSR was piloted in Lagos by Options Consultancy Services under the E4A Mama Ye program. This program created tools for advocacy, and training curricula for key stakeholders, and worked to create a political commitment for strengthening the policy. The program prioritizes strengthening coalitions to sustain advocacy for the health of women and newborns.[65]

3.1.3.5 Nigeria Every Newborn Action Plan (NiENAP)

The 2016 Nigeria Every Newborn Action Plan (NiENAP) policy was initiated to end preventable newborn deaths and stillbirths in Nigeria.

NiENAP presents four major approaches to intervention packages required for newborn health: (i) promotion of facility-based deliveries at scale by addressing equity issues; (ii)

strengthening community-based interventions; (iii) strengthening facility readiness for providing quality care for the newborn; and (iv) providing of quality care for the newborn with a focus on labor, birth, and immediate care after birth during the first week of life.[66]

Orjingene et al. described the policy as a framework for each state of the federation as well as the Federal Capital Territory (FCT) to implement strategies that would mitigate the occurrence of newborn deaths in the country. Their research revealed that increased uptake of ANC services would save 43% of the deaths of newborns in northern Nigeria, based on evidence that ANC is an important factor in the reduction of both maternal and neonatal mortalities.[67]

3.1.3.6 Adolescent Health Services in PHCs

The National Policy on the Health and Development of Adolescents and Young People in Nigeria (2020-2024) was designed to provide a strategic direction for improving the health and development of adolescents and young people in Nigeria as well as to reenergize the national commitment and stakeholders engagement to address current and emerging issues in adolescent health.[68] A recent evaluation shows that programs promoting young people's health are increasingly being planned in Nigeria and implemented to revealed the health and well-being of adolescents and young people (AYP), suggesting an increased focus on young people's health by the government. The government developed a guideline for the integration of Adolescent and Youth Friendly Services (AYFHS) into PHCs in Nigeria[59] in 2013 and the National Standards and Minimum Package for Adolescent and Youth Friendly Services in 2018.[70] A study showed, however, that adolescent sexual and reproductive health services are yet to be integrated at the subnational level. In a state like Plateau, for instance, health workers still have poor knowledge of adolescent-responsive services.[71]

3.1.3.7 The Task-Shifting (Sharing) Policy

The National Task-Shifting (Sharing) policy was developed to complement other government initiatives to address the health workforce shortage problem and for adaptation and implementation at all levels of the national health system. It aims to meet the universal health coverage goal through the mobilization of available human resources to ensure equity, accessibility, and effectiveness in the delivery of essential healthcare services.

Task shifting and sharing involve the redistribution of tasks among the health workforce such that tasks may be moved from highly qualified health workers, who may not be

available in certain settings, to available but less qualified healthcare workers to make more efficient use of the health workforce.[59]

The policy is a product of the partnership between the Ministry of Health and nonprofit organizations, notably, Jhpiego, the MacArthur Foundation, and the WHO.[59] Nigeria developed the National Task Shifting and Sharing Policy because of the unequal distribution of health workers in the country especially at the primary level of care, and because of the low numbers and production rate of skilled health workforce. The Evidence suggests that community health extension workers in Nigeria can provide a wide range of healthcare services with training.[72] Barriers to the effective implementation of task shifting and sharing include: persistent shortage of health workers, inter-cadre rivalry and resistance from more qualified providers, perceived sub-optimal capacity of the beneficiary cadres, and lack of adequate equipment for delivery of needed services.[72,73] In addition, government funding for the policy remains largely inadequate.[73]

3.1.3.8 The National Child Health Policy

The 2022 NCHP aims to improve child survival in Nigeria and ensure their optimal growth and development.[74] It is a product of collaborative efforts involving health MDAs and researchers from different universities in the country.

The policy makes a case for advocacy for legislation and enforcement of existing laws that make for a safer and enabling environment for the improvement of the health of children.[74] It recommends community involvement as the fourth layer in the health system, advocacy for the implementation of the policy, and behavior change for improved child health through the use of mass media and social media.

The policy documents efforts aimed at strengthening the health sector at various levels through the establishment of newer programs and initiatives to address child health. Such initiatives include the Integrated Management of Childhood Illness (IMCI), Essential Newborn Care Course (ENCC), Integrated Community Case Management of Childhood Illness (iCCM), National Programme on Immunization, Integrated Management of Acute Malnutrition, Early Child Development, Primary Health Care Under One Roof (PHCUOR), etc. The initiatives are aimed at improving the access of children to quality health care that will improve their survival, growth and development. However, implementing national policy at the subnational level may be challenging, often because of the misalignment of structures across levels of government.[75]

3.1.3.9 Midwives Service Scheme

The Midwives Service Scheme (MSS) was initiated in 2009 to address the challenge of the shortage of healthcare providers in primary care facilities in rural areas which are usually difficult to reach.[76]

The MSS scheme is based on evidence that when the number of midwives increases, the uptake of services increases, women who use services will be more satisfied with the quality of care, and maternal and newborn health outcomes will improve.[76]

The scheme employs newly graduated, unemployed and retired midwives and posts them to PHCs in rural communities for a one-year period (renewable if performance is satisfactory). In this way, the scheme redistributes the health workforce in the country.[76] Midwives on the scheme were to be paid by the Federal, state and local governments, but compliance at the subnational level was poor.[77]

3.1.3.10 Primary Health Care Under One Roof (PHCUOR)

The PHCUOR policy seeks to integrate the Primary Health Care governance and programs at the state level, under the State Primary Health Care Development Agency or Board to reduce fragmentation in PHC management and service delivery. This leads to the strengthening and decentralization of the health system. The policy is based on the principle of "Three Ones": One Management, One Plan and One Monitoring & Evaluation System.[78] The policy provides that membership of relevant agencies/

boards/committees include men and women, and that women are represented in their leadership. The PHCUOR policy is designed to ensure the use of a minimum service package (MSP) at the PHC. The policy document explains that the MSP addresses 90% of maternal mortality & morbidity and under-five mortality conditions, so it is a rapid way to attain universal health coverage.[78] The policy benefited significantly from DFID support.[79] The implementation of the policy has been poor at the subnational level.[80] The Foundation has therefore supported state-level PHCUOR advocacy initiatives.[81] Another major challenge to its implementation is health workers' low level of understanding of key concepts in the policy.[82]

3.1.3.11 National Policy on Maternal, Infant and Young Child Nutrition (NPMIYCN) 2021

The FMoH adopted the NPMIYCN to address the problems of malnutrition in children and poor nutrition in mothers. It aims to "ensure optimal nutrition for the survival, growth, and development of every child, adolescent girl, and woman in Nigeria".[83] As stated in the acknowledgements section of the policy document, several organizations partnered with the FMoH to develop the policy; these include UN agencies such as the WHO, UNICEF, the World Bank, and local and international NGOs (notably, Save the Children, FHI-360, Action Against Hunger).[83] The policy acknowledges advocacy as one of the ways of achieving its goals, including community-targeted advocacy. One study demonstrated that the geographical reach of organizations involved in nutrition advocacy, their budgetary allocations to advocacy, and networks with policy champions increased the effectiveness of nutrition advocacy in Nigeria.[84]

3.1.3.12 National Strategic Framework for the Elimination of Obstetric Fistula 2019-2023

The National Strategic Framework for the Elimination of Obstetric Fistula makes a case for the use of advocacy in ensuring the adoption of best practices across states;[85] However there is little evidence or no documented evidence of the role of advocacy in its adoption as a national program. The UNFPA, USAID, MSF and researchers and practitioners from Nigerian universities were major players who worked with the FMoH to develop the program.[85]

One study suggested that the 2011-2015 framework, the precursor of the current program, did not sufficiently engage with subnational level government and civil society stakeholders, and failed to address key underlying factors such as early and child marriage.86 The program aligns largely with the Millennium Development Goal #5 to

improve maternal health.[87]

3.1.3.13 Kangaroo Mother Care (KMC) Operational Guidelines

Nigeria has implemented KMC,[74] and research evidence from Nigeria supports its cost effectiveness and efficacy in improving the health outcomes of newborns.[88,89] KMC knowledge is high and attitudes are positive among healthcare providers.[90] Reports have shown that knowledge of KMC is high among mothers and the attitudes are is positive, especially among those mothers who are knowledgeable about KMC.[91] Another study showed that it is preferred to conventional care by Nigerian mothers.[92] KMC has been practiced in Nigeria since the 1990s but it was reintroduced around 2007. Notable KMC advocacy efforts include mentorship, training and endorsement of global recommendations of KMC by professional organizations such as the PAN and the Nigerian Society of Neonatal Medicine. Many individuals have also been identified as champions who have pushed for the scaling up of the KMC program in Nigeria, in different ways.[93] Partnership between the Federal Ministry of Health and local KMC champions promoted the adoption of the KMC as a national health program in Nigeria. One study showed that the program suffers partly because it has not stepped down to the health facility level in some states[94] despite its adoption at the national level. The practice of the KMC is low in limited resource settings and there is a need to create awareness, educate the public and support mothers to practice it.[95,96]

Research has shown that mothers willing to practice KMC are dissuaded by the mocking public or disapproving relatives who are part of household decision-making, suggesting that there is a need for advocacy to build public will for the practice of KMC.[97,98]

3.1.3.14 National Strategy for Scale up of Chlorhexidine in Nigeria

Studies have documented harmful cord care practices in Nigeria.[99-101] Considering the proportion of neonatal deaths caused by sepsis resulting from infection of the umbilical cord, the Ministry Health adopted chlorhexidine gel for cord care in Nigeria.[102] Chlorhexidine is one of the thirteen Life-Saving Commodities of the UN Commission on Life-Saving Commodities for women and children.[103] The national chlorhexidine implementation plan identified advocacy targeted at subnational level policymakers, opinion leaders and gatekeepers as essential to the effective implementation of the program scale up.[102] The adoption of chlorhexidine at the global level is a product of participatory collaboration in the form of a working group – the Chlorhexidine Working Group, which research suggests was effective for a number of reasons, including maintaining a balance between disciplined leadership and flexibility.[104] The advocacy efforts were productive because of strong transparent leadership that created a sense of shared mission and ownership for all stakeholders. The leaders were neutral brokers with skills to facilitate communication among partners and promote group cooperation.[104]

Advocacy efforts improve community-level acceptance of and demand for chlorhexidine in Nigeria,[105] especially when targeted at men, who are household level primary decision makers.[106]

3.1.3.15 National Guidelines for Comprehensive Newborn Care

In 2021, Nigeria generally adopted comprehensive guideline for all newborns. This guideline covers care for respiratory conditions/disorders, nutritional support, clinical monitoring and supportive care, pain management and palliative care, as well as home care and advice at discharge for small and sick newborns.[107] In addition, it provides details of facility and manpower (professionals and required skills) needs for optimal newborn care at all levels to address a broad range of newborn medical conditions. The guidelines, which are designed for the use of healthcare providers, are aimed at standardizing neonatal care across Nigeria's secondary and tertiary health institutions.[107]

A recent study suggested that many healthcare providers have not yet adopted this guideline, and some argued that it fails to meet the specific needs of late preterm newborns; it is somewhat cumbersome; and, in some instances, it is obsolete.[108]

3.1.3.16 National Guidelines for Basic Newborn Care

The National Guidelines for Basic Newborn Care is a guide to services and interventions delivered at the community level by healthcare workers who are residents in communities (that is, potential mobilizers, influencers, promoters of positive health behavior, and basic service providers in communities) and health workers at primary health centers (PHCs) across the country.[109] The services and interventions pertain to pregnancy care; newborn care, including newborns with low birth weight, those who need resuscitation; and those with other medical problems; and referral to higher levels of care.[109] However, post implementation evaluation rated the guideline low in stakeholder engagement and very low in rigor and applicability.[110] The guideline, like several others designed by the FMoH, adopts a top-bottom approach and lacks stakeholder buy-in and ownership.

3.1.3.17 National Guidelines on Safe Termination of Pregnancy for Legal Indications

The document is a guide to the provision of safe abortion within Nigeria's legal framework, that is, in circumstances where the continuation of the pregnancy threatens the life of the pregnant woman and potentially contributes to maternal mortality.[111] The editorial team was drawn from the FMoH, teaching hospitals and other professionals from local and international NGOs. Evidence shows that the guideline is yielding results in preventing unsafe abortion.

While the guidelines recognize the presence of severe congenital anomalies as grounds for termination of a pregnancy, Nigerian laws are not explicit about this. Nonetheless, the guideline has been applied to prevent unsafe termination of pregnancy in one case of extreme congenital deformity.[112]

A combination regimen of misoprostol and mifepristone has been included on the National Essential Medicines List of the country.[113] A number of factors contributed to the inclusion of the combination regimen, including the advocacy efforts of a coalition of NGOs and researchers.[113] International NGOs have also provided training to service providers to improve their knowledge and awareness of the policy. Generally, laws prohibiting abortion contribute to unsafe abortions in sub-Saharan Africa,[114] and abortion-related complications are more common in conflict zones.[115]

3.1.3.18 Ending Preventable Maternal Mortality

There is little policy focused on non-biomedical, contextual and structural factors related to maternal and newborn health. To achieve the SDG targets for maternal and neonatal health (MNH) in 2030, maternal deaths should be reduced by more than 90%. Achieving this goal requires effective leadership and political will to implement strategies already in place to reduce preventable maternal mortality.[30] Most maternal deaths in Nigeria are due to preventable obstetric causes[116]. Complications resulting from preterm birth, intrapartum events and infections account for more than 80% of newborn deaths and stillbirths.[117]

Only a few programs are in place to target structural social determinants of maternal health such as religious and cultural barriers and MNH policies.[116] Efforts to improve MNH in Nigeria may need to focus more on implementing MNH interventions and measuring context-specific challenges beyond health facilities.[116,118]

3.1.3.19 Subnational programs and policies

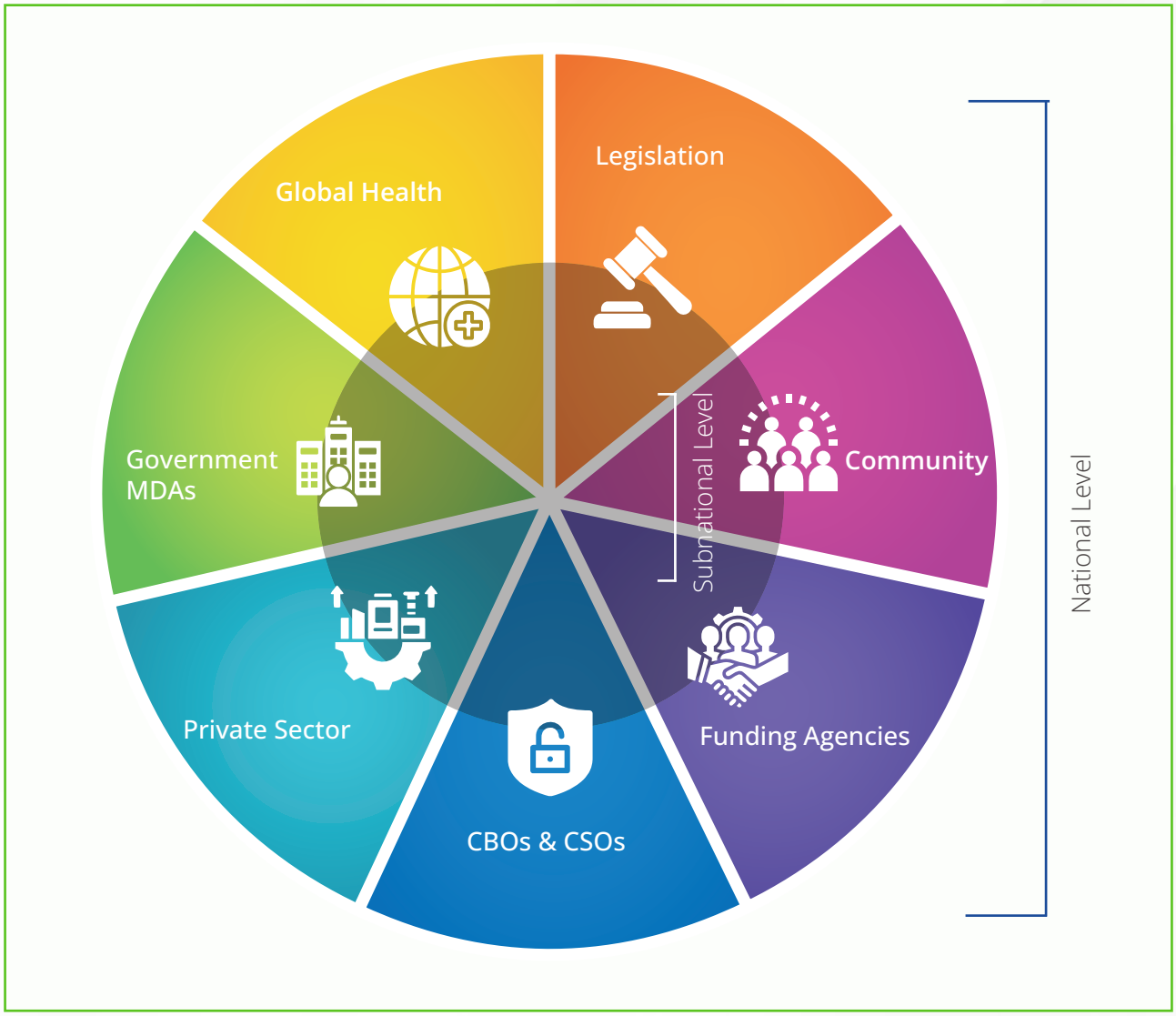
Many national policies and programs have been adopted at the subnational level, but to varying degrees partly because state governments have several competing priorities, despite their limited human and financial resources.[119]

Women's health policies appear largely to be designed at the national level, with subnational government MDAs playing very little role in the design.[78] Addressing women's health challenges through policies and programs requires understanding the inter-sectoral linkages inherent.

The National Health Promotion Policy, for instance, supports interventions that see women's health as an issue to be addressed from multiple fronts, including sexual and reproductive health education and services, legal aid for victims of gender-based violence, addressing cultural barriers and harmful gender norms to women's health, and women's economic empowerment.[120] Living in a rural area is also a key risk factor in women's health.[121–123] Due to these inter linkages, women's health policies and programs by design should be multi-sectoral, cutting across ministries responsible for the welfare of women, culture and national orientation, rural development, women's economic empowerment and livelihoods.

3.1.4 Women's Health Advocacy Ecosystem in Nigeria

Figure 15: Nigerian WH advocacy ecosystem



The government has largely led women's health programs and policies in Nigeria sometimes, in response to advocacy from civil society groups, the academia, media practitioners, and international development agencies. The quest to address negative MNCH outcomes underlies the introduction of MNCH policies on the policy agenda at the national and sub-national levels.[124] Notable among the policies are the global Partnership for Maternal, Newborn and Child Health; Integrated Neonatal, Maternal and Child Health (2007-2014); Free MCH Services (2009 – 2015); Midwives Service Scheme (2009-2012); and SURE-P Maternal and Child Health (2012 – 2015).[124]

Advocacy coalitions may be initiated by external actors who reach out to advocacy champions and share the vision with a larger group for buy-in. Local organizations may also initiate the processes and approach policy champions such as First Ladies to push the cause.

Researchers have also accessed grants to promote MNCH programs by training media practitioners.[124] In 2012, the White Ribbon Alliance for Safe Motherhood Nigeria (WRAN), a 'people-led' network of advocates at the national and local levels, forged a movement for women's health in Nigeria, collaborating with the Africa NMNCH Coalition Nigeria to map CSOs working on RMNCH. This collaboration led to the formation of a coalition of CSOs and media organizations which has since pushed for improved commitment to women's and children's health.[125] In 2015, after the government stopped the SURE-P MCH, with consequent deterioration of MNCH outcomes, advocacy coalitions identified a policy window and used the evidence for advocacy.[124]

The coalitions aimed to create awareness about key MNCH problems, receive public and government attention, address the problems, and identify potential partners. In addition, they aimed to engage policy influencers, provide technical expertise, participate in the implementation of policies and review/monitor program implementation to provide feedback for improvement.[124]

An advocacy coalition, the Partnership for Advocacy in Child and Family Health (PACFaH), was supported by the Gates Foundation after the discontinuation of the SURE-P MCH intervention (2014-2017). It was a coalition of CSOs, the media and activists that engaged the government to increase it's their fulfilment of FP-related policies and financial commitments to FP programs and improve the FP policy environment at the national and subnational levels. Some of the CSOs included the Community Health Research, the Civil Society for Scaling Up Nutrition, the Pharmaceutical Society of Nigeria, the Civil Society for Legislative Advocacy, and the Federation of Muslim Women Association of Nigeria.[126] The PACFaH was implemented by the AAFP, which serves as an umbrella body for all organizations working on FP in Nigeria.[126-127] It is a national coalition of FP advocates comprising government MDAs, development partners, NGOs, CSOs, and the private sector.

The Health Sector Reform Coalition is a national coalition of organizations committed to ensuring universal access to and use of affordable quality health services.[128] The coalition pushed for law and policy reforms in health and has been, involved in efforts to improve health equity in Nigeria.

At the subnational level, coalitions exist, that work on women's health advocacy or health in the broader context. For instance, the Lagos Accountability Mechanism for Maternal, Newborn, Child and Adolescent Health was established in 2016 to provide an evidence-based plan of action to ensure improved accountability and implementation of maternal, child and adolescent health programs.[129] The coalition is comprised of government officials, CSOs, health practitioners, and the media. Similar coalitions exist in states such as Bauchi, Kaduna, Niger and Yobe.[130] These state level coalitions are opportunities for ensuring greater investment in women's health at the subnational level, and they provide subnational level partners with which to push for stepping down national programs at the subnational level.

The Civil Society Scaling Up Nutrition in Nigeria (CS-SUNN) is a coalition of organizations with the aim of mobilizing non-state actors for advocacy and generating evidence, building capacity and stimulating communities to scale up nutrition in Nigeria.[131] The coalition works on maternal and child nutrition and

organizes capacity building workshops on advocacy and budget tracking, efforts believed to improve accountability at the subnational level in Nigeria. This coalition works at both the national and subnational levels.

The Private Sector Health Alliance of Nigeria (PSHAN) – a 'country-owned' coalition of major private sector players who organize and pool private sector resources and apply the same to Nigeria's healthcare crisis. The alliance seeks to synergize with the public sector to ensure equitable access to healthcare in Nigeria.[132] PSHAN was involved in a public, private sector and CSO engagement in achieving the reproductive, maternal, and child health SDG targets.[133] PSHAN established the Nigerian Integrated Coalition for Improving RMNCAH + Nutrition (NICIR) in nine states of the federation.[133]

The activities of the PSHAN reflect the existing opportunity for private sector involvement in improving maternal health advocacy in Nigeria and the ongoing partnerships and support received from PSHAN are potential door openers for joint women's health advocacy.

3.1.5 Examples of FP-MNCH Advocacy Programs in Nigeria

a. SURE-P/MCH: This advocacy program focused on maternal and child health with a common agenda, shared priorities for action and collaborative advocacy initiatives to ensure governmental accountability to health commitments, utilizing alliance brokering to influence change.[124] Advocacy strategies applied by the implementers of the program included workshops, symposiums, town hall meetings, one-on-one meetings, press conferences, demonstrations, and media engagements. Advocates built coalitions made up of committed individuals and institutional policy actors with strong inter-organizational and interpersonal ties working together to influence maternal and child health policy. The advocacy strategies in this program led to increased political will, positive shifts in decision-makers' attitudes and increased policy support for MCH issues in Nigeria, especially following the suspension of the free MCH program.[124,134]

However, there was a lack of proper understanding of the goals, mission and vision of the advocacy group. In addition, advocacy efforts faced the challenge of struggles for dominance among multiple coalitions, and the mobilization of coalition members and resources was dependent on the existing political system.

The key lessons learned from this program include the need for the alignment of an advocacy initiative with political agendas to ensure long term sustainability, as well as the use of available evidence for network with powerful committed champions in facilitating alliances for advocacy. Due to a government

change, program funding was discontinued, but strong advocacy led to the retention of the free MCH component of the program at PHC centers.[124,134]

b. Partnership for Advocacy in Child and Family Health at Scale: The Partnership for Advocacy in Child and Family Health (PACFaH) project (2014-2017) and its successor, the Partnership for Advocacy in Child and Family Health at Scale (PACFaH@Scale) project (2017-2022) are health accountability and advocacy interventions that have been implemented in Nigeria.[127] The project was implemented by the Development Research and Projects Centre (dRPC) and funded by the Bill and Melinda Gates Foundation. The focus of this program was child and family health (including FP, nutrition, routine immunization and child killer diseases), PHCOUR and capacity building. The PAS program aimed to prompt strategic policy actions to effect policy commitments, to make adequate budgetary provisions supported by timely releases, and to bring down regulatory barriers to service delivery by providers in the health space.

This advocacy project was aimed at promoting accountability, transparency and responsiveness of government at the national and state levels around policy, budgets and administrative regulations for child and family health.[127] The key advocacy message was increased and sustained funding of family planning, routine immunization, ending childhood killer diseases, and PHCUOR. The advocates formed coalitions but also utilized direct advocacy and workshop strategies to influence change.

Other advocacy strategies deployed included: project roll out and introduction, capacity building for champions and legislature, policy dialogue, press briefing, town hall meetings, use of evidence, and strategic engagement. This program strengthened advocacy among CSOs in Nigeria to ensure that FP remained a development priority at the national and state levels.[127]

c. Advocacy for Nutrition in Nigeria: This advocacy program focused on malnutrition and aimed to increase public financing for nutrition while promoting the mainstreaming of malnutrition prevention and treatment interventions into the federal health system and selected states (Kano, Katsina, Bauchi, Jigawa, and Gombe States).[135] The common strategies included mass and social media advocacy, direct advocacy, and forums anchored on partner collaboration. Bi-weekly meetings of partners enhanced effectiveness. The advocacy process was heavily guided by the analysis and use of data.[135] However, key achievements and challenges of this program were not available in the public domain.

d. Giving birth in Nigeria - Advocacy and Communication: This program aimed to ensure increased awareness of policies and strategies that improve access to quality maternal health care. However, there is no clear indication of what advocacy strategies were deployed to influence policy change, what key achievements were delivered, what challenges were faced and what key lessons were learned from the program.[136]

e. Civil Society Advocacy in Nigeria - Promoting Democratic Norms or Donor Demands: This advocacy program was HIV-oriented and targeted to prevent and mitigate The impact. HIV Advocates utilized peer education, rallies, mobilization of community and religious leaders to influence change. There was networking among CSOs although the key achievements were not reported.

This program faced two key challenges – insufficient funding to sustain the advocacy movement and concentration on promoting donor demands at local levels, without targeting policy and funding at the national and state levels.[137]

f. Health Policy Plus: This program focused on the integration of tuberculosis (TB) and HIV into national and state health insurance schemes, and increasing government commitment and expenditure for health.[138] During this program, co-creation and direct engagement of stakeholders were key strategies in addition to multi-sectoral collaboration and strategic engagement. The advocacy strategies resulted in increased appropriation and sustainable financing for HIV and TB in Lagos state. The program faced difficulty in securing appropriation (budgetary line). The generation and application evidence, to

strategically engage the stakeholders, were the key to its success.[138] Even though the project ended in 2022, government officials are still championing this initiative to improve allied health programs in Nigeria.

g. The MamaYe: The focus of this program was maternal, child and adolescent girls' health. It aimed to ensure an increased quantity and quality of investments in health, as well as capacity development for local decision-makers, to respond to the needs of women and girls through co-creation and multi-sectoral engagement at state levels.[139] The advocacy program led to increased financing for maternal and neonatal health.

However, the program was limited by cultural and socioeconomic factors influencing service uptake and utilization. This program presents a replicable model that institutionalizes multi-sectoral platforms such as Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH).

h. Advocacy for Primary Health Care Reform: This program focused on facilitating improvements in health outcomes by fostering key reforms at the national and state levels in three core areas - PHCOUR, free maternal, newborn and child policy, and National Health Bill - through the formation of a coalition that ensured mentorship and capacity transfer. This strategy supported advocates to secure the passage and signing of the 2014 National Health Act by the National Assembly (NASS) and President Goodluck Jonathan, via the aegis of the Health Sector Reform Coalition. Although the challenges were not clearly stated, the reform was government-driven (led by the Health Reform Foundation of Nigeria).[140] The project closed, but the Health Sector Reform Coalition remains.

i. Breakthrough Action's Advocacy Core Group Model for Integrated Social Behavior Change Programming in Nigeria: The Advocacy Core Group (ACG) Model is a programmatic component of the Breakthrough Action/Nigeria Integrated SBC program. This involves advocacy outreach to community influencers, religious, traditional and opinion leaders to promote priority maternal, newborn, child health and nutrition (MNCH+N), malaria, birth spacing, and postpartum family planning behaviors, by influencing community level norms and individual ideations and behaviors that influence the uptake of health services and other positive health behaviors.[141]

The ACG was aimed at building the capacity of members to function as advocates; engaging with stakeholders in priority health areas; promoting the benefits of childbirth spacing; and supporting the establishment of strong linkages between communities and health facilities. The ACG comprised religious, traditional, youth, and women leaders, who were active members of their respective communities who were elected based on their experience leading existing community structures, religious groups, and associations.[141]

The advocates utilized different advocacy strategies including house visits, community religious events and ceremonies (sermons), community dialogue, mass media, and town hall meetings. The model improved linkage to the health facility, helped in shifting social norms, and increased the reach of health services. In addition, the model helped in advocating for resources and support to governments, communities, non-governmental organizations, relevant institutions, and other stakeholders.[141]

j. Strengthening Routine Immunization through Memorandum of Understanding (MOU): In 2016, recognizing that reforms were needed to mobilize and coordinate resources to address low immunization coverage rates, the Sokoto State government entered a partnership with the Bill and Melinda Gates Foundation (BMGF), the Aliko Dangote Foundation (ADF) and the United States Agency for International Development (USAID).[142] A three-year quadripartite memorandum of understanding (MoU) for strengthening RI systems summarized the terms of the partnership. The MoU was aimed at establishing sustainable financing for the Sokoto immunization program and ultimately improve vaccination coverage rates through improved coordination and accountability mechanisms.[142]

The MoU aimed to achieve this goal by first assessing the costs of making the program fully functional at the state, local government area (LGA), and health facility levels and then establishing a separate "basket fund" account, enabling the government and the foundations to contribute to the full operational costs of the program. To foster sustainability, MoU stakeholders agreed to a plan whereby the foundations provided most of the funding in the first year of implementation and decreased it over time while the state increased its contribution.

USAID contributed to the agreement through its Maternal and Child Survival Program (MCSP), which provided technical assistance and knowledge transfer support at the state, LGA, and health facility levels to improve program performance.[142]

The MoU was strong, and it provided an innovative pathway for sustainable financing for RI in Sokoto. These structures were effective, and they significantly increased coordination and accountability. Advocacy to pass the amended PHCUOR bill was effective; the integration of the RI into a single unit brought unified management of immunization programming; and the RI Working Group and sub-working groups enabled effective management, implementation, monitoring, evaluation, and amendment of the MoU. However, there were challenges in developing a shared understanding of workplan activities. Some partners who were not MoU signatories did not align their own workplans with the harmonized workplan, resulting in a lack of coordination and inefficiencies. The measures defined by the MoU were effective in ensuring sound financial management and accountability. The creation of the state, LGA, and health facility accounts; financial reporting requirements; migration to electronic records management at the state level; and implementation of audit systems improved fiscal transparency, accountability, and efficiency at all levels.[142]

3.1.6 Examples of FP-MNCH Advocacy Programs in Africa

In Uganda, the strategies adopted in women's health advocacy include targeting powerful allies in government[125] and a multi-level approach which targeted government at the national and sub-national levels[143,144].

This approach made it possible for advocates to gain the support of actors with the levers of power who can effect changes at the policy level. A coalition of advocates in Uganda initiated bottom-up oversight and accountability by citizens to the government; an approach that is believed to be transformational.[143] However, evidence has shown that such an approach may be faced with resistance from government officials.[142] Advocacy efforts have also resulted in citizens' greater involvement in holding governments accountable through improved monitoring in Uganda.[143]

In some contexts, however, there may exist an interesting twist, where key actors in government have formed an alliance to bring about an 'undesirable' change. An important example of how advocacy coalitions fare in such a situation is found in the joint advocacy efforts documented in Ghana. Advocacy efforts were aimed at ensuring equitable access to water in Ghana in the face of a proposed public-private partnership that was believed by advocates to commercialize water resources and reduce poor people's access to water. The evidence suggests that there may be a lack of agreement, especially when some coalition members are singled out for recognition. For example, coalition members posited that some partners strategized obtain the credit even though all had been involved in advocacy.[145] This is a potential threat to commitment to advocacy and an important factor to address in coalition building.

In another example from Ghana, evidence showed that advocacy to improve long-lasting insecticide net distribution and use involved community-based efforts aimed at behavior change. The community-based advocacy strategies included community outreach and door-to-door activities, school health programs, community information centers (where they existed), and local festivals such as the durbar.[146] These strategies complement efforts to get government buy-in and build political will to ensure improved public investment in women's health. Among policymakers and community members, advocacy coalitions have been successful in increasing knowledge about women's health and in bringing about behavior change through community engagement in Ghana.[147] While a compromise may be an achievement, it may also be a major challenge, depending on the components of the proposed programs and policies adopted or dropped and depending on who and how it is viewed.[145]

Insights from family planning advocacy in Kenya suggest that an essential strategy in policy advocacy is reach the right decision-makers with the right message at the right time.[148] This strategy focuses on people, messages, and timing which may require taking advantage of policy windows.[149,150]

To get to the 'right' people, media advocacy was employed. With media advocacy, coalition members strategize to use the media to disseminate evidence-based messages in a targeted manner.[148] In addition to providing helpful information, media advocacy also dispelled myths and addressed misinformation on women's health.[148] Advocacy coalition efforts using media advocacy typically need to strengthen the capacity of journalists for improved messaging on women's health, as shown in family planning advocacy in Kenya.[148] To unlock the power of media advocacy, women's health journalists had to be equipped for the task. Another major lesson from media advocacy research was that coalition member organizations needed to trade off their visibility for the cause.[148]

Family planning advocacy efforts in Kenya were also geared toward unlocking local funding opportunities.[148] Such funding may come from private sector actors, but it can and should also come from the public sector.[148] Advocacy efforts strive to increase public investment in women's health programs, and increased public investment complements and serves as evidence of political will or commitment to the programs.

An important consideration in women's health advocacy is situating women's health in the broader development context. Advocates have succeeded in showing how women's health fits into the larger development agenda for communities and states and all stakeholders, and by making a business case for investment in women's health for all major stakeholders.[148]

Advocacy coalitions have recorded remarkable successe in several parts of Africa. Sometimes, implementing programs requires task shifting, where there is a mismatch between available personnel and the need for trained service providers.[151] Advocacy efforts have contributed to success stories in task-shifting in Kenya and Zimbabwe. In Kenya, advocacy coalitions succeeded in compelling the government to take middle ground, by considering the concerns of different opposing advocacy coalitions.[145] In this way, advocacy efforts deepen engagement in women's health and make it necessary for decision-makers to consider what evidence supports different policy alternatives. Usually, evidence

is drawn from similar settings and can inform decisions about programs and health investments.

Because shared value is a requirement for effective collaboration, an essential strategy for advocacy coalition building is ensuring that the organizations involved have shared values. The study by Klugman & Jassat points out that funding needs to be flexible for advocacy coalitions to be adaptive and innovative in achieving their goals.[152] There is evidence, for instance that advocacy efforts in South Africa have been successful in increasing political accountability in contexts where accountability was never a primary consideration in the public sector.[152,153] Coalition advocacy efforts have also resulted in significant increase in public support for women's health programs, including increased funding for and implementation of FP programs in South Africa.[152]

3.1.7 Examples of Global FP-MNCH Advocacy Initiatives

a. Punjab Hypertension Project in India: In India, the Punjab Hypertension Project was launched via a partnership between the Global Health Advocacy Incubator (GHAI), the state government of Punjab and the Postgraduate Institute of Medical Education and Research (PGIMER)[154], a government-designated "center of excellence" in medical science. The project sought to test and deploy innovations that would remove barriers to hypertension treatment with the goal of making services available to all. The project focused on three priorities: increasing the utilization of hypertension control and treatment, improving drug procurement and delivery systems and increasing budget allocations.

Resolve to Save Lives (RTSL) engaged the Global Health Advocacy Incubator (GHAI) in 2019 to pilot an innovative, multi-stakeholder partnership and prioritize hypertension treatment as part of a broader effort to strengthen the country's primary healthcare system. In addition to the technical and institutional improvements instituted in Punjab, political will and public support were necessary to implement and sustain project goals.

For this to happen, health policies need to change, and CSOs need support in engaging with policymakers. The public also needed to hear clear and concise messages. For this purpose the project enlisted trained health experts and undertook a media campaign to complement the concomitant engagement of CSOs with state policymakers. Additionally, the project facilitated workshops to provide journalists with evidence and context for the hypertension burden in India and were intentional in focusing on key dates, such as World Hypertension Day and Diwali (a nationwide religious public holiday in India). At the same time, community outreach stations were set up that provided free blood pressure readings, screenings and encouragement for at-risk individuals to seek treatment.

The coalition for joint advocacy between GHAI, the state of Punjab and PGIMER made it possible to expand access to primary healthcare services, even during a pandemic. Following the successful implementation of the project, Punjab was ranked the top state for Health Wellness Center (HWC) implementation by the national government, prompting other states to replicate Punjab's success and leading to scale up to four additional states.

b. Protecting Heart Health in India: Another coalition project in India:
The Protecting Heart Health in India – was targeted at reducing the burden of heart disease in India through obtaining government approval for strict limits on trans-fat in food, made available to the public[155]. Prior to the inception of the project, India accounted for more than one in five deaths from cardiovascular-related issues worldwide[156]. A coalition of partners, supported by GHAI, started advocacy in 2018 with the Food Safety and Standards Authority of India (FSSAI), the relevant Indian regulatory agency, to make the case for trans-fat elimination in line with WHO recommendations. The coalition organized meetings between FSSAI and public health advocates to build consensus around international best practices. It also provided technical support for a draft of regulations, used evidence to counter opposition groups; supported research on healthier alternatives to trans-fats and engaged decision-makers about ways to boost the availability of healthier oils. In addition, the coalition conducted a digital media campaign to highlight the dangers of trans-fat, and push for stronger regulation. The project facilitated a series of workshops to engage national news outlets and journalists in states with especially high burdens of non-communicable diseases (NCDs). CSOs were supported in building lasting relationships with state-level food authorities. They worked with them to educate food safety officers about the importance of testing food products for trans-fat. In December 2020 and February 2021, the FSSAI approved two regulations, requiring trans-fat to be reduced to less than 2% of total fat by January 1, 2022 – a year ahead of the WHO-recommended schedule[157] – in all food products in which edible oils and fats were used as an ingredient.

c. National Child Drowning Prevention Program in Vietnam:
Prior to inception of the project[158] in Vietnam, drowning was the leading cause of death in children under-15 years of age in Vietnam, accounting for the deaths of 2,000 children annually[159]. Dong Thap and Yen Bai are two provinces with large natural bodies of water and notoriously high rates of drowning deaths. The project aimed to reverse these trends by deploying targeted interventions, such as survival swim lessons, water safety education, awareness campaigns, community childcare centers that supervise children, and the installation of barriers and signs. In Dong Thap, a joint advocacy coalition between the GHAI and DCA, key decision makers at the Ministry of Labour, Invalids and Social Affairs (MOLISA) and the Dong Thap People's Committee were established for the prevention of child drowning. The joint advocacy coalition between global and local partners thus led to safer and healthier futures for the province's children.

In Yen Bai, the technical support provided through the project enabled the facilitation of local partnerships for Yen Bai's Department of Labour, Invalids and Social Affairs (DOLISA), including the identification of private swimming pools that could be used for surviving swimming classes. Via an agreement between local businesses and the Yen Bai DOLISA, children were able to receive survival swim training, paid for by the province, at a substantially reduced cost. Subsequently, local hotels were also enlisted to support the program by offering their swimming pools at a discounted rate, lowering the cost per lesson even further.

Through the implementation of all these strategies since 2021, Yen Bai has been able to self-fund its drowning prevention program in line with Vietnam's 10-Year Action

Plan on Child Injury Prevention 2021-2030.

The partnership between local businesses and the government was key to reducing government expenditures on infrastructure, thus allowing the program to rapidly train large numbers of children in survival swimming, while also improving training quality through better-equipping training facilities. The private sector was also key in supporting the program's growth because it aligned with their CSR goals, making it a win-win for all stakeholders across the board.

d. Colombia: The Role of Legal Strategies for Health Promotion:
In 2016, a few months before the Colombian Congress was considering a proposal to tax sugar-sweetened beverages as a measure to address rising obesity rates, a Colombian non-governmental organization (NGO), Educar Consumidores (EC), adapted an evidence-based public service announcement (PSA) for Colombia, highlighting the links between sugary beverages and non-communicable diseases (NCDs), such as diabetes and heart disease. The PSA was part of a public information campaign aimed at addressing growing rates of obesity. At the time, there was low public awareness about the connections between sugary drinks and diet related NCDs. Armed with significant funding and resources to influence the government and media, the food and beverage industry in Colombia then hit back, blocking the dissemination of PSAs to the public via the Superintendence of Industry and Commerce (SIC).

The aim of the joint advocacy coalition[160] was to empower Colombian Civil Society organizations (CSOs), to push back against the tyranny nature of the food industry and make it legal once again for the PSAs to be broadcast to consumers and the public. With the support and backing of the GHAI, the CSO coalition developed a communication strategy that responded to the immediate challenge of the SIC ban without jeopardizing the long-term legal goal.

It included key messages that were effective without putting the organization at risk of not complying with the order or harming the legal case. The long-term solution was a strong legal defense, backed by media advocacy to generate global media coverage highlighting the case.

In 2017, following an intense legal campaign, Colombia's Constitutional Court ruled that civil society organizations have the right to share public health information and that consumers have the right to see it. Through this decision, the tribunal also recognized the legitimate role of non-profit organizations in discussions of public interest.

e. Buckle Up Kids to Save Lives:
Although the World Health Organization had cited traffic injuries as the leading cause of death for people aged 5-29 globally[161] and there was evidence to show that car seats could reduce the risk of death in a crash by up to 80 percent for small children[161], at the inception of this project[162], parents in the Philippines had not been required to use them. Local civil society organizations identified the pressing need for a law mandating the use of car seats to protect children involved in road crashes.

GHAI provided technical support to local CSOs in mapping the policy process and building a strong coalition - identifying key stakeholders and potential champions within and outside of government - and evaluating media coverage of road safety to determine how to best structure their campaign to gain political support and engage the public. The information that emerged from this was used to develop an integrated campaign plan that helped guide strategy. The coalition launched an evidence-based media strategy.

They engaged well-known and respected campaign champions to spread a single message about child restraints and road safety via television and radio. The coalition also received support for paid advertising with a reach of 95 million – almost the entire population of the Philippines.

The open political system in the Philippines also helped to grant CSOs access to policymakers and build a coalition of support within the legislative chambers. The buy-in of these representatives helped pave the way for the legislation to successfully move through the House of Representatives and Senate.

In January 2018, an Act providing for the Special Protection of Child Passengers in Motor Vehicles was passed with no objections in the House of Representatives. Later that year, the senate passed a companion bill, again via a unanimous vote. In February of the following year, the President signed the bill into law. However, for members of the joint advocacy coalition, which was only the beginning of a new phase - the implementation and enforcement of the new law were still needed to ensure that the lives of the vulnerable children of Philippines were protected on the roads.

f. Health Policy Project:
The Health Policy Project (HPP) was funded by the United States Agency for International Development and implemented by Palladium, in collaboration with Avenir Health, Futures Group Global Outreach, Plan International USA, Population Reference Bureau, RTI International, ThinkWell, and the White Ribbon Alliance for Safe Motherhood.[163] In Guatemala, the project's objective was establish policy changes that improve access to reproductive health services, education, and nutrition among indigenous women and families in rural areas of Guatemala.[164]

The project supported the launch of two new indigenous women's networks (CSOs) and successfully advocated for the official publication

of the Healthy Motherhood Law Regulations,165 eliciting a written commitment from the Minister of Health for continued support to women's health issues HPP 2012.

In Madagascar, the project focus was on the 'Costed Implementation Plan for Family Planning'. Its objectives were to end preventable maternal and child deaths, secure access to healthcare and financial protection and address unmet needs for family planning.[166] Via a systems approach, the project offered a variety of user-friendly software and computer models that helped in-country partners better understand the magnitude of health challenges, explore policy and resource options, establish priorities, advocate for tax exemptions for contraceptive products, free resources to fund the plan; mobilized stakeholder investment in priority areas and helped with targeting resources to the most disadvantaged areas.

In Latin America and the Caribbean, the programs were led by a national network of diverse civil societies. The objective was to pressure governments to expand comprehensive sexuality education programs for young people by implementing declarations already signed by the government.[167] the Strategies employed included: developing scorecards to evaluate and report on if and how, governments were making progress in implementing the ministerial declaration, working with the media to publicize the scorecards, and comparing individual governments' progress with that of neighboring countries.[167] The project supported the development of budgets and policies advancing comprehensive sexuality education in the region.

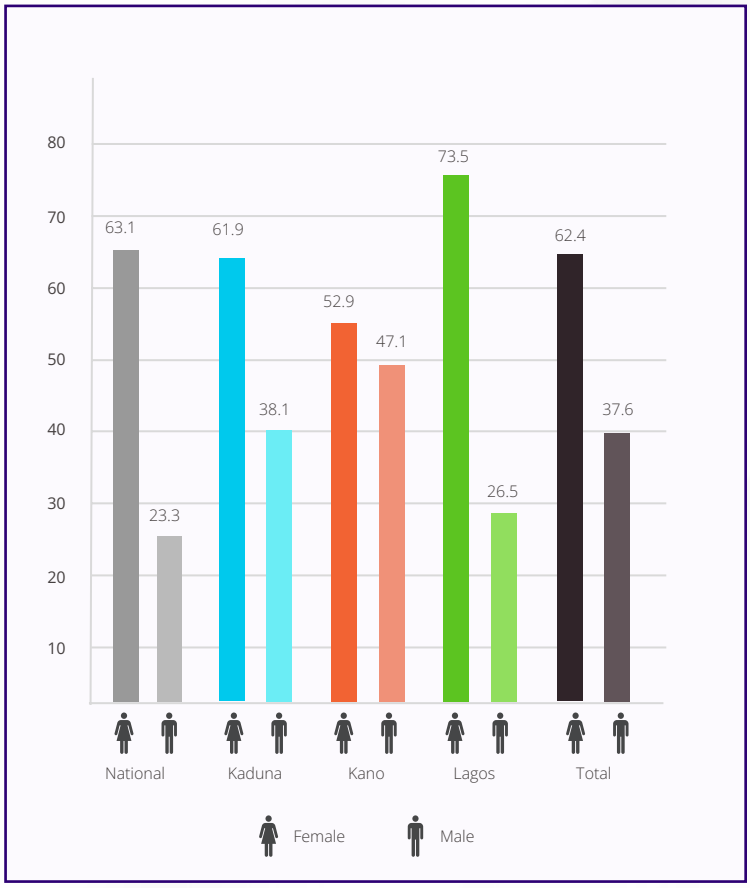
The Health Policy Project implemented another multi-country program[168] with the aim of ensuring access to HIV prevention, care, treatment, and support services for gay men and other men who have sex with men the MSMGF 2010. The coalition is composed of a diverse range of stakeholders from various sectors and countries around a common cause. Their governance structure is presided over by a 20-member steering committee that reflects the composition and diversity of its members.[169] The Policy Implications for the role of civil society in country ownership were clear. Strategies employed included publishing individual country information via their website; disseminating information to local HIV/AIDS and MSM advocates and networks through electronic digests, discussion forums, and traditional and social media initiatives.[169]

3.2 The Survey

3.2.1 Participants Demographics

A total of 442 stakeholders responded to the survey out of a sample of 472, yielding a 94% response rate. The sample differed slightly according to geographic location (study locations) as described in Table 1 (section 2). Of the 442 respondents, 62% were female and 38% were male.

Figure 16: Respondents-gender by state



There are more women working in women's health space than men, and this opportunity should be leveraged to advance advocacy for women's health priorities in Nigeria.

In line with Nigeria's gender and inclusion policy, approximately 5% (4% of women and 6.6% of men) of people living with disability were included in this study.

However, this proportion differed across the states, with the national proportion being as low as 1.9% of its total study sample.

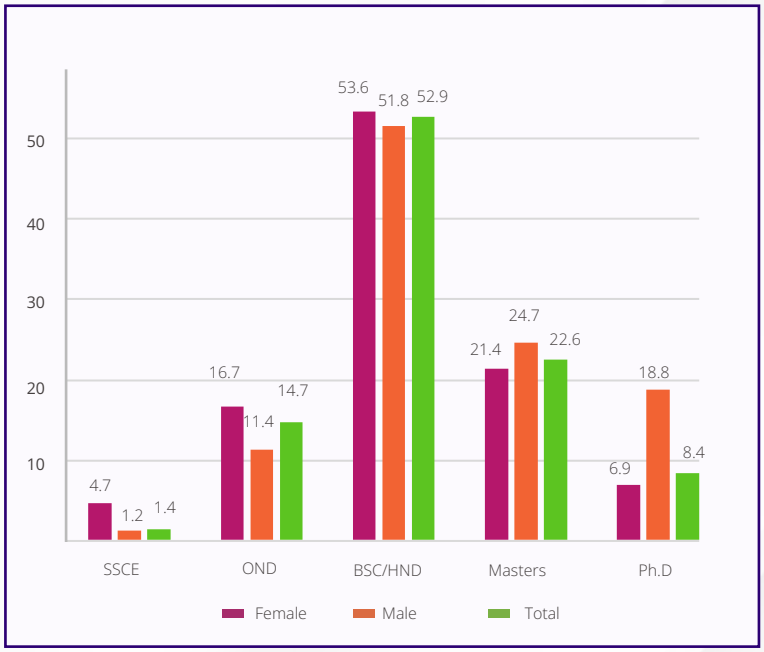
At least 50% of the participants were graduates with qualifications (BSc/HND). However, this varied according to the gender of the participants and according to the study location.

Men have a greater tendency of acquiring masters and doctorate degree than women.

Disaggregated analysis showed that people working at the national level were more educated than those working in Kaduna, Kano, and Lagos exemplified by the proportion of the respondents with a masters and doctorate degrees.

Comparatively, 52.4% of respondents at the national level had MSc/PHD, which was higher than that of their state counterparts. Approximately 31% of Lagos respondents had MSc/PHD, compared to 25.6% and 17.8% in Kano and Kaduna, respectively.

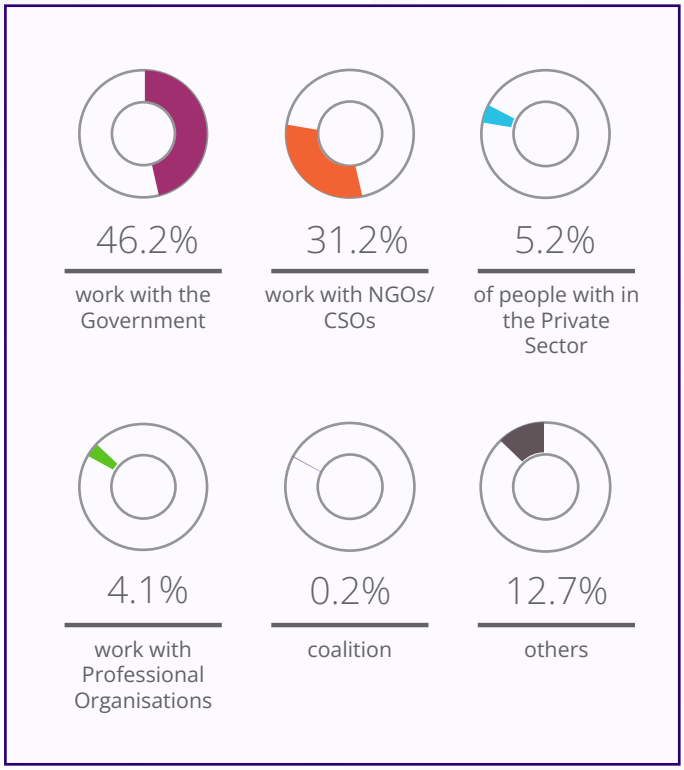
Figure 17: Educational status by gender



Almost half of the participants were found to be government workers, followed by NGOs/CSOs which reflected the multi-sectoral nature of women's health joint advocacy. A proportion of the participants (12.7%) worked in other places including media and academia.

The findings suggest that participants have the requisite work experience to understand the gaps and opportunities for advancing WH joint advocacy. About 80.5% had worked for >4yrs in the WH advocacy space.

Figure 18: Participants' workplace



Data were collected from lower, middle and upper cadre employees with different levels of experience in the women's health advocacy space; 45.2% had worked for more than 10 years, 35.5% had worked for 4-10 years, and 25.5% for had worked for 3 years.

Overall, approximately 61% of the respondents were health professionals including doctors (11.8%), nurses/midwives (17.4%), pharmacists (1.6%), health education/promotion specialists (11.1%), and public health specialists (19.%).

A deep dive into the professions of the respondents indicated that there may be a gap in the technical capacity existing among women's health advocates across the study locations. About 39% of the respondents were from professions that are not health-related, although there was no indication that they had acquired additional health certifications that position them better as women's health advocates.

3.2.2 Key Barriers to Women's Advocacy

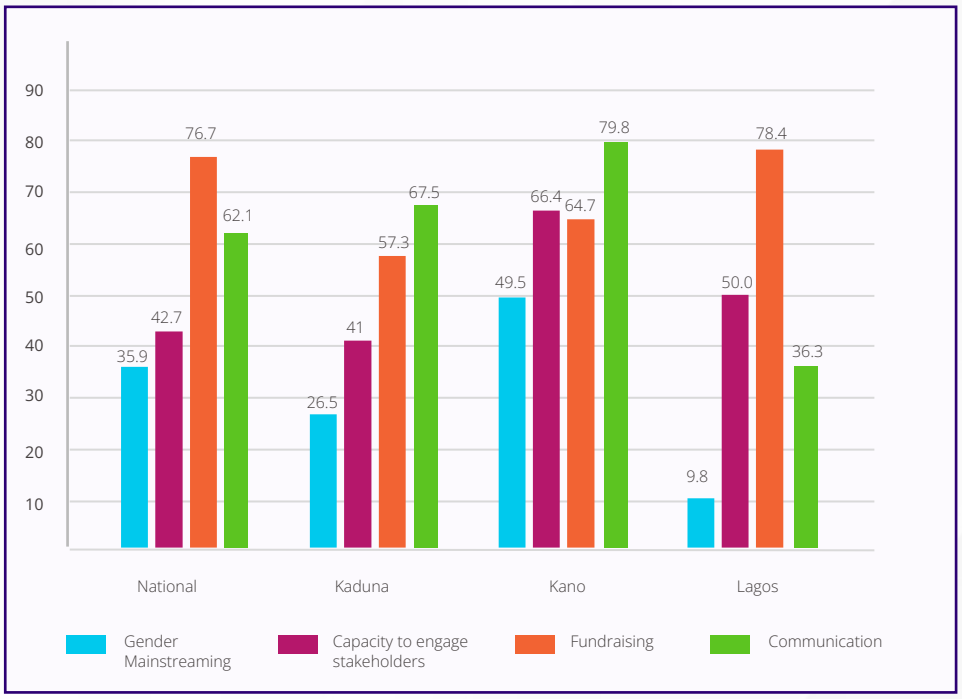
Capacity gaps

The findings demonstrate that the gaps are wider in Kano and Kaduna than in Lagos and at the National level. Gap in gender mainstreaming was greater in Kano, orchestrated by strong religious and cultural norms.

Fundraising skill was the highest capacity gap identified at the national level and in Lagos, while limited communication skill was more predominant in Kaduna and Kano, respectively. There was also a limited capacity to engage stakeholders, which was more prevalent in Kano and Lagos than in other locations.

Regarding advocacy capacity, there were geographic differentials - the incidence of poor communication skills was greater in Kano (79.8% and Kaduna (67.5%) than in Lagos (36.3%) and national (62.1%), respectively.

Figure 19: Capacity gaps

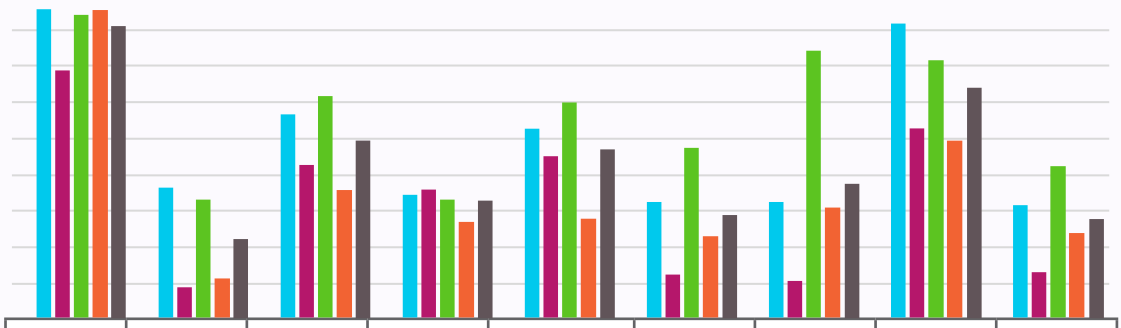


Perceived barriers to advocacy

Advocates perceived myriads of barriers to future WH joint advocacy, However, financial difficulties and religious and cultural barriers were predominant across the states and national. Other perceived barriers included: work environment, limited support from colleagues, inadequate legal support, inter and intra -coalition politics, and unintended negative consequences of advocacy.

Nevertheless, further exploration of the geographic dynamics highlights some notable differences across the states. Approximately three-quarters of the participants in Kano reported poor advocacy process and a lack of political commitment as major barriers compared to participants in Kaduna, Lagos and National who highlighted poor funding, and religious and cultural barriers as major barriers. Advancing women's health advocacy will require strategic barrier reduction approaches that are measured and reported.

Figure 20: Perceived barriers to WH advocacy



	Poor funding/ financial difficulties	Lack of corperation between coalition members	Slow Political Alignment	Target population not ready to change	Ineffective Communication	Provider Behaviour	Poor Advocacy Process	Religious and cultural beliefs	Inadequate knowledge of advocacy principles/ processes
National	85.4	35.9	56.3	34	52.4	32	32	81.6	31.1
Kaduna	68.6	8.5	42.4	35.6	44.9	11.9	10.2	52.5	12.7
Kano	84	32.8	61.3	32.8	59.7	47.1	73.9	71.4	42
Lagos	85.3	10.8	35.3	26.5	27.5	22.5	30.4	49.0	23.5
Total	80.5	21.9	49.1	32.4	46.6	28.5	37.1	63.6	27.4

3.2.3 Existing Advocacy Efforts and Outcomes

Overall advocacy focus

About 92.3% of the participants reported that their organizations advocated for women's health. the findings show that 32.8% of the organizations implement advocacy alone (solo implementation), while 59.5% implement it as a partnership/consortium /coalition.

Joint advocacy priorities

Joint advocacy priorities were mainly MNCH and FP, with little prioritization for other thematic areas (including nutrition, GBV, adolescent health, and fistula).

Very little advocacy is currently occuring at the community level across all states and the national. Current advocacy efforts are mainly targeted at generating demand for health services. There is a minimal connection or presence of the national at the state level.

Figure 21: Joint advocacy priorities

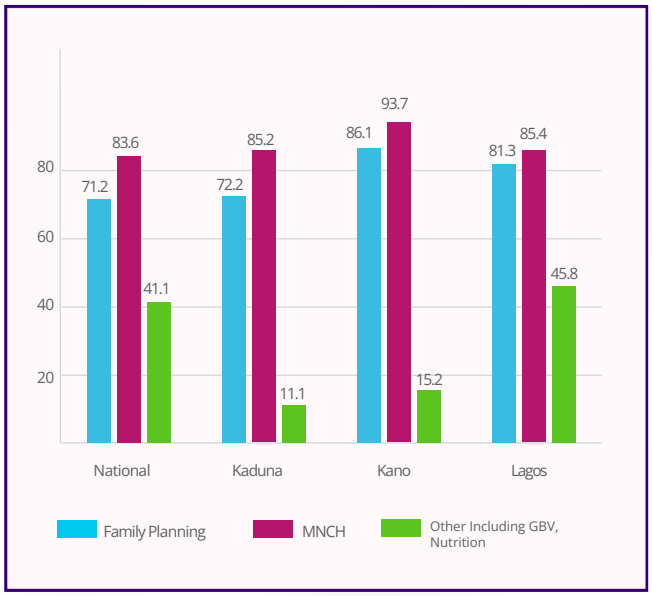
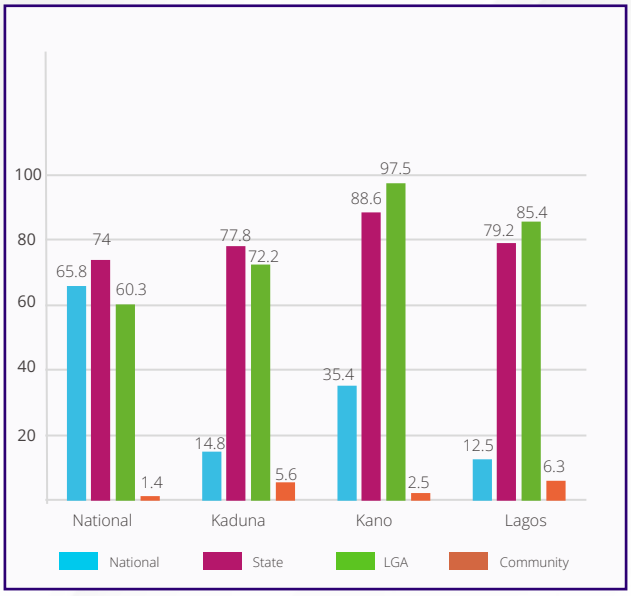
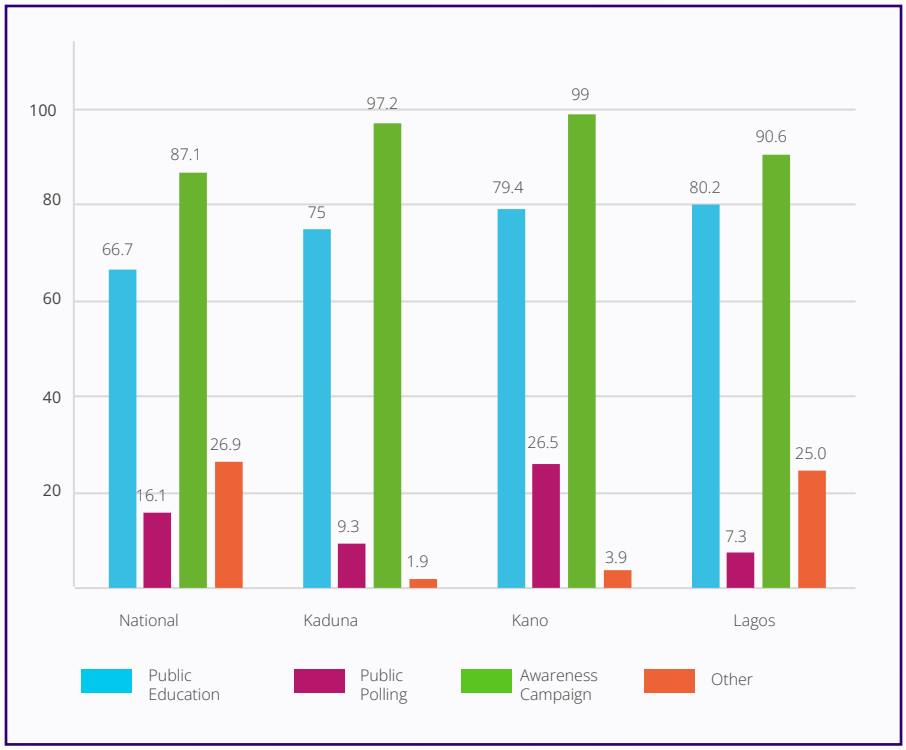


Figure 22: Current settings for joint advocacy



Current approaches for joint advocacy

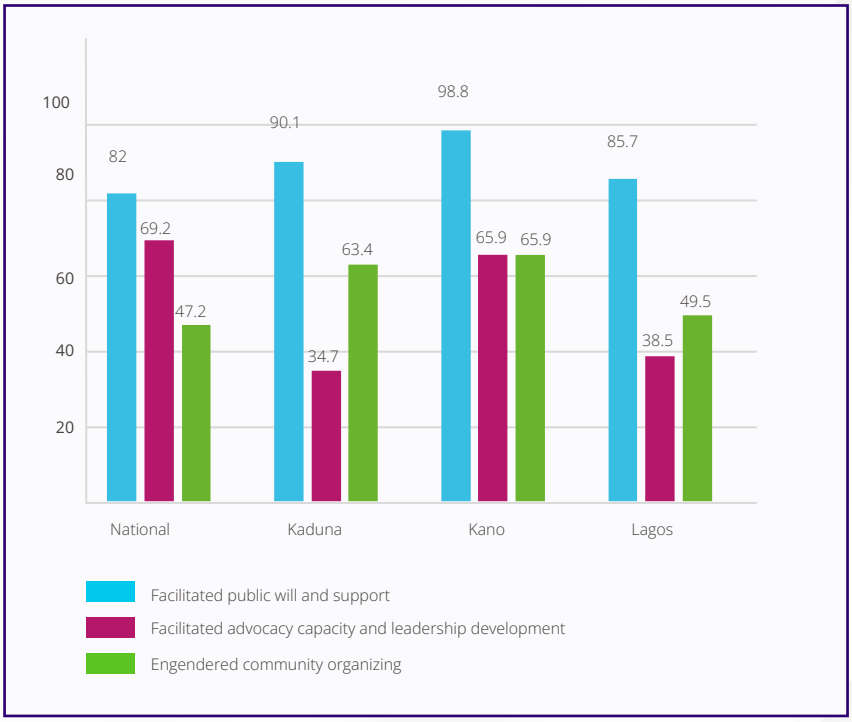
Figure 23: Approaches for joint advocacy



The key strategies for joint advocacy were awareness campaigns, public education and public polling, with awareness campaigns dominating in all locations of the study.

Impact of joint advocacy on public will

Figure 24: Impact of joint advocacy on public will



Overall, joint advocacy efforts generated public will and support.

However, there are gaps, indicating that for joint advocacy strategies to generate effective public will may need to be remodeled.

More effort is required to ensure community organizing across locations.

3.2.4 Opportunities for Women's Health Joint Advocacy

Overall, 82.6% of the participants believed that there were opportunities for women's health joint advocacy in Nigeria.

Approximately 80% of the respondents opined that women's health joint advocacy is an excellent initiatives.

Interestingly, stakeholders believe that women's health joint advocacy initiative will help to build broad-based support across communities, including among religious, political, and other leaders.

This is evidenced by the feedback from the respondents – National (66%), Kaduna (100%) Kano (90%), and Lagos (75).

The findings from this study indicate that women's health joint advocacy may add credibility to advocacy activities in Nigeria. In addition, women's health joint advocacy initiatives will help advocate for positive policies and the needed infrastructure for FP and MNCH programs and dispel myths and misconceptions about women's health priorities in Nigeria.

There were mixed reactions about where women's health joint advocacy networks should be located. While 60% and 65% "of the respondents thought that it should be located at the state and local government levels respectively, 40% of the respondents thought it should be located at all levels of government with all women's health priorities being served through joint advocacy.

3.3 Findings from Key Informant Interviews and Multi-stakeholder Dialogues

3.3.1 Typologies of women's health joint advocacy coalitions

At the national level, we found evidence for the existence of a government-led multi-stakeholder coalition RMNCAEH +N TWG. In Kaduna, four coalition typologies were identified: Government-led multisectoral coalition (RMNCAEH+N); Hybrid/Mixed Leadership (e.g., Family Health Advocates Nigeria Initiative (FHANI) and Open Government Partnership (OGP); CSO-led (e.g., Kaduna State Maternal Accountability Mechanism (KADMAM); and Community-Led (e.g., Ward Development Committees).

In Kano, three joint advocacy typologies were identified in Kano state: Government-led – multi-sectoral coalition (RMNCAEH+N); Hybrid-Led/Mixed Leadership KANSLAM (Kano State Led Accountability Mechanism); Community-Led, e.g., a), Kano State Emirate Council Committee on Health and Development (KSECCoH) and Ward Development Committee (WDC).

In Lagos, we found at least four coalition typologies supporting women's health advocacy efforts namely, the Lagos State Accountability Mechanism (LASAM), Lagos State Advocacy Working Group (LAWG), Lagos State Civil Society Open Partnership (LACSOP), and RMNCAEH+N TWG (RMNCAEH +N TWG is the government-led multisectoral typology).

> *The RMNCAH multi-stakeholder, multi-partnership forum [which has] been in existence for a very long while now, and it used to be called the Core Technical Committee for RMNCAH.*
> *- Stakeholder dialogue, Lagos*

However, LASAM complements the activities of the RMNCAEH +N TWG and has representatives among the RMNCAEH members

.

3.3.2 Joint advocacy coalition structure

While the coalition is government-led, it is a multi-stakeholder partnership involving a wide range of actors representing different organizations (including the private sector, academia, national and international NGOs, government, professional associations, legislatures, media, communities, etc). The RNMCAEH+N TWG has four subcommittees (Advocacy, Resource Mobilization & Communication; Leadership, Coordination & Partnership; Accountability, Data & Knowledge Management; and Quality Technical Delivery). The Membership of sub-committees is voluntary and determined largely by members' preferences.

> *When those committees were carved out, we asked people to choose whatever committee [they] wanted to belong to, so at the end of that very first meeting, we had all the subcommittees listed. They had a day one meeting to acclimatize with each other. So there and then, nobody forced anybody to be the chair; they left it*

open. So all they do is to get back to the secretariat to say, this person is the chair, this person is the secretary for the subcommittee, amongst themselves they select.
- Stakeholder dialogue, National

The RNMCAEH+N coalition is domiciled within the FMoH and headed by the Minister of Health, with the Director Department of Family Health as the deputy.

> *So it's usually the Director of Family Health that chairs the TWG for RMNCAH+N*
> *- Stakeholder dialogue, National.*

The leadership of the coalition is by appointment since it resides in the office of the Minister of Health and its secretariat is in the office of the Director, Department of Family Health. The implication is that the leadership of the coalition is affected by transfers and retirements as a government official noted.

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

The people occupying offices in which the leadership of the coalition is domiciled may also be occupied with other tasks and may not commit sufficient time or priority to activities of the coalition.

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

The sub-committees have fixed terms of two years. However, because the meeting are inconsistent, they delays electing new leaders at the end of each tenure.

> *We have not met. We're just trying to see how we can put our strategy together. It is only when we call for the stakeholders meeting, a meeting, stakeholders meeting that we can now deliberate on the strategy and election to get new persons to be at the helm of affairs of those subcommittees'*
> *- Stakeholder dialogue, National*

In Lagos, for RMNCAEH + N TWG, the Permanent Secretary of the Ministry of Health is the Chair of the committee. The members included representatives of LASAM and LASCOP; relevant departments and agencies of the health sector, such as the Family Health and Nutrition Department, the Primary Health Care Board and the Health Service Commission; and ministries such as Education, Women Affairs, Poverty Alleviation, The Ministry of Youth, Information and Strategies, and the Office of Disability Services. The Lagos State Domestic and Sexual Violence Agency and other government functionaries, or key partners, are also included as members of the committee. In addition, funders and development partners are members of the committee

The Lagos RMNCAH Committee has sub-technical working groups such as the Safe Motherhood Technical Working Group, a Family Planning Technical Working Group, a Child Health Technical Working Group, and an Adolescent Health Technical Working Group. The sub-committees meet quarterly.

> *You have the knowledge management subcommittee, which includes all the press people. Within these groups, government program officers who sits within to provide information and support, but the bulk of the work is supposed to be led by the CSOs and the press men. Then you have the evidence subcommittee, which is where you have a lot more government personnel due to the nature of their work*
> *- Stakeholder Dialogue, Lagos*

The Lagos RMNCAH TWG is domiciled in the Ministry of Health, while the LASAM secretariat is shared by the government and a CSO. The RMNCAEH TWG is functional, and its meetings hold twice a year. LASAM has provided some form of accountability oversight in the state.

> *When the Permanent Secretary is not around, he will cede leadership to the Director of Family Health and Nutrition, in whose directorate RMNCAH interventions are domiciled*
> *- Stakeholder Dialogue, Lagos*

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

In Lagos, the headship of the RMNCAEH+N TWG, resides in the office of the Permanent Secretary of the Ministry of Health, therefore, succession depends on appointment. However, for the LASAM, the leadership positions held by CSO actors are determined by election, and there is a two-year tenure.

> *It was decided by a vote process. Right now we have the CSO who has taken over and then we have a secretary, she has been secretary for a while, there is actually a tenure, you're supposed to run for two terms, I think it's two or three years, but there's also the case where you may want to leave [the leadership role] and someone else may want you to continue. They may say, "You're doing such a good job, we want you to continue*
> *- Stakeholder dialogue, Lagos*

3.3.3 Awareness creation strategies

Table 3: Awareness creation strategies

Domain	National	Kaduna	Kano	Lagos
Awareness Creation				
Public	Public awareness strategies include a combination of activities like social media campaigns, videos, leaflets, and one-on-one interactions to generate awareness on women's health issues. Targeted messaging is used to tailor awareness campaigns based on individuals' understanding of the issues at hand. Community outreach, social media, television, and radio are utilized to increase public awareness on gender-based violence (GBV) and social welfare services.	Joint advocacy efforts targeting decision-makers in the executive and health-related MDAs aimed at budget development, approval, and fund release for family planning and nutrition-related items.	Various advocacy efforts, excluding healthcare providers, have been observed to raise awareness about women and children's health issues, particularly regarding family planning in Kano State.	Public awareness strategies include community outreach programs, peer-to-peer education, and media engagement. Social media advocacy is utilized, particularly through young social media influencers.
Influencers	Key influencers such as religious leaders, traditional rulers, and community leaders are engaged through lectures, workshops, and involvement in government programs to create awareness within their communities.	Education and awareness-raising among public figures and influencers to amplify women's health matters, including addressing cultural barriers.	Strategies target influencers such as philanthropists, employing tailored advocacy messages and documentation submission to solicit support.	The First Lady is engaged as a key influencer to advocate for budget allocation and policy support from the Governor.
Decision makers	Decision-makers at both the executive and legislative levels are reached through stakeholder meetings to ensure their involvement in addressing women's health issues.	Joint advocacy efforts targeting decision-makers in the executive and health-related MDAs aimed at budget development, approval, and fund release for family planning and nutrition-related items.	Advocacy extends to government officials and traditional leaders, emphasizing the importance of family planning and maternal and child health issues, resulting in policy changes and support.	Decision-makers are reached through communiques, news outlets, and targeted advocacy to key government offices and officials. Key decision-making fora, such as the national reproductive technical working group, are targeted to influence policy at both state and national levels.

The Public

Advocates use a combination of activities to create awareness and generate public will.

> *We do price briefing, social media campaigns, we do videos, we do leaflets, we do posters, we do one on one. I can show you some videos that we did*
> *- KII, Medical Women Association, National.*

Regarding joint advocacy strategies aimed at changing public will/behaviors, advocates reportedly employ community outreach in the form of town hall meetings and market outreaches, usually done to commemorate key international days. However, radio, in the form of jingles and call-in programs, appears to be a highly successful (and more favoured) mode of public outreach in northern Nigeria. Advocates also used evidence to educate the public during community outreaches.

> *In the north, (let me speak where I am, [where] I've gone), they don't play with the radio programs. Radio programs are very key, especially in the local context.*
> *- NGO representative, Kaduna*

> *We do community outreach; we do research to be able to provide evidence. Currently, we are working with Amplified Change and we are researching the discussion around abortion in Lagos, to see what the views about it are*
> *- KII, CSO, Lagos*

Several activities are organized during the 16 days of activism against gender-based violence. Some of the activities are designed to create awareness off women's health issues, and programs and policies are put in place to address them. One important issue raised about public education is targeted messaging.

> *You can't have one message for all. No, not in advocacy. You have to understand where the person is coming from, his understanding of issues*
> *- KII, CSO, National.*

We found some evidence of advocacy efforts focused on strategies to increase awareness with regard to GBV and social welfare services (child protection, adoption, psychological and counselling support for GBV, economic skills development) via community outreach, social media, television and radio. This was reflected in the quote below.

> *Social mobilization, which some of the primary healthcare are doing. Honestly, I won't tell you lies. They're doing it to ensure that they go out once a week into the communities, to tell them, come to the health facilities where you want to deliver"*
> *- Stakeholder dialogue, National.*

Additionally, in terms of efforts to increase public awareness, advocates conduct group discussions and partner with local peer educators as the quote below.

> *The majority of their work is outside the facility, which is in the community, 60% of their time. They [local agents] ... go into the communities to actually meet them [women from] house to house. In addition they go with that key 19 household practices. Family planning is one of it; to tell these women, if you don born [have had] ten [children] 'wetin you still dey born?' [what more are you looking for?]*
> *- Stakeholder dialogue, National.*

> *We engage media to create awareness, and of course, there was a time that they were trained so that they would know how to express [frame women's health messages] and to pass across the information [effectively]*
> *- KII, Policymaker, Lagos.*

SMoH and it's partners, such as the National Orientation Agency and Kaduna State Media Corporation (KSMC), also collaborate to implement joint community outreach activities. Religious women groups such as WOWICAN also organize awareness campaigns to increase demand for priority women's health services.

> *National Orientation Agency, they use their theatre for development. They dramatize issues relating to nutrition in the community. It's [a] joint effort with the state. Then the KSMC, which they use to enlighten people on the importance of good nutrition. Like breastfeeding week, they used to carry jingles, free and other things. They even called us for interviews, as it relates to the nutritional status of people, and also a way forward to improve the nutritional status of vulnerable groups in the state.*
> *- KII, Policymaker, Kaduna*

> *Therefore, the women's wing of CAN is doing much about this; they go to local governments and organize women's seminars. Last month, they were in Oduwa local government and even here in Kano. They go block by block and church by church.*
> *- Christian Religious Leader, Kano*

Advocacy efforts aimed at increasing public awareness of on women's health have begun to yield the desired results, as the quote below suggests.

> *People are getting more and more aware now and are trying to dissuade themselves from focusing more on attacking the federal government to save Nigeria, if I may put it that way Emphasis is now going down the states*
> *- Stakeholder dialogue, National.*

Except for health care providers, almost all participants reported actively engaging in some form of awareness creation around women's and children's health issues. Although they did not support their claim with statistics, one respondent reported that awareness creation within the general public improved acceptability/demand for family planning in Kano state:

> *For childbirth-spacing, which people have accepted, all commodities are put to use judiciously without wastage. I think it's [FP commodities] not even enough. Women and men are demanding for family. planning; they got awareness about childbirth-spacing.*
> *- Policymaker, Kano*

> *We gave lectures, fliers, banners, we also engage our spiritual leader at least on so many government programs like Children's Day, [and] Mothers' Day [celebrations]"*
> *- KII, Faith-Based Organization Rep, National.*

Advocates organize workshops with community and opinion leaders, building their capacity to help give a voice to women's health priorities. At such workshops, influencers are engaged and trained on women's health issues. This strategy rests on the assumption that influencers are able to 'influence' behavior in their communities. Influencers have a strong impact on health-seeking behavior. Media can, however, be used as a major channel for influencing the public. Women's health advocates also train journalists as potential influencers.

> *Recently, we had a training of the journalists so that they can have appropriate messages [and] they can communicate appropriate messages to the public on adolescent issues. Through training, they are aware of adolescent programs and adolescent issues, how to appropriately target [channels] their messages and send the right message to the public"*
> *- KII, FMoH, National.*

> *Well, there was this community we went to in Zaria. We realized that there was little attendance for ANC, and FP, by adolescent girls. there was a large number of girls coming with VVF. So we have to go to that community, talk with the religious leader of that community and the traditional leader of that particular community. So the first thing we did was outreach.*
> *- KII, program officer Kaduna*

There are philanthropists influencing awareness creation initiatives at the state and community levels. Efforts are also targeted at advocating to these influencers with the right messaging showing positive results.

> *We have philanthropists in the state or in the communities. Sometimes there will be....you see, we will get willing people to support this initiative.*

In Lagos, advocates have also strategized to explore social media advocacy, using young social media influencers.

> *They [young people] are the ones on Twitter, they are the ones [we are] dealing with, we need this group of young women to become the advocate, to ask for security of their health. So, it is an opportunity because they're exposed, they are the Gen-Z's, they need to lead the conversation online. So, we need to open that opportunity for them to become the leaders in this conversation that would probably help us with innovation and creativity'*
> *- KII, CSO representative Lagos*

Decision makers

Advocates reach out to members of the National Assembly and other decision makers and invites them to attend stakeholder engagement meetings and some positive responses have been documented as one of the advocates explained below:

> *We usually meet them and invite them for stakeholder meeting... they send representatives and they get a report from whatever we do there*
> *- Stakeholder dialogue, National.*

> *We conduct advocacy to the Ministry of Health, Ministry of em, Primary Healthcare Board and we have added a policy partnership with the Lagos State Health Management Authority LASHMA. So at the state, at the local level our community stakeholders who fall under different local governments spearhead our advocacy to the local government chairperson, ... the Head of, the HOD of Health and then other concerned stakeholders around health issues - that has been our area of focus*
> *- KII, CSO, Lagos*

Advocates also adopt a multi-pronged approach that maps and targets both the executive and legislative arms of government, and several MDAs within the executive arm of government at the federal level. In Kano, advocates reported successfully leveraging windows of opportunity provided by political campaign seasons, during which decision makers are most likely to offer a listening ear.

> *We engage with the Federal ministry of health through the Department of Family Health, National Primary Health Care Developmental Agency (NPHCDA), NHIA in terms of financing and ensuring that family planning and RMNCH issues continually be on part of the membership package. So right from the legislative, we have the senate committee on health and appropriation; we have a house committee on primary health care being part of the conversations"*
> *- KII, CSO, National.*

> *We are doing something on policy or commitment to child health. On this particular one we met with the accountant general's office, we met with the legislators, and clerk of the house, we have met with the different ministries and even Ministers.*
> *- KII, CSO, National.*

> *We are the ones advocating to the Ministry of Budget, to the Ministry of Finance, to please release allocations that have been made for family planning. We have done that. I can remember we came for a meeting ... and we had to go to Minister of Budget to say look, these monies even though it is written that it has been approved but they are not released*
> *- KII, Medical Women Association, National*

> *They [gubernatorial aspirants] only remember CAN when they are vying for office. They will come to visit us just for us to campaign for them. therfore, we also seize that opportunity to say - okay, if you win, these are the things we want you to do for us.*
> *- KII, Christian Religious Leader, Kano*

In Kaduna, there was evidence of joint advocacy to create awareness among decision makers, such as those in the executive responsible for overseeing budget development and approvals, as well as key decision makers within the health-related MDAs responsible for ensuring the action of budgets and the release of approved funds. Some respondents spoke about involvement in joint advocacy to institute dedicated budget lines for FP and nutrition-related items. Our evidence showed that advocates engaged decision-makers to ensure cash backing on already approved budgets following delays in fund

release. In Kano, advocacy to decision makers led to increased funding, communities and consumables for women's health priorities.

> *The governor approved what is allocated for family planning and even for the health sector. He promised to approve 15% of the health sector in which family planning was prioritized. In this year, money was not released for family planning. We advocated, we followed up, we did all we could do.*
> *- KII, Program officer, Kaduna*
>
> *They advocate to the state government. So when they advocate[d] to the state government a certain amount was set aside for that*
> *- KII, ASRH Officer, Kano*

Some of these advocacy efforts engineered policy change, improved policy implementation, and quality control.

> *We support and went for advocacy to the Commissioner for health and requested him to allow us to carry out spot checks on family planning, and he allowed us".*
> *- KII, CSO representative, Kano*

3.3.4 Outcomes of joint advocacy

Table 4: Outcomes of joint advocacy

Domain	National	Kaduna	Kano	Lagos
Outcomes of Joint Advocacy				
Collaboration among partners	Collaboration is essential in advocating for women's health (by bringing together different resources, skills, and expertise to advance women's health goals) Collaborative efforts have been observed between local and international organizations, government MDAs, and the private sector. Examples: digitalization of family health department activities through a partnership between FMoH and PSI, collaboration with Palladium and Breakthrough Action to address women and children's health issues across different states, and funding support from UNFPA, Marie Stopes International, John Snow, and SFH for advocacy efforts. Collaboration across tiers of government is important for effective implementation of strategies at the state level.	Collaboration among partners in Kaduna state involves obtaining free airtime on radio and TV through relationships with media organizations, joint advocacy efforts led by CSOs and involving various government departments, NGOs, and international organizations such as UNFPA, Society for Family Health, and CHAI.	Diverse Groups Collaboration: Evidence of collaboration among various groups, including Islamic and Christian communities, around advocacy work for women and children's health. Interfaith Cooperation: Islamic and Christian groups actively participate in advocacy meetings, with mutual awareness announcements made in mosques and churches regarding available services.	Collaboration among partners is strong in women's health advocacy, with functional advocacy working groups and partnerships with government agencies and community-level actors. Managing complex partnerships and addressing institutional barriers are ongoing challenges that require reforming institutions and investing in both institutions and individuals to achieve true progress.
Coalition building	The government-led coalition, RMNCAEH, plays a crucial role in advocating for women's health in Nigeria. It consists of four subcommittees and involves various stakeholders from the government, professional associations, CSOs, media, and the executive arm of government. There are challenges in terms of consistent meetings and capacity strengthening within the coalition, however. Regular meetings have not been held as stipulated by policies, and there is a need for continuous training/capacity strengthening among key actors and healthcare providers to enhance women's health advocacy efforts.	**Government-Led Multisectoral Coalition (RMNCAEH+N):** Two subcommittees focusing on family planning and advocacy, social mobilization, and communications. Leadership elected through a group voting process with varying tenure lengths. Monthly meetings stipulated by policy but not consistently held. Advocacy for nutrition primarily through planning and budget commission with CSO assistance.	**Government-Led (RMNCAEH+N):** Chaired by the Director of Public Health. Advocacy subcommittee led by the State Health Educator, lacking clear performance indicators and facing functionality issues due to member commitment. Core meetings held quarterly. **Hybrid/Mixed Leadership (KANSLAM):** Highly functional coalition overseeing government activities, with diverse membership.	The First Lady is engaged as a key influencer to advocate for budget allocation and policy support from the Governor.

		Hybrid/Mixed Leadership (FHANI) Co-chaired by CSO and government, with multi-sectoral membership. Leadership determined through election but lacks clear performance indicators. **CSO-Led (KADMAM)** Co-chaired with government, involving various stakeholders, with subcommittees for different functions. Highly functional, meets quarterly for evidence generation and service monitoring. **Community-Led (Ward Development Committee):** No clear performance indicators reported for leaders.	Conducts public polls and utilizes evidence-based scorecards to monitor advocacy indicators. Co-chaired by government, conducting both physical and virtual meetings effectively. **Community-Led** **KSECCOH:** Membership includes representatives from various sectors, lacking reported performance indicators. **Ward Development Committee (WDC):** Diverse membership, with no reported performance indicators.	
Advocacy capacity building	Capacity building and training programs (to enhance understanding of women's health issues and improve communication skills) have been conducted for advocates, healthcare providers, media practitioners, and market women. Mentoring and support from RH coordinators at the state level contribute to capacity building efforts. Collaboration with journalists has led to training programs on adolescent health and women's rights. Capacity strengthening activities have also targeted members of sub-national advocacy working groups and market women on health insurance.	KADMAM Increased resilience and sustainability having had funding support and technical guidance via E4A Mamaye program.	No clear evidence for capacity building reported	Capacity building activities, like training and retraining, are conducted by women's health advocates to address knowledge gaps and improve understanding of maternal health issues. INGOs like the Population Council provide funding for capacity strengthening activities, including trainings on financing and family planning methods. Key opinion leaders at the community level are also trained to disseminate information and engage with stakeholders.

Successful mobilization of key voices	Advocates have successfully mobilized key voices, including civil society organizations, women's groups, youth, media, and CSOs for women's health. Joint advocacy efforts have led to increased ownership of initiatives by public office holders.	Successful mobilization of key voices for women's health advocacy includes the impactful involvement of past governors' wives, such as Umni El Rufai, who spearheaded initiatives like the Kaduna State Emergency Nutrition Action Plan, influencing even the governor and ensuring continued efforts in the field.	Advocacy efforts led to the approval of women and children's health initiatives by district and village heads, who then disseminated the importance of healthcare services to their communities. Engagement with councilors ensured stakeholders took advocacy efforts seriously, leveraging their influence within the community.	The Lagos Civil Society Participation for Development (LACSOP) provides a platform for different advocacy groups to collaborate and promote women's health policies and programs. LACSOP has successfully mobilized key voices, including the wife of the Governor of Lagos, to advocate for budget allocation and policy changes. Advocates in Lagos have also been successful in mobilizing government officials at the directorate level through regular meetings, where they discuss advocacy outcomes and report to higher authorities. They have further mobilized religious and community leaders to engage in women's health issues, using platforms such as meetings of governors to showcase progress and advocate for change.
Policy change/ legislation	Advocacy efforts have resulted in the drafting and approval of women's health policy documents like the National Advocacy Strategy for RMNCAEH + N, National Advocacy Guideline for Family Well-being, and National RMNCAEH strategy guidelines. They have also led to policy changes in the health sector, such as the establishment of Family Health Departments at the state level, introduction of budget lines for adolescent health, and domestication of WHO guidelines on self-care for sexual reproductive and maternal health.	Joint advocacy efforts have resulted in policy changes and legislative actions, such as achieving the allocation of 15% of the state budget to health in Kaduna State, aligning with the Abuja declaration. Additionally, advocacy has shifted focus toward state-level initiatives like PHC under one roof.	Joint advocacy efforts, involving states, partners, and CSOs, led to the successful implementation and domestication of an adolescent policy document in the state, demonstrating the impact of collaborative advocacy on policy reform.	Advocacy efforts have led to changes in policies and legislation, such as the introduction of family planning budget line and the release of a significant portion of the approved RMNCAH+N budget. Advocates have also successfully worked to abolish compulsory blood donation during childbirth and shift policy regarding postpartum detention of women who cannot pay medical fees.

Collaboration among partners

Several collaborative advocacy efforts, involving local and international organizations, government MDAs, and the private sector, have been recorded in women's health programs and policies. For example, respondents recounted a collaboration between the FMoH and PSI aimed at facilitating the digitalization of family health department activities through three days of workshop training. Other organizations that have partnered with the government to push women and children's health issues include Palladium (through the LAFIA program) and Breakthrough Action (through the support of USAID) across Sokoto, Ebonyi, Kebbi, Bauchi, Gombe, Lagos and Cross Rivers. In addition, the government has partnered with the Center for Communications and Social Impact (CCSI) (with funding support provided by a consortium of partners, including Johns Hopkins and BMGF) to carry out demand creation advocacy. In the past, participants also shared that the RMNCAEH+N TWG had received funding in support of advocacy from the UNFPA, Marie Stopes International, John Snow and Society for Family Health (SFH).

During the national stakeholder dialogue, participants validated the existence of collaboration among organizations and other entities (such as inter-religious organizations) in advocating for women's health.

> *In 2019, the WHO put out a self-care guideline that some countries saw the importance of bringing it to their geographies because of the contributions that it will make in accelerating progress toward universal health coverage. In Nigeria, a number of organizations came together to advocate for the domestication of that policy. So in the lead for that were… Pathfinder was there, JSI was there, White Ribbon Alliance, SFH with WHO taking the lead'*
> *- Stakeholder dialogue, National.*

> *Now, in Kaduna State we get free airtime on radio and TV, because of our relationship with the media organizations.*
> *- CSO representative Kaduna*

> *Most of the time we have the advocacy with the CSOs, they are the ones that may lead to the advocacy. The human services and social development, youth sports and youth development, and reproductive health. Then we have the, [um], Kaduna State Action against Aids. Yes, all being together. The Ministry of Health, Ministry of Education. UNFPA, Society for Family Health, Lafia Project, CHAI, CIHP, all of these people. They contribute.*
> *- PHCB Staff, Adolescent health, Kaduna*

> *So, it's two ways - we are working as a consortium of NGOs; we are working as an institution, CPEJ, and we are working with the government.*
> *- NGO representative Kaduna*

> *We meet a lot of Islamic friends there. They have a women's wing of Islam too and different things there, and I am sure that the awareness is there. They also announce it. Even if we announce that these services are not for everyone, the Sheikh will also announce them in the mosque.*
> *- Christian Religious Leader, Kano*

Advocates have collaborated under the umbrella of different coalitions to push for women's health policies and programs in Lagos State. Key actors attested to the existence of partnerships with the national government

> *We had always carried along the Ministry of Health, and we also had partners in the primary health care board, TAC, and the Youth Challenge Initiative.*
> *- Stakeholder dialogue, Lagos*

Advocates acknowledged that collaboration comes with significant benefits to the cause. We also found evidence of collaboration and partnership across tiers of government. The partnerships are, however, sometimes complex and difficult to manage due to the 'split oversight' mentioned above.

> *When you do something like that, a joint effort, different entities bring different resources, different skills, different expertise to the table. For that, we had JSI since they are an institute really working on the data. Pathfinder is known for advocacy since 1965. There are organizations that have been in the field like SFH. They came together, put up a plan, presented it to the Federal Ministry of Health and they agreed to domesticate that WHO guideline in the country.*
> *- Stakeholder dialogue, National*

> *What we tell people is that the easiest way to work is to come so that we sort out all the bureaucracies. Come to us, and we will write the letters to the Ministry of Local Government, Chieftaincy Affairs and chairperson of that local government. We will ensure that that groundwork has been done for you so that your entry is as seamless as possible.*
> *- Stakeholder dialogue, Lagos*

However, institutions are sometimes not properly structured for partnerships that yield results, even though certain individuals, because of their passion and work ethic, may play a pivotal role in fostering collaboration.

> *In my organization, we work with the Ministry of Health and Women Affairs, and we have observed that there are individuals who are like superstars within these institutions. We need to make the system work and make the institution work effectively, rather than relying solely on exceptional individuals. True progress comes when we invest in both institutions and individuals, reducing bottlenecks*
> *- Stakeholder dialogue, Lagos*

Coalition building

At the national level, the government-led coalition (RMNCAEH+N TWG) is domiciled within the Federal Ministry of Health (FMoH) and made up of four subcommittees (advocacy, resource mobilization & communication; leadership, coordination & partnership; accountability, data & knowledge management and quality technical delivery). It is a national-level coalition that consists of a multisectoral group of participants ranging from staff of the FMoH, members of professional health associations, health care providers, CSOs such as CCSI and The Challenge Initiative (TCI), media personnel and media organizations, to members of the executive arm of government.

At the national level, the core RMNCAEH+N body is led by the Honorable Minister for Health and Social Services, with the Director of Family Health as secretary. It is supposed to meet twice a year, but meetings was have not been consistent. However, In February 2024, a three-day validation workshop held to update the National RMNCAEH strategy document (first drafted in 2018) and ensure that it aligns with current national health policy guidelines; integrating guidelines on elderly individuals, gender, school health, and updating indicators. The RMNCAEH advocacy subcommittee has not been able to meet regularly as stipulated in their policies. Although the policy stipulates quarterly meetings, the national

RMNCAEH advocacy subcommittee has met only approximately twice since the end of the COVID-19 pandemic and did not meet for the entirety of 2023.

Kaduna state RMNCAEH (Govt – Led) has two subcommittees dedicated to advocacy. This includes a subcommittee on advocacy for family planning, and a social mobilization and communications sub-committee. However, both sub-committees are chaired by men. With regard to functionality, members reported that the government-led structure is functional, though activities are hampered by a lack of necessary funding. The policy stipulates that RAMNCAEH meet monthly. However, in practice, meetings occur once every quarter. On the other hand, we found a CSO-Led coalition - Kaduna Maternal Accountability Mechanism (KADMAM), chaired by a male at the time of the scoping review. KADMAM comprises a multisectoral membership, including members of the public sector, traditional, religious, professional bodies, media and civil society organizations.

In this typology, the government only plays a supportive role. KADMAM works 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 existing policies and approved budgets or demand that they address gaps in service delivery, health workforce, or quality of care.

> *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.*
> *- KADMAM executive Kaduna)*

In Kano, as is the case with Kaduna state, there is an existing government-led, government-domiciled joint advocacy RAMNCAEH coalition in Kano state. The coalition is led by a male who is the director of health and disease control for the SMoH. Here, there is just one subcommittee for advocacy that caters to all advocacy matters across RMNCAEH + Nutrition and GBV. Kano has an active state accountability mechanism, originally set up as a CSO-led joint advocacy coalition – Kano state Accountability Mechanism) (KANSLAM) - via the aegis of the MamaYe project. Much like their counterparts in Kaduna, they function to hold key-decision makers and stakeholders in government accountable through evidence collated on scorecards populated with data derived from government-embedded monitoring and evaluation mechanisms at the local-government-level:

> *Policy development, policy implementation and budget; we carry out advocacy on that. Budget improvement. We also carry out strengthening the operationalization of the health care system.*
> *- KANSLAM representative, Kano*

However, in practice, the organization saw the need to allow KANSLAM to evolve into a hybrid joint advocacy coalition with to allow for more effective collaboration with the government. Hence, it is now co-chaired by a representative of government (male) and by a CSO representative (female).
Lagos also has a RMNCAEH + N TWG comprised of a diverse multisectoral group of individuals from the public and private sectors, including partner organizations. The Lagos state RMNCAEH TWG is led by the Lagos SMoH and has three subcommittees, one of which is an advocacy and demand strategy subcommittee that meets on a quarterly basis. The SMoH, working in close collaboration with the Lagos State Primary healthcare board (PHCB), acts as the secretariat for the state RMNCAEH. The RMNCAEH TWG acts in an advisory capacity to the Honorable Commissioner for Health on all RMNCAEH-related

issues in Lagos state. All consensus decisions reached during TWG meetings are communicated to the office of the Honorable Commissioner for Health via memos or official communiques.

A second coalition - the Lagos Accountability Mechanism for Maternal Newborn, Child Maternal Neonatal and Adolescent Health (LASAM4CMNAH; also known as LASAM), is a program sustainability effort of the MamaYe project, similar to its equivalents in Kaduna and Kano.

In Lagos, there is the Lagos Civil Society Participation for Development (LACSOP), which offers a platform for all advocacy groups to jointly promote women's health policies and programs. The LASCOP is comprises more than 400 organizations, including NGOs, trade unions, FBOs, CBOs, social movements, that are, committed to strengthening democracy and good governance. LASCOP promotes ownership of governance through collaboration with different arms of government, different MDAs and the media.

Advocacy capacity building

Although capacity gaps still exist, some advocates have benefited from capacity building (specifically training and mentoring).

> *... they said, we are advocates, they have to train us on how to carry out smart advocacy. That was the first one we did ... and it was successful'.*
> *- Stakeholder dialogue, National.*

> *We have some tools, then we support the states, in, kind of, increasing their awareness and then [in] understanding the issues and [in] building their capacity*
> *- KII, Policymaker, National.*

Healthcare providers involved in community-level sensitization are trained in community-level advocacy. Our findings also show that capacity building activities have also been extended to media practitioners.

> *Recently, we had training for journalists, so that they could communicate appropriate messaging to the public on adolescent issues.*
> *- KII, Program officer, National.*

Some of these capacity building initiatives were driven by NGOs.

> *We work with a group of some journalists in Nigeria. We have trained approximately 600 of them on child and women's rights, and they have come out to be well positioned in the family planning space.*
> *- KII, CSO, National.*

Evidence from the national level indicates that training has also been organized for key opinion leaders, faith-based organisations, healthcare providers, media, market women and members of advocacy working groups at the sub-national level on health insurance, through different state level accountability mechanisms (SLAMS). These findings highlight that continuous capacity strengthening is required for advocacy coalitions to be effective. Key actors in the sector need to be trained and re-trained to become advocates to others within the space. In particular, there is a capacity building need for healthcare providers, to understand patient-friendly service provision, ethics and respectful healthcare service provision.

> *People are at different stages of understanding of issues, so like today what we are doing is a refresher course, so even when people are trained, they should be refreshed. There is a knowledge gap around maternal health; for example, there is a knowledge gap about abortion issues, so we still need to fill that gap so that people won't still be on the same stage.*
> *- KII, CSO representative, Lagos*

> *So we develop some ICE materials relevant to their needs; we build the capacity of people whom we are to involve, and we meet some key stakeholders. Then we used to call KOL, Key Opinion Leaders who were to talk to others about what we are trying to do within the community.*
> *- KII, CSO representative, Lagos*

> *At CHIP, on HIV/AIDS and gender-based violence, they trained us, and we now had to take it down to the community, so we gathered women together, children and we had a sensitization program for them, and thereafter, we now carried out HIV counselling and testing on them, which we did at a local government.*
> *- KII, Faith-based organization, Lagos*

> *We engage media to create awareness, and of course, there was a time that they were trained so that they would know how to express and pass across the information.*
> *- KII, Policymaker, Lagos*

Successful mobilization of key voices

At the national level, we found evidence that advocates including media, professional association, community and religious leaders have successfully mobilized key voices for women's health.

> *In developing the FP2030 for Nigeria commitment, AFP mobilized civil society organizations at the sub-national level, especially women groups, youth, media, and CSOs, who work at the sub-national level to be part of developing the FP 2030 commitments.*
> *- NGO representative, National*

> *We have had situations where we engaged the WOWICAN, the women [wing of] CAN, and they understood because they're women.... we engage traditional rulers.... we have had meetings with those key stakeholders where we have the Chief Imam of Lagos, we have representatives of CAN, we have NMA, we have SOGON, we have FOMWAN, we have Journalists, we have all these groups, CPN representatives of the Child Protection Network... we have all of these groups together, and through that meeting, we're able to design [intervention programs]*
> *- KII, CSO representative, Lagos*

Our findings show stakeholders' interest and action around joint advocacy.

> *Everybody that is a good advocate will know that you cannot do it alone and you can't claim that you are the only one because you mobilize people and make sure that they are part of it to succeed. You can even partner with your so-called enemy for a particular advocacy thrust.*
> *- NGO representative National*

Public office holders may have taken ownership and increased financing of initiatives as a result of joint advocacy efforts, as seen at the national level and Lagos

> *We saw ownership of some of the policies. We heard them talking about some of the policies. We saw some investments across some states in family planning and MNCH. It has changed the narrative and brought some consciousness and increased funding, increased investment, increased governance, into the area of concern around MNCH, especially within the issue of family planning*
> *- NGO representative National*

> *We organize quarterly meetings where we invite the Directors in charge of family planning, reproductive health, adolescent health and adolescent health. So, we bring them together to get feedback on how to get the result of our advocacy visit and then relay our advocacy visit report to the Permanent Secretary and the Commissioner*
> *- Stakeholder Dialogue, Lagos.*

In Kaduna and Lagos, we found evidence of successful mobilization of key political voices for women's health advocacy, including Governors, First Ladies at the sub-national level, and the Nigeria Governor's Forum.

> *Yes, for the past governor's wife, she was an ambassador of nutrition because till date we are enjoying her handwork [Kaduna State Emergency Nutrition Action Plan]. It was the pet project of the former first lady of the state - Umni El Rufai - and to date, they are working, and they are trying because they are influencing even the governor.*
> *- Staff SMoH Nutrition, Kaduna*

> *I led a team of advocates to meet with the wife of the Governor to know her position, as our own second option, that can also help us talk to the Governor to see how they can allocate this budget and release it as appropriate, and we got very good feedback from the First Lady of the state*
> *- Stakeholder Dialogue, Lagos.*

> *The Nigeria Governors Forum is championing the idea of, the issue of nutrition in the mission and of course they are never afraid to tell the governors [the truth] at the governors' forum 'see your state and see how many malnourished children that you have*
> *- KII, Policymaker, Lagos*

In Kano, participants cited examples of advocacy efforts where awareness creation, targeting key community influencers, resulted in successful mobilization of key voices. This effort led to strong community organizing initiatives that increased access to priority women's health services.

> *The district head accepted and did it (gave approval for women and children's health advocacy efforts) whereby the village heads, ward heads, went down to their communities and gathered their own community members and inform[ed] them of the importance of pregnant women going to hospitals for antenatal care, going for immunization for their children and for breastfeeding issues."*
> *- CSO Representative Kano*

> *At times, we engage the councillor, so that when he talks, the stakeholders will take it more seriously than one who works within the organization.*
> *- Program officer, Kano*

Policy change/legislation/regulatory feedback

The coalition actions have led to the drafting of three policies since it'inception. These policies include: National Advocacy Strategy for RMNCAEH + N the National Advocacy Guideline for Family Well-being, and the National RMNCAEH strategy guidelines. Furthermore, the national-level RMNCAEH has successfully obtained approval for the establishment of family health departments at the state-level. However, our findings indicate that lack of funding to visit spoke sites has stalled the implementation of the new policy. TO date, efforts to domesticate the policy have been limited to only seven states: Kano, Lagos, Borno, Yobe, Jigawa and Ondo. Only two states (Lagos and Ondo) have been able to establish family health departments. A number of policy changes in the health sector have been attributed to women's health advocacy efforts.

> *So, in the last 5-7 years, there have been many policies that were developed by the Federal Ministry of Health, mostly around improving access to family planning (talking about from 2014 to the last one), the task shifting/task-sharing policy, the DMPASC, accelerated introduction and scale up and so many others.*
> *- Stakeholder dialogue, National*

> *In Nigeria, a number of organizations came together to advocate for the domestication of that policy.... They came together, put up a plan, presented it to the Federal Ministry of Health and they agreed to domesticate that WHO guideline in the country.-*
> *- Stakeholder dialogue, National.*

At national level and in Lagos state, advocacy efforts the culminated in creation of a budget line, and budgetary allocation for different program including adolescent health as a result of advocacy efforts. Respondents also gave account of joint advocacy through regulatory feedback and accountability mechanisms. In Lagos for example, LASAM4CMNAH has successfully advocated for the implementation of a specific family planning budget line in Lagos State. In addition, in 2020, the coalition successfully advocated for the release of 81.04% of the approved Reproductive, Maternal, Newborn, Child and Adolescent Health+ Nutrition (RMNCAH+N) budget.

> *One of the advocacy efforts was actually before 2020 there was no budget line for the adolescent in the ministry but now we have a budget line we have a policy that has to be revised.*
> *- KII, CSO, National.*

> *We advocate for allocation to health to meet up with the 15%; you know, Abuja declaration that all state health budgets should be 15% of the state entire budget. 15% should go to health. So we have achieved that long ago, years ago (2014-15) we have achieved that in Kaduna State. Only once that the budget slightly drop to 14.9% but we are happy did it has gone back to 15% now.*
> *- CSO representative Kaduna*

> *Our focus used to cover ministry for local government and chieftaincy affairs to get the local government chairperson to commit themselves to supporting RMNCH services. You get it? However now with the achievement of PHC under one roof, you know, our focus is now at the state level.*
> *- CSO representative Kaduna*

In Kano and Lagos, advocacy efforts have resulted in changes in policies and legislation.

> *The most recent one is an adolescent policy document. It has played a vital role because, without that advocacy (joint advocacy with the states, partners, CSOs and all that), we could not have domesticated that policy document in the state.*
> *- KII, Program officer, ASRH, Kano*

> *In Lagos, for example, there is this faster blood donation that is compulsory; you know when somebody wants to give birth... we have been able to work with SERAP to go to court to abolish that...' The second issue which we have shifted policy on is the issue of detention. So, we had realized that most women after giving birth are detained in the medical facility because they cannot pay, so we have had a woman who was there for over a year, and we have had another woman who died in LUTH.*
> *- KII, CSO representative, Lagos*

3.3.5 Gender Equality and Social Inclusion

Table 5: Gender equality and social inclusion

Domain	National	Kaduna	Kano	Lagos
Gender equality and social inclusion				
Awareness	Key actors in women's health advocacy are generally aware of the importance of gender equality and social inclusion, but there is varying understanding of the need for GESI integration.	Respondents acknowledged the importance of Gender Equality and Social Inclusion (GESI) in women's health advocacy efforts, noting that women are often the primary recipients of reproductive health services and are more vulnerable. Efforts are being made to include persons with disabilities in advocacy activities. Importance of Male Inclusion: Some respondents recognized the significance of including men in advocacy efforts, as they are also important stakeholders in reproductive health and family planning initiatives.	Awareness of the necessity for Gender Equality and Social Inclusion (GESI) integration, emphasizing the importance of gender equity and equality in all programs and advocating for women to lead efforts related to the health of women and children due to their deeper understanding of the issues involved	There is a high level of awareness of gender equity and social inclusion among women's health advocates. Key actors recognize intersectionality of gender with other drivers of inequality.
Willingness	Advocates demonstrate willingness to consider and take action on gender issues, using gender disaggregated data for advocacy and showing commitment to gender sensitivity.	RMNCAEH lacks clear prioritization of Gender Equality and Social Inclusion (GESI) in its composition and leadership, contrasting with KADMAM's intentional gender representation, which includes overrepresentation of women and deliberate consideration of male involvement for logistical and media purposes.	Demonstrated willingness and action toward Gender Equality and Social Inclusion (GESI) integration by ensuring that advocacy messages include support for women, the physically challenged, and minority groups, as well as by empowering women through direct support and involvement in relevant initiatives.	Many advocacy coalitions have a high proportion of female participants, and there is a willingness to mainstream gender in monitoring and evaluation processes.
Barriers	Barriers to gender equality and inclusion include underrepresentation of female healthcare personnel, lack of awareness of GESI integration, and limited representation of women on key committees despite their meaningful contributions.	The primary obstacle to GESI integration, besides insufficient awareness among those responsible for its implementation, is entrenched patriarchal sociocultural norms	Respondents in Kano highlighted religious and cultural barriers to GESI integration in joint advocacy efforts, emphasizing the need for interventions promoting male involvement and providing education to influencers to ensure support for gender equity initiatives.	Poor representation of women in the legislative arm of government and lack of committed individuals in agenda-setting pose barriers to gender equality and social inclusion in women's health joint advocacy.

Awareness of GESI

At the national level, key actors involved in women's health advocacy are aware that gender equality and social inclusion are essentials for women's health advocacy. Advocates also work with the understanding that the female population is not homogenous. They vary by other markers of inequality such as race, religion, socio-economic status, and disability.

> *Our approach is that women are not homogeneous, so we're conscious of the inter-sectionality and we deal with that as it is*
> *- KII, CSO, Lagos.*

> *We need to show that dynamics are always there, we give that room for people who need to be on the table to be part of the conversation, so the gender inclusivity is always there, and the gender and social inclusivity are very strong. We intentionally ensure that there is voice given to people so most times you will not see someone like me saying it, I rather allow the people, the beneficiaries those people who actually understand the issue, to speak to those issues by themselves. So, gender inclusion is there, we are conscious about it.*
> *- CSO representative, National*

However, while some stakeholders are aware of the push for GESI integration, as at the time of this scoping, not all understood the need for it, underscoring the need for training/capacity building for advocates with regard to the GESI.

> *Gender composition of RMNCAEH [membership]? Does it matter?*
> *- National policy and decision maker*

Amongst those who understood, not all could explain if/how their organization had been intentional in integrating the GESI in their coalition composition, structure, and day-to-day operations of their women's health advocacy efforts. Some respondents seemed aware.

> *Yeah, you know, virtually when you say RMNCAEH, you're talking about women. Because they are the receiving end. Women get pregnant. Reproductive services are being more provided to women than men.*
> *- CSO representative Kaduna*

> *You know, we look at it, we talk about adolescents, both male and female. But we feel that the females are more vulnerable. So our target is more to the female than the male.*
> *- Program Officer, ASRH Kaduna*

There is little or no evidence that the GESI was prioritized in the membership or leadership of the advocacy coalition (RMNCAEH) at the national level.

> *It was open and maybe they got more males than females who were willing to say, okay, I want to be the chair. Nobody forced any chair on anybody.*
> *-Stakeholder dialogue, National.*

In Kano, we found evidence of awareness of the need for GESI integration among Kano and Lagos advocates, some stakeholders opining that women-led advocacy will yield more success in driving women's health priorities.

> *Whatever program, we do we make sure there is gender equity and equality in it because we know the importance of that.*
> *CSO representative Kano*

> *The best [way] to advocate for the general well-being of women and children is to let the women lead. So, a team of advocates that can advocate for changes in legislation and other things, let the women lead with a very small number of men because women know their problems better than men.*
> *NGO representative, Kano*

This is evidence of the need for the education of female advocates in Kaduna, in particular, to see the benefits of becoming actively involved in leadership, and encouraged to pursue strategic offices that will position them as decision-makers and policy champions in the interest of FP and MNCH advocacy efforts.

> *Well, before, they've been neglected actually. But now we are trying to see that there is integration. Whatever we do, persons with disabilities are being included. So we include them in whatever we're doing so they advocate with persons with disabilities and do the normal advocacy, or we go out together with them.*
> *Program Officer, ASRH, Kaduna*

By taking rudimental time to educate the people, the people that it affects the more. Because when a woman knows that... I need to, if I don't do something, I will die and this man will leave me to go and marry another person, she will be on her toes to face anything that comes, because it's her life.
NGO representative Kaduna

Nevertheless, some of the participants were not only aware of the importance of GESI integration, but also clearly, the need for male inclusion:

> *Yes sir, we consider gender. There are MDAs where there are men, so we carry them along. All of them, all of us, are important. We cannot do without men [laughs].*
> *- Program officer, Kaduna*

Willingness (consideration and action for GESI)

At the national level, advocates reported using gender disaggregated data for advocacy and demonstrated a high level of gender responsiveness.

> *We use gender disaggregated data most times in the number of female that will benefit, number of men that will benefit, number of household that will benefit, we use that a lot because when they see it and they say women we will say this is why we say women because the number of women that are dying every day and this is why is important that women*
> *- CSO representative, National*

Although advocates were open to prioritizing gender equality and inclusion, the stakeholder dialogue

participants did not necessarily attribute success to leaders' gender.

> *I don't think we have an issue with that, for the longest time we had [male leader] who was very good at pushing women's activities. In all our meetings he chaired for our technical groups, and he pushed the maternal health and family planning program. So, we haven't had any issues with us having someone in charge who was anti-gender, anti-female or whatever"*
> *- Stakeholder dialogue, Lagos).*

In Kaduna, for the government-led multisectoral coalition typology (RMNCAEH+N TWG), there is no clear evidence that the GESI was a priority in the composition and structure of membership and leadership; the leader for both advocacy subcommittees were men. On the other hand, unlike the case with the Kaduna state RMNCAEH, for the CSO-led coalition typology (KADMAM), careful consideration has been given to gender and inclusion both in the planning and implementation of KADMAM membership composition and advocacy efforts. The Respondents shared that since inception, the chairperson of KADMAM had always been female until approximately one month prior to the scoping exercise when, by popular vote, a male was elected chair. However, based on their policies, the chair of the advocacy subcommittee is mandatorily female. Regarding the gender distribution of KADMAM, findings indicated that KADMAM had been intentional in over representing women within its membership. Male members were included mainly for logistical/practical purposes. The KADMAM also showed intentionality in male involvement on issues of gender equity.

> *70% female, 30% male. Because the males speak out, adding their voice to their issue, it really helps their matters. Yeah, it does help matters. Because most of the males you see in the advocacy team, actually, they are maybe people from the media.*
> *- KADMAM executive, Kaduna*

There is evidence of willingness and action in prioritizing the marginalized and vulnerable populations of Kano and Lagos.

> *During our advocacy we make sure that in our key message we include the need for support of women, the physically challenged, the need for support of what we call the minorities. Minorities in form of when you are in your community and some people (if it's the a Hausa community, the other tribes are minorities). So, we make sure that our key message includes those minority groups. We try to include them in our request because these are vulnerable groups and most of the issues we are talking about, affect those vulnerable groups.*
> *- CSO representative Kano*

> *If we want to do any empowerment, we do give them [the women's arm of the organization]. They deal with women, and we have little direct contact with women.*
> *- Christian Religious Leader, Kano*

> *We are a gender mainstreaming organization, so we mainstream gender, and we use gender tools for our monitoring and evaluation*
> *- KII, CSO representative, Lagos*

Barriers to GESI integration

There are some barriers to gender equality and inclusion, including lack of awareness of the need for GESI integration, at all levels, even when marginalized groups are present in the room. Therefore there is a need to adequately engage and train representatives of marginalized groups in advocacy and build the necessary capacity among women groups and people living with disability.

> *One is that female healthcare personnel are underrepresented in the healthcare space; a situation worsened by the recent surge in the migration of healthcare personnel, especially female personnel, to countries in Europe and America. The phenomenon is reducing the number of trained women healthcare providers locally available.*
> *- Professional Association, Rep*

Women are somewhat underrepresented in the legislative arm of government and on key committees, although, they make meaningful contributions to their various committees.

> *The few women that are there, ... it's just that I think they are not privileged to be the chair or the vice chair or whatever of the committee, but they make contributions that are very, very positive to move the subcommittee forward.*
> *- Stakeholder dialogue, National.*

> *The parliament [Lagos Assembly], so the parliament is a parliament of men, very few women are there, they're just about four or there about, and the women that are there are not tilted towards women's health conversation, you know some of them don't even discuss gender equality*
> *- KII, CSO, Lagos*

Patriarchal sociocultural norms constitute a major barrier to GESI. Due to socialization, some women do not feel autonomous in making decisions.

> *Because for us women, we are under men. So at least, at home they are the policy makers, let me say it that way.*
> *- Program officer, Kaduna*

There is prioritization of culture and religious authorities over secular government and this constitutes a major barrier where religious teaching does not align with women's health rights and priorities.

> *There are very limited chances and as you know, Kano is an Islamic state, so many cultural practices are in conformity with Islamic rules and regulations.*
> *- NGO representative, Kano*

> *I am not underrating women, but there is this slight discrimination and inferiority complex between men and women. Women are regarded as weak creatures by men so that is why if women unite and go and speak and advocate for policy change, legislation, and funding, optimal attention is not given to them because they are women*
> *- NGO representative, Kano*

Some perceive GESI, or any form of women's empowerment, as potentially detrimental to men, unless the men in question are already clearly at an advantage compared to women:

> *Fine, it is good to empower the wife, when the men get going, but when they go and do not see anything to bring [home], they are tormented before they eat. It has sent so many men to their early graves. He will be thinking about how he will go to his own house, because his wife might be a problem, and this might lead to high blood pressure. Please, since you have been hearing about slumps and die, how many women have slumped and died?*

> *I pray for you that God will bless your struggles; you won't have any reason to be fed by a woman. But there are men [who are dependent on their wives]....we are leaders of the faith, and we hear talks.*
> *- Christian Religion Leader, Kano*

Perspectives such as this lend credence to the vital importance of intervention components that provide for male involvement in GESI, to avoid negative unintended consequences such as an increase in gender-based violence or sudden occurrence where it never existed ab initio. They also highlight the need to educate influencers (religious and cultural leaders) and provide advocacy capacity building and training in the GESI to ensure that all parties engaged in joint advocacy efforts are indeed advocates and not the opposition.

> *It [the gender composition of the advocacy team] comprises both men and women [....] we may say that [sic] let women lead with a small number of women; that is when it comes to community level [....] but that is not a standing rule. It depends on the situation. If women lead better or could lead better and be listened to better than men, let women dive in there with support from men. That's it. Because of religious and cultural beliefs. We are very conscious of this.*
> *- NGO representative, Kano*

Not having persons committed to women's health advocacy represented in agenda setting is a major barrier to gender equality and social inclusion in women's health joint advocacy.

3.3.6 Key factors for the feasibility of joint advocacy

Table 6: Key feasibility factors for joint advocacy

Domain	National	Kaduna	Kano	Lagos
Feasibility Factors for Joint Advocacy				
Facilitators	Facilitators of women's health joint advocacy efforts are CSOs, professional organizations, international organizations, funding agencies/ partners, traditional rulers, key government officials, academics, and healthcare service providers, First ladies at all levels of government, Market women groups, Professional women associations (e.g. MWAN), Women religious organizations (e.g., FOMWAN and WOWICAN), CSO coalitions, Press/Media, Donors, Implementing partners	Community champions (volunteers at the community level) who disseminate information and mobilize communities to utilize services in facilities, Service providers within healthcare facilities Program officers at the local government level, CHIPS agents, facility health committee members, village head committee team, community volunteers, and CDC champions, Kaduna State Social Committee on Health	Commissioner for health, Director public health and disease control, All heads of MDAs (across various sectors, Personal assistants to heads of MDAs, Implementing partners, CSOs, Ministries for LGAs, Religious women organizations (FOMWAN/ WOWICAN), Professional organizations (MWAN, SOGON, APHPN, PAN), Women's Affairs (Director Child health, Gender desk officer), RMNCAEH+N program officers, Chairperson committee on health, Media (especially radio), Dept. of Budget & Planning, Dept of Finance, First ladies at all levels of government, Hisbah, Academia.	Facilitators of joint advocacy efforts for women's health include government leadership, policymakers, funders, religious leaders, local NGOs, community members, and the media.
Barriers	Barriers to joint advocacy include the time-consuming process of building coalitions and partnerships with trust, opposition coalitions with spies among advocates, lack of funding or delayed fund-release, absence of an independent accountability mechanism, unequal distribution of resources within the health sector causing programs to suffer or benefit unevenly, difficulties in transforming federal policies to the sub-national level for implementation, and office holders who lack commitment to women's health advocacy.	Conflict of interest between personal interests of coalition members/organizations and that of the joint coalition.	The potential barriers to FP+MNCH joint advocacy in Kano include the influential role of traditional and religious leaders, whose perspectives vary from potential allies to significant roadblocks due to deeply entrenched beliefs regarding family planning and reproductive health.	Barriers to joint advocacy include poor public investment in women's health, weak political will and commitment from the government, previous failed attempts, inadequate resources and commitment from partners within coalitions, individual attribution of success within coalitions, and resistance from certain government units or structures.

Facilitators

Key facilitators of women's health advocacy include civil society organizations (CSOs) and professional organizations pushing for joint advocacy. The willingness and capacity to harmonize the voices of advocates is a factor in successful joint advocacy. The success recorded thus far is partly due to the ability of advocates to exert effort:

> *Harmonize our [their] voices as much as possible.*
> *-CSO representative, National*

International organizations such as the WHO and international funding agencies/partners were identified as facilitators of women's health joint advocacy. There are also traditional rulers, facilitators, academics, media, the private sector, philanthropists, healthcare service providers and key government officials who are 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, Lagos.*

> *They have been visiting before so they know what is happening and they cannot play with it. You will be hearing all sorts of stories even with their community what they have been doing to make sure that these women are key to this particular project.'*
> *- KII, FBO, Lagos.*

In Lagos, a major facilitator of successful joint advocacy is the leadership of the government as well as policymakers in government.

> *It has been very productive you know, when the government seeks quite a number of organizations coming together to, you know, and help them scale up what they also desire, it is always a great testimony'*
> *- KII, CSO, Lagos.*

> *Let Government be part of your effort. I think we need to bridge that gap by ensuring the both the implementer and the government of the state you're currently working with.*
> *- KII, CSO, Lagos*

> *Policymakers in government, like the Permanent secretaries for the ministries, the directors of Food and Nutrition, Minister of health*
> *- Stakeholder dialogue, Lagos.*

Barriers

A major barrier to effective joint advocacy is that it takes time to build coalitions and nurture them to true partnerships with trust. The period of partnership development may be considered too long for the

desired cause or for the project lifespans, especially when reporting cycles are short and performance indicators are short-term.

> *So, it could be more time wasting and time prone, more time consuming.*
> *- CSO representative, National*

Opposition coalitions may arise and impact advocacy efforts. The Respondents cited intra-coalition conflicts of interest as a potential barrier to joint advocacy.

> *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.*

> *Our main challenge as a civil society, is conflict of interest because we have several personal activities and then we have the coalition activities. Then, we have other activities, so sometimes it is the conflict of interest of our activities that might be our main challenge, but overall, there is a great commitment.*
> *- Stakeholder Dialogue, Kaduna*

The majority of national- level stakeholders cited a lack of funding, or delayed and insufficient fund-release of approved budgets as barriers to joint advocacy efforts. This also includes the absence of independent accountability mechanisms and structures that could potentially attract external funding.

> *Like, I remember eight years ago (coming back to activities) 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, Kaduna*

Gaps in the domestication of federal level policies at the sub-national level also present a barrier.

> *There's that really big gap between policies that are developed at the national level and getting them to the sub-national level because that is where implementation takes place. And when you do those policies at the national level, of course, you get some representation from the states, but it's not more than five, six states out of the 30-something that will be there.*
> *-Stakeholder dialogue, National.*

This findings reveal that policy and decision makers whose interests are not aligned with women's health priorities constitute a barrier to women's health advocacy.

> *... Most people will want to work when they foresee that there is some level of motivation. once that is not very clear, then participation becomes perfunctory. Just say, let me go so that my boss will say I didn't go to the meeting he sent me to. However sitting there is different from coming with the zeal to say, what difference can I make?*
> *- Stakeholder dialogue, National.*

Commonly cited potential barriers include the influences of gatekeepers in the form of religious and traditional leaders and community leaders. So powerful is the reach and influence of some of these

gatekeeper, 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 interest of cultural sensitivity). Interestingly, while some advocates view these traditional and religious leaders as potential allies for women's health joint advocacy efforts, others view them more as gatekeepers:

> *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*
> *- KII, 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*
> *- KII, 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, participants pointed out that as gatekeepers may act facilitators or barriers depending on context and interest.

> *Gatekeepers like the PS in PHCBs, Ward Health Committees are both gatekeepers and facilitators. Gatekeepers include community leaders, women leaders, and religious leaders, [and] the media can serve as facilitators and gatekeepers'*
> *- Stakeholder dialogue, Lagos.*

Regarding family planning, certain religious teachings/strongly held beliefs might pose a barrier to FP advocacy efforts in general and to the demand for FP commodities more specifically.

> *This God that sent Islam, he created the man, he created the woman. He created the child and the adult. Woman is a creation God created so she can be of help to [the] son of Adam which is the male. Second, when they both meet, they should multiply. This is left for people to obey the rules Islam has set aside for marriage.*

> *A child in his mother's womb has a future that God has set aside for him. There is a way God has ordained for him for his daily bread; what he drinks, his breath, ability to hear and all that.*
> *- KII, Muslim Religious Leader Kano*

Ideologies such as the above assertions are birthed from the strong belief that God, not man, is responsible for child spacing/ family planning, and if God causes a child to be conceived, then God would

also automatically provide all that the child needs to thrive and survive. These attitudes and beliefs shift agency/responsibility from humans and obviate perceived need or demand for control of one's reproductive processes. However, others appear to think that lack of political alignment with decision makers 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 him 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, Kano*

Some stakeholders cited both funding issues and conflicts of interest as barriers to joint advocacy for women's health.

> *Challenges come when you do not have funds.*
> *- Stakeholder Dialogue, Kano*

> *You know, when you have your own selfish interest.*
> *- Stakeholder Dialogue, Kano*

In the SMoH and PHCB, we found evidence of a critical shortage of skilled human resources for health (HRH), with many of the available staff occupying multiple offices, indicating an urgent need to prioritize sustainable solutions for HRH.

Stakeholders do not have clear performance indicators for coalition leaders and thus cannot objectively evaluate the performance of the leadership of the coalition. On whether there could be a gender dimension to the performance of leaders, they argued that there is no basis to reach such a conclusion. They would rather attribute success or performance to commitment.

> *It's commitment and that is all I see. It's just commitment.*
> *- Stakeholder dialogue participant, National*

However, there are terms of reference for each sub-committee, that could be employed in developing performance indicators.

> *It's only in terms of reference. For each of the subcommittees, we all have terms of reference*
> *- Stakeholder dialogue, National*

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.

> *and they earmark such budget [funds] but to release has really, really been a bad luck for us. So, there has been government … allocation but we don't see the allocation [funds being released for implementation]*
> *- KII, CSOrepresentative, Lagos.*

There was a lack of political will and alignment, as did previously failed attempts on the part of the government.
Barriers to women's health advocacy may range from inadequate resources to a low level of commitment on the part of partners.

> *Sometimes, we had to change venues because, at the last minute, a partner might pull out and say 'Oh, we thought we had resources to fund this, but we're not able to fund it.*
> *- Stakeholder dialogue, Lagos.*

Stakeholders opined that bureaucratic bottlenecks such as power transitions and administrative structures may serve as a barrier to women's health advocacy.

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

> *The personnel are personnel of the primary healthcare board, but their funding goes to the local government. So every now and then, it seems like they're stuck in between two fathers. So you get all those, even the people who work within the local government system have those issues.*
> *- Stakeholder Dialogue, Lagos.*

3.4 Co-Creation: Synthesis

3.4.1 Workflow

This process involved a two-day behavioral insight application co-creation workshop, with diverse stakeholders at the national, sub-national and community levels. The participants cut across different sectors – government, international and national NGOs, CSOs, and coalitions working in the women's health space. It involved a multi-layered human-centered design approach that enabled stakeholders to iterate the ideal typologies of women's health advocacy coalitions in Nigeria. We built on evidence from a literature review, KIIs and stakeholder dialogues to identify typologies and further explore opportunities to co-create improvements/adaptation to the best two typologies.

3.4.2 Steps in co-creating a plausible women's health joint advocacy model

Five typologies of joint advocacy initiatives were identified from the scoping review (literature, KII, and stakeholders' dialogue. The typologies include:

- The "CSOs/NGO-led" comprising of a coalition of organizations (community-based, local and international organizations, private sector, academia, media, activists, etc.).
- The "government-led multi-sectoral" groups including the government, academia, media, CSOs, communities, the private sector, media, and implementing partners. This typology always has its secretariat domesticated with the government with a strong convening power.
- The "Government embedded" model where a partner or funder may second staff(s) 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 where a group of private sector organizations can 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

.

These typologies were further explored by the participants during the cocreation workshop as described in Figure 25 and 26.

Figure 25: Steps in co-creating a plausible women's health joint advocacy model

1. Identifying the key features

Ideation techniques and other participatory tools from human-centered design were used to elicit information from stakeholders. They were asked to identify the key features envisioned in an ideal women's health joint advocacy model.

About 25 features were identified from series of activities including the ideation exercise, literature review and stakeholder engagements (KIIs and stakeholders dialogue).

2. Affinity Mapping

The listed features were grouped/clustered based on recurring patterns and similarities.

Over-arching Labels/headers that captured all elements in a cluster were attached to them , culminating in 8 major groups

3. Scoring the key features

The MoSCoW Matrix was applied to score the 8 features based on their importance, as described in the subsequent slide. This includes the feature that an ideal WH coalition model must have, should have, could have or won't have.

This represents a 4 point likert with weights ranging from highest (Must have) to lowest (won't have).

4. Prioritization: scoring the 5 typologies across the 8 identified features

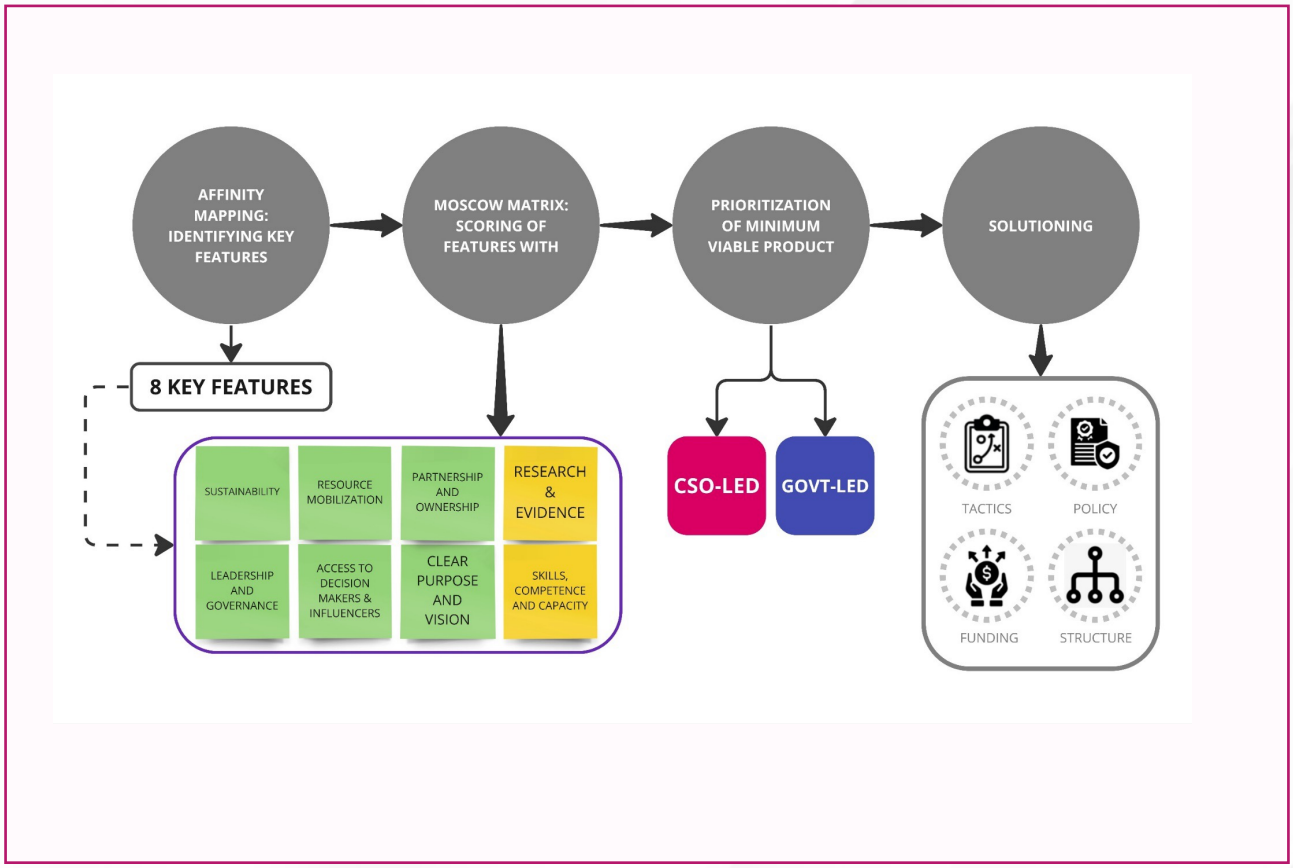
Each of the WH advocacy typologies was rated from high (3) to low (0) across the 8 features – clear purpose & vision; partnership & ownership; access to decision makers & influencers; sustainability, resource mobilization; leadership & governance; skills, competence & capacity ; and research & evidence.

A composite/aggregate score was computed for each typology which guided their ranking. The rating and prioritization were achieved through voting.

5. Solutioning: Co-creating Improvements for best two typologies

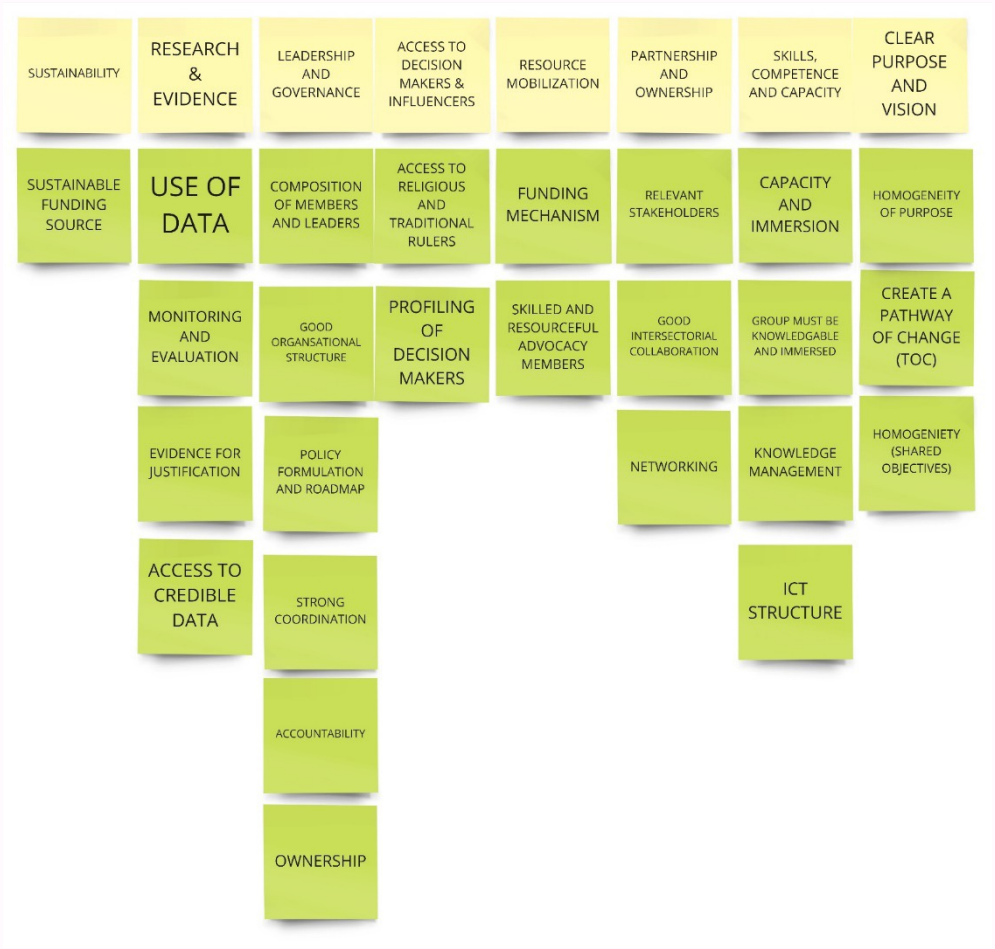
The recurrent weakness of the two top –ranking typologies were solved through a co-creation break out session. Afterwards, the stakeholders deepened their ideation on improving the two typologies in 4 main domains namely; tactics, policy, funding, structure. This process led to a consensus of designing a hybrid model with cross-cutting attributes.

Figure 26: Co-creation workflow



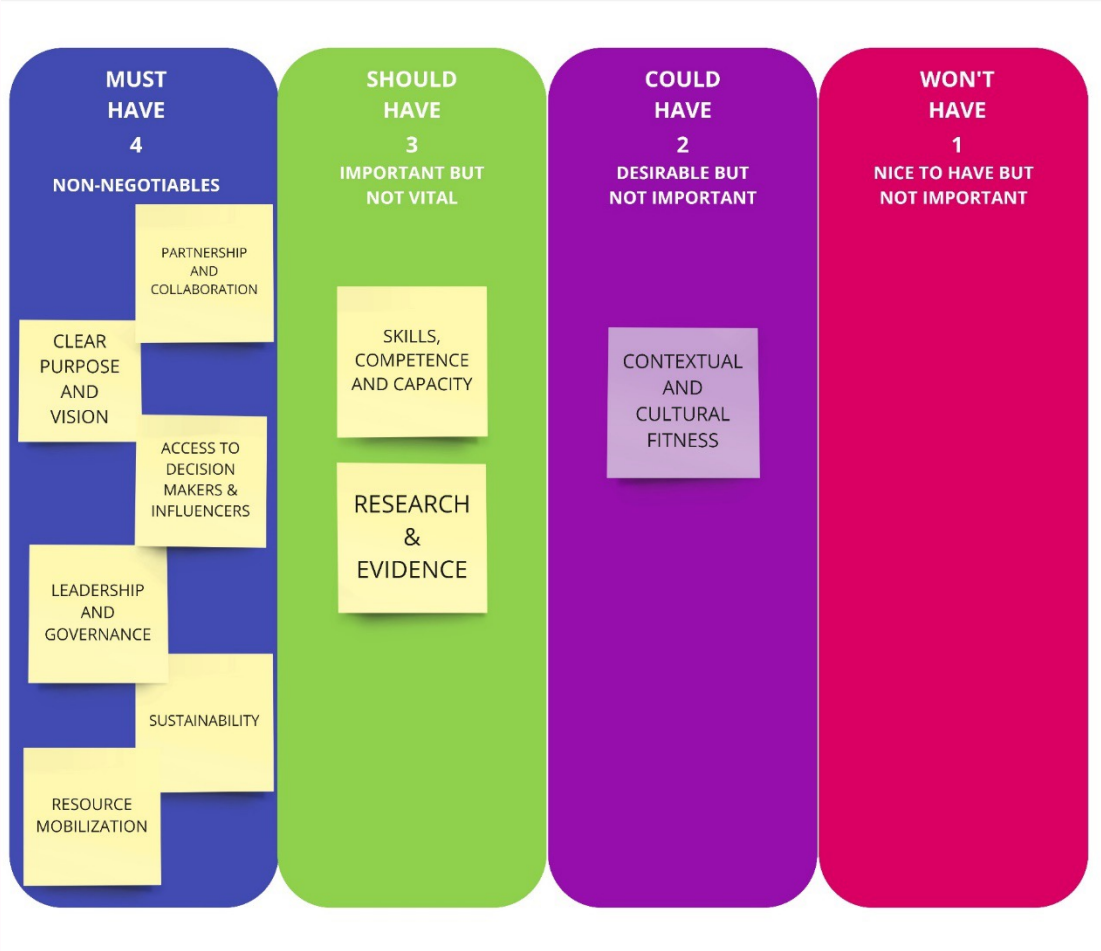
Affinity Mapping: Identifying and Clustering the Features of an Ideal Joint-Advocacy Coalition

During this process, the stakeholders were asked to envision features and characteristics that are essential for a successful women's health advocacy coalition. They noted their ideas on sticky notes and randomly pasted them on a white board. Some of the features were realigned and clustered based on similarities and recurrent themes. Eight over-arching features were identified and each cluster was labeled by consensus.



Prioritization of features

The MoSCoW Matrix was applied to score the 8 features based on their importance. The MoSCoW Matrix enabled the weighting of the eight features in a Likert manner; must have (4), should have (3), could have (2) or won't have (1). Five (5) features fell under the "Must Have" category because they were important and non-negotiable while the remaining two fell into the "should have" category. However, an additional feature was suggested contextual and cultural fitness. Stakeholders voted this feature under the category of "could have" in the MoSCow Matrix



Participants engaged in a live poll to vote of features - from a high, medium, low or No degree. The MoSCoW Matrix was ranked from 4-1, whereas the High, Med, Low, and None were ranked as 3,2,1and 0 respectively. After the ranking and weighting, the top 2 highest scoring typologies (CSO-Led and Govt-Led) were further deliberated on in the breakout sessions. The MoSCoW matrix speaks to 'What should be' and this scoring speaks to how the features present in real world situations. When the extent of manifestation of the features was assessed across the different typologies, sustainability had the least manifestation (47%) compared with other features. Two features (partnership & ownership; leadership & governance) manifested the most (80%) across the typologies.

Breakout Session: Solutioning

This break-out session involved identifying the weakness (mostly sustainability) of the top two typologies (CSO-led and government-led) and brainstorming solutions to this weakness.

Participants co-created ideas for improving the two top typologies under 4 main headings, namely; tactics, policy, funding, and structure. There was a strong quest and expectation for basket funding, leveraging existing experience with basket funding in Kaduna and Kano States. The solutioning process recognized that realigning political commitment with coalition goals remains essential for sustaining future coalition models.

There was a consensus to keep the coalition structure "loose" to avoid intra-coalition tussle, regardless of the typology adopted in the future. Both typologies require the mentoring of coalition staff (e.g., government staff) for capacity transfers.

3.4.3 Addressing the Problem of Sustainability as a Recurrent Weakness

Table 7: Addressing the problems of sustainability as a recurrent weakness

CSO-led	Government-led Multi-sectoral
Clear structure: Even though it can be registered with the CAC, it is important to leave the structure "loose" to avoid tussles for dominance and opposition coalition. **Clear purpose and objectives:** The CSO-Led Coalition must have a common goal and a clear objective to function, allowing for community participation and ownership. The charter/ guidance document must spell out the roles and responsibilities of coalition members as well as the vision and mission of the coalition. **Funding:** The coalition should explore multiple streams of funding including membership registration fees, donations, grants, counterpart funding from individual CSOs/projects, and should leverage existing basket funding initiatives. State-wide domestication: The coalition should have state offices, clear mechanisms for mentorship and continuity of leadership, and a succession plan which must be embedded from the coalition formation stage. **Alignment with existing structures:** The coalition should endeavor to align with existing women's health advocacy coalition mechanisms, leveraging expertise and experience. **Accountability:** The must be clear mechanisms for accountability and transparency within the leadership and coalition members exemplified in documentation and reporting principles. **Leadership:** There has to be a clearly defined tenure with clear mechanisms for gender and social inclusion. Leadership selection criteria must be clearly enshrined in their charter. Evidence-based advocacy: Advocacy strategies (social and conventional media, physical, etc.), must be evidence-based	**Policy guidelines:** There must be a clear policy guideline that establishes the coalition, with a clear purpose and objectives that are clearly aligned with existing government strategies. **Partner integration with government:** Coalition partners must be fully integrated and aligned with government (including TWG and other accountability mechanisms). **Funding:** The coalition should leverage basket funding initiatives within the state or initiate one where it does not exist. The coalition must sign a Memorandum of Understanding along with the government and other participating entities of the basket funding initiative. The basket funding initiative can be legislated. Other streams of funding must be explored (such as grants, counterpart funding from individual CSOs/projects). **Mentoring:** It is important to institutionalize capacity transfer mechanisms within the coalition and between the coalition and government. **Leadership:** There has to be a clearly defined tenure with clear mechanisms for gender and social inclusion. Leadership selection criteria and succession plan must be clearly enshrined in the policy document. **Indicator framework: I**ndicators (measures of advocacy success) must be clearly defined at the beginning, monitored and evaluated regularly. **Institutional memory:** Clear strategies for archiving must be institutionalized (including mechanisms for documenting and reporting advocacy efforts and successes).

3.4.4 Improving the Two Typologies

Table 8: Improving the functionality of the top typologies

Tactics	Policy	Funding	Structure
Ensuring mechanisms of voting the leadership into offices Operating a national secretariat and state chapters Adopting hybrid meetings to save costs and ensure wider participation. Structured meetings, with an agenda, and a facilitator applying clearly defined ground rules. Mentoring and coaching with clear mechanisms of capacity transfer Profiling of coalition members Political economy analysis for key stakeholders (target population)	Ensuring gender equity and social inclusion.	Leveraging implementing partners Institutionalizing a clear sustainability plan Basket funding initiatives Ensuring private sector participation. Proposals	Multi-disciplinary and multi-sectoral structure Quarterly meetings Co-chaired (CSO+Govt) Select members based on character, competence, capacity and representation Adopt a loose coalition structure Tenure of 2 years Media and private sector participation 4 sub-committees and management committee Evidence-based advocacy

3.4.5 Considerations for Adopting Future Typologies

Evidence synthesized from the literature, stakeholder engagement, and co-creation workshops suggests that the CSO-Led women's health coalition is the most viable typology, followed by the government-led multi-sectoral typology.

However, the weaknesses of both typologies demand the consideration of a hybrid model in the interests of viability, ownership, sustainability, accountability and transparency.

Such a hybrid model builds on the strengths of the CSO-Led (the highest scoring typology) while adopting positive features (such as convening and regulatory power, ownership, and policy influence) from the government-led multi-sectoral model to compensate for the inherent weaknesses of the CSO-Led model.

One such example is the "strengthening routine immunization through memorandum of understanding (MOU)". In 2016, recognizing that reforms were needed to mobilize and coordinate resources to address low immunization coverage rates, the Sokoto State government entered a partnership with the Bill and Melinda Gates Foundation (BMGF), the Aliko Dangote Foundation (ADF) and the United States Agency for International Development (USAID). A three-year quadripartite memorandum of understanding (MOU) for the RI systems summarized the terms of the partnership. The MOU aimed to establish sustainable financing for the Sokoto immunization program and ultimately improve vaccination coverage rates through improved coordination and accountability mechanisms. This is also ongoing in Kaduna and Kano.

A viable hybrid model must ensure strong alignment and partnership with government structures, and priorities including adopting a sector-wide approach.

In addition, the model must prioritize gender equity and social inclusion.

Table 9: Considerations for adopting future typologies

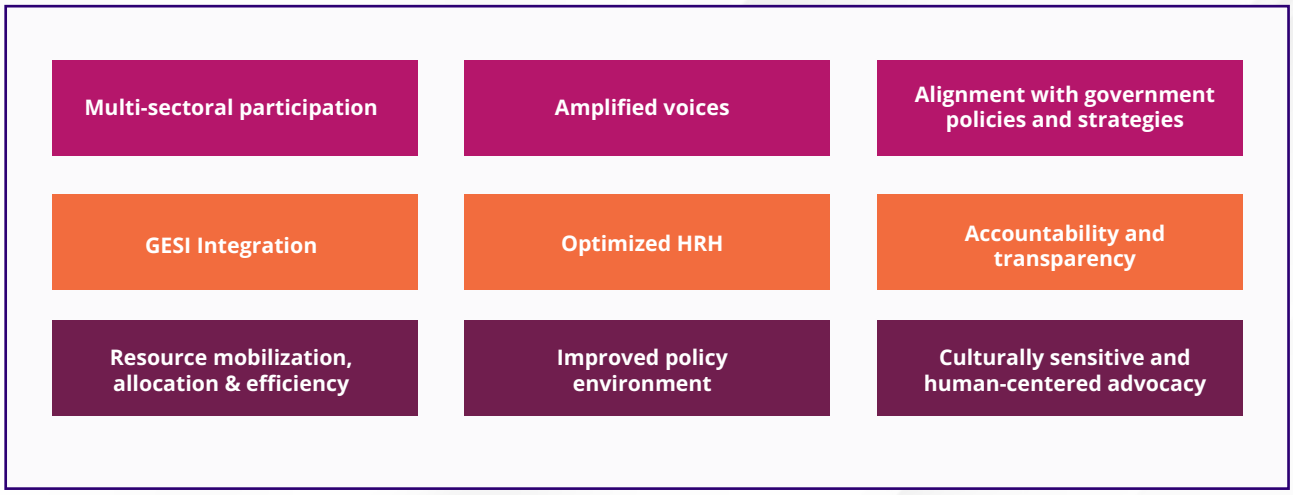
Typology	Requirement and Consideration (people, process, system, funding)	Enablers	Anticipated challenges
Hybrid model	Comprising a coalition of organizations (community-based, local and international organizations, private sector, academia, media, activists) in strong partnership with the government. Co-chaired by CSO and government representatives – with the government playing a supportive role. Leadership should be tied to the office and not a person. Bottom up approach - will encourage community participation and ownership. The secretariat should be domiciled with the government. Access to multiple funding streams including basket funding from the government, partners, private sector, grants, counterpart, statutory budgeting, etc Should have Memorandum of Understanding to promote commitment, accountability and transparency. Requires very strong governance structure for setup.	Sound technical expertise of coalition members on women's health. Better credibility for fund attraction. Efficiency/good resource management capacity. Private sector participation and potential to negotiate corporate responsibility Strong political alignment May build on existing structures such as RMNCAH+N, SLAM, Presidential Taskforce etc. Vantage position for quick policy decisions and implementation. Possibility of basket funding (Government, partners, private sector) Capacity transfer and systems strengthening	Struggle for dominance & power play. Subject to donor control. Limited funding commitment from the Government itself (self-funding in budgetary lines).

CSO-led	Comprising a coalition of organizations (community-based, local and international organizations, private sector, academia, media, activists, government, etc.). This typology should have its secretariat domiciled in the Prime CSO office. Bottom up approach - will encourage community participation and ownership	Sound technical expertise of coalition members on women's health. Better credibility for fund attraction. Efficiency/good resource management capacity.	End of CSO project may limit participation in the coalition. May have poor access to political leaders especially NASS Limited convening power to aggregate stakeholders. Struggle for dominance & power play. Limited resource mobilization capacity compared to the Government. Lacks vantage position for quick policy Decision & Implementation.
Government-led	The "Government-led Multi-sectoral" groups which includes the government, academia, media, CSOs, communities, private sector, media, implementing partners. The secretariat should be domesticated with the government with a strong convening power. Access to multiple funding streams including basket funding from govt, partners, private sector, grants, counterpart, statutory budgeting, etc Should have Memorandum of Understanding to increase commitment, accountability and transparency.	Private sector participation and potential to negotiate corporate responsibility Strong political alignment May build on existing structures such as RMNCAH+N, SLAM, Presidential Taskforce etc Multi-disciplinary/ multiple skills and perspectives. Vantage position for quick policy decisions and implementation. Possibility of basket funding (Government, partners, private sector) Credibility for fund attraction. Capacity transfer and systems strengthening	Poor Accountability mechanisms. Subject to donor control. Limited funding commitment from the Government itself (self-funding in budgetary lines) Deep dive into regressive funding

3.4.6 Measures/Indicators of Advocacy Success

Stakeholders highlighted measures of successful advocacy coalition efforts, as listed in Figure 27.

Figure 27: Indicators of women's health coalition success



Multi-sectoral participation – this ensures not only inclusivity but also the bringing together of advocates with multiple areas of expertise, unique perspectives and strengths. Furthermore, it is very much in keeping with the sector-wide policy put forward by the current government, thus addressing issues of ownership and continuity.

Amplified voices – A successful coalition leverages collective voice by bringing more attention to pertinent issues that would otherwise not occur if advocates continued to work in silos.

Integration of GESI principles - It is essential that whatever typology is adopted should employ strategies that amplify the voices of marginalized and vulnerable populations (including women and children) with regard to their health needs, allowing and encouraging women to advocate for themselves and to take up positions of leadership in advocating for change.

Alignment with government policies and strategies – It is imperative that the typology of choice align with government policies and strategies to foster ownership and seamless adoption at sub-national levels, as well as transition postproject completion.

Optimized HRH – To advocate and realize advocacy outcomes, a strong cadre of willing advocates across all sectors and levels is necessary. However, as has been previously highlighted, there are gaps in the availability of highly skilled labor that must be filled. For advocates to advocate successfully, there is a need to train and recruit adept players. A successful coalition must invest in strengthening the capacity of coalition staff/members both pre-service (through degree programs offered) and in service training.

Accountability and transparency – a characteristic that is typically a hallmark of CSO-led SLAMs, accountability and transparency are vital not only is generating public trust and buy-in, but (equally important) for engendering intra-coalition cohesion.

Resource mobilization, allocation for efficiency – The coalition must have a well-laid plan for funding detailed in the coalition charter or MoU. The funding sources, commitments, timelines, disbursement plans, signatories, accounts, patterns of funding and transitions (if regressive funding is employed) must

all be clearly outlined and then implemented with fidelity to the charter. A sustainability plan for post-project funding and coalition continuity must also be clearly established.

Improved policy environment – The evidence overwhelmingly shows that Nigeria does not lack policies or the capacity and skills to develop policies. The commitment to implementing existing policies. is needed National level policies must be adapted or adopted at the state level with the right enabling environment for successful implementation.

Culturally sensitive and human-centered advocacy – In close relation to the preceding point, it is critical that the necessary attention should be given to adopting a culturally sensitive and human-centred approach to advocacy to ensure success. Women's health advocacy-related policies must be domesticated in ways that are respectful of the culture, local politics and systems of the target population. As evidence shows, one way of approaching this is to invest in the education and counselling of influencers and gatekeepers of target populations. Another approach is to strategically engage gatekeepers and influencers as champions of women's and children's health advocacy. Additionally, there is evidence that women-led initiatives, and approaches that reduce hurdles/barriers to desired changes in behavior, tend to produce the most successful outcomes.

4. Recommendations

CSOs

1	Develop and adopt a clear implementation plan that addresses issues of sustainability post project phase to ensure continuity, including monitoring and evaluation plan (results-based framework). Also, clearly outline to key stakeholders such government and the private sector academia, and the media the gains inherent in women's health joint advocacy programs.
2	Contextually relevant approaches to women's health should be given"should be given"should be given"should be given"should be given"should be given"
3	Outline roles and responsibilities of key actors.
4	Set up and manage the CSRM platform: The stakeholder management platform (dashboard) developed during this scoping assessment is intended to serve as a precursor to a stakeholder relationship management platform. Collaborative Stakeholder Relationship Management (SRM) is an engagement software created to help different teams collaborate and interact (SRM) seamlessly to achieving set objectives. It supports communication, coordination, and collaboration among all stakeholders involved. The hope is that, when fully developed, digitalization of advocacy efforts will help bridge gaps in functionality, especially with regard to the frequency of meetings, communications and quick and reliable information sharing.
5	Pilot evidence-based initiative activities, learning and adaptation.
6	Develop and test the mentoring curriculum, the mentoring network's framework and protocols.
7	Ensure consensus building, capacity and systems strengthening activities for coalition members to address major barriers to effective women's health joint advocacy and ensure resilience against opposition and adverse events [e.g., understanding how to deal with opposition coalitions, fostering open dialogue, promoting evidence-based discussions, cultivating partnerships across diverse sectors, navigating government systems, communication, and legal analysis/legislative process].
8	Coalition efforts for women's health should be aligned with the current sector wide approach of the government in principle and focus while leveraging the influence of policy champions in domesticating at sub-national levels and encouraging advocates to take up decision making positions in relevant institutions/government.
9	Ensure the integration of GESI principles while ensuring a women-led approach and diversity (including male and social inclusion).

Government

1	Political commitment to women's health.
2	Policy champions at the national level
3	Alignment of government priorities to evidence

4	Enabling policy environment
5	Host and provide enabling an environment for stakeholder relationship management platforms.
6	Develop a clear charter (or memorandum of understanding) that must be validated by all coalition members. The MoU should ensure the integration of GESI principles.
7	Leading participatory institutional dialogue at different levels within the ecosystem to design and co-create a strategic plan and roadmap that reflects a phased approach to institutional and systems change is strongly recommended.
8	Family health departments should be established, and national health promotion policy, and other relevant policies should be established at sub-national level for better coordination of women's health joint advocacy.
9	Collaborate with the Nigeria Universities Commission to institutionalize first-degree courses in health promotion.
10	Framing women's health programs reflects cultural sensitivity and larger development goals. Adopt a human-centered approach to advocacy.

Donors

1	The adequacy, sustainability, coverage, and flexibility of funding for women's health advocacy, should be prioritized allowing advocates to navigates and respond swiftly and innovatively to evolving circumstances.
2	Explore more collaborative opportunities to scale impacts.
3	Use evidence to inform investments.
4	Ensure inclusion and transparency.
5	Ensure situational analysis/stakeholder and network mapping of participating coalitions preceding implementation. This is to ensure that the selected players are well aligned in terms of their common goals, ethos and values, reducing any potential for conflict in the future. In line with this, particular attention must be paid to ensuring the alignment of goals and organizational culture among actors through a careful selection process (based on antecedents).
6	Support set up of family health departments and domesticate the national health promotion policy, and other relevant policies, at sub-national levels for better coordination of women's health joint advocacy.

5. Lessons Learned

1. There are resources in individuals and organizations that are yet untapped. Advocates could enhance their use of passionate individuals dedicated to women's health as a valuable asset of human capital. At some point, states were committed to addressing women's health issues and they committed funds to addressing these issues, However this was not sustained.

2. Interest and commitment need to be nurtured, and efforts should be made to sustain commitment on the part of key decision-makers.

3. Resources that have been channelled to women's health could be better managed for better results with greater accountability, ownership, and compliance with existing laws.

4. The opportunity to monitor and evaluate women's health programs and learn from previous rounds of implementation has also been lost.

5. The absence of monitoring and evaluation has made it difficult for those involved in women's health advocacy and program planning and implementation to identify the problems with the ongoing work.

6. Our findings revealed that in regards to advocacy for women's issues, there is also great potential for engaging religious and traditional leaders who have hitherto gone untapped. Furthermore, religious leaders in particular are not only aware but also willing to lend their voices as change agents to women's and children's health issues and are open to receiving advocacy capacity building training.

7. Strategies to increase demand must prioritize cultural sensitivity and human-centered design approaches as well as advocacy capacity building for service providers.

8. There is a disconnect between national policies and subnational implementation and call for increased rates of subnational level implementation.

9. Addressing the concerns of opposing parties or, at the very least, anticipating their objections is crucial to ensuring advocates are well-prepared.

10. Greater coordination of ideas and activities are needed among advocates. Improved coordination will require broadening the scope of collaboration to include people outside civil society, including researchers, practitioners and policymakers.

11. Continuity in the representation of organizations is also a major requirement if women's health advocacy coalitions are to be productive. Furthermore, persons representing the different member organizations should be people with decision-making capacity.

12. In terms of cost-effectiveness and efficiency in the use of resources, leveraging and strengthening existing women's health advocacy structures should be a prioritized.

13. Women's empowerment must be prioritized, as part of advocacy capacity building, to advance women's health joint advocacy efforts.

6. Conclusion

There is a consensus that advocacy coalitions are more impactful for facilitating collective action to amplify stakeholder voices and obtain the buy-in of advocacy or policy champions in promoting social change. Some challenges associated with building successful advocacy programs include a lack of alignment on vision, contentions for dominance among multiple coalitions, dependence on resources from existing political systems, transitions in government and lack of sustainable funding plans. 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.

Reaching the right decision-makers with the right message at the right time is critical for the success of advocacy programs, and smart timing of advocacy projects may require taking advantage of policy windows to gain political commitment and public support for policy change or interventions. To ensure that advocacy programs are successful, it is important to deploy contextually relevant approaches that build strongly aligned coalitions, strengthen capacities, mobilize effective multi-sectoral partnerships, engage powerful allies in government and leverage sustainable funding models for subnational and national level impact.

There is strong evidence that designing joint advocacy programs and interventions in Nigeria may require a hybrid of the different advocacy typologies described in this review. In deciding what joint advocacy model(s) would best fit the Nigerian context, it is important to weigh the strengths of the different advocacy strategies and draw from the lessons learned, as advocacy initiatives are not one size fits all.

Finally, to ensure effective documentation of the success of women's health advocacy initiatives, it is important to explore integrated measurement indicators that demonstrate achievements, gender integration and linkages to the broader developmental agenda of the government.

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8. Appendix

PROJECT NAME	THEMATIC AREA	PROPOSED ADVOCACY OUTCOME (SHORT/LONG TERM)	ADVOCACY STRATEGY/ ADVOCACY TACTICS/ ADVOCACY EFFORTS.	COALITION STRUCTURE (IF ANY)	KEY ACHIEVEMENTS	CHALLENGES	LESSONS LEARNED
SURE-P/MCH	Maternal and Child Health	Common agenda, shared priorities for action and collaborative advocacy initiatives to ensure governmental accountability to health commitments.	Conduct of public forums, policymaker education and political will campaigns, media advocacy and program demonstrations.	Coalition - Alliances made up of committed individuals and institutional policy actors with strong interorganizational and interpersonal ties working together to influence policy.	Increased political will. Positive shift in decision-makers' attitudes and increased policy support for MCH issues in Nigeria, especially following the suspension of the free MCH program.	Multiple coalitions with struggles for dominance. Mobilization of coalition members and resources dependent on existing political system. Lack of cohesion regarding group goals, mission and vision	Advocacy initiative aligned with political party agenda to ensure a sustainable structure. Availability and use of evidence on the issue, networking with powerful and interested champions, and alliance building in advocacy.
Partnership for advocacy in child & family health| Partnership for advocacy in child and family health at scale.	Child health, Family health – (Family planning, Nutrition)	Accountability of national and state government in the areas of policy, budgets and administrative regulations for child and family health.	Policymaker education, public and political will campaigns, built advocacy capacity of CSOs, regulatory feedback, Media Advocacy, conducted public forums	CSO-led Coalition	Strengthened advocacy among CSOs in Nigeria to ensure that FP remains a development priority at national and state levels. Improved policy environment at national level and in 3 states in Nigeria. Establishment of a conducive environment for implementing the PPMV 3-tier accreditation system. Reassessment of task shifting and task sharing policy. Augmented budgets for primary healthcare delivery	The volatile political landscape, bureaucracy, divergent government priorities, and spending restrictions.	The importance of persistence and strategic engagement. The program's strength was in its commitment to evidence-based advocacy and adherence to government policies.

Advocacy for nutrition in Nigeria	Child malnutrition.	Increase in public financing for nutrition. Mainstreaming of malnutrition prevention and treatment interventions into the Nigerian Health System (Kano, Katsina, Bauchi, Jigawa, and Gombe +National).	Media advocacy and conduct of public forums	Partner collaboration	Not clear	Not clear	Bi-weekly meeting of the coalition enhanced effective-ness. Benefits of evidence-driv-en advocacy
Giving birth in Nigeria: Advocacy and communication	Maternal health	Increased awareness of polices and strategies that increase access to quality maternal health care	Not clear	Not clear	Not clear	Not clear	Not clear
Civil society advocacy in Nigeria: promoting democratic norms or donor demands	HIV	Prevention and mitigation of HIV	Peer education, rallies, community mobilization of community and religious leaders	CSO networking	Not clear	Funding to sustain the advocacy movement. Focused more on promoting donor demands	The focus was more at local level and not targeted at policy and funding at national and state levels.
Health Policy Plus	TB and HIV	Integration of tuberculosis (TB) and HIV into national and state health insurance schemes, thereby increasing access to those services. Increased government commitment and expenditure for health.		Multisectoral collaboration and strategic engagement	Increased appropriation. Sustainable financing for HIV and TB in Lagos	Difficulty in securing appropriation (budgetary line)	Use of evidence to engage government who continued to champion the course even after project end.

The Mamaye	Maternal, child and adolescent girls' health	Increase in the quantity and quality of investments in health. Capacity development for local decision-makers to respond to the needs of women and girls.	Lack of cohesion regarding group goals, mission and vision	Advocacy initiative aligned with political party agenda to ensure a sustainable structure.	Increased financing for MNH	Cultural and socioeconomic factors influencing service uptake and utilization	Multisectoral approach. Institutionalized multisectoral groups such as RNMCAH+N
Advocacy for Primary Health Care Reform	PHC reform	Improvements in health outcomes by fostering key reforms at the National and State level in three core areas: Primary Heath Care under One Roof (PHCOUR), Free Maternal, New–born and Child policy, and National Health Bill	Policy analysis/ research, Legislation, Built advocacy capacity	Coalition	Advocated & secured the passage of the 2014 National Health Act by the National Assembly (NASS) and supported its signing into Law by President Good luck Jonathan through the Health Sector Reform Coalition	Not clear	The reform was government-driven (led by the Health Reform Foundation of Nigeria) and the health reform coalition still exists

Gatekeepers	Facilitators
Traditional Rulers	CSO organizations
Health Desk officers (responsible for budgetary release at state-level)	Community volunteers
Village heads (known as Mai angwa, district level heads (aka Dakachi)	Government staff
Chief executives of parastatals (e.g., PHCB, FP, KASIA, KASHSA, KASACA)	Donor organizations such as UNFPA, BMGF
Commissioner for Budget and Planning	Partners at local government and community-level, including ward development committee chairmen.
Commissioner of Environment	Community champions
Ministry of Finance	Service providers in facilities,
Commissioners of health,	program officers at local government level
Government (all arms and levels, including: state executive arm of government, legislative arm of government - specifically, the Chairman house Committee on Health and the Chairman house committee on appropriation).	CDC champions
Policymakers and public office holders (such as local council chairman and other officials responsible for approving or disbursing funds)	Facility health committee members,
	Village head committee teams,
	CHIPS agents,
	Kaduna State Social Committee on Health.

Table 12: Gatekeepers and Facilitators - Kano

Gatekeepers	Facilitators
Kano State Emirates Council Committee on Health (KSECCoH)	Commissioner for Health,
Commissioner for health	Director public health and disease control
Director public health & disease	Ministry of women's affairs
Traditional leaders	All heads of MDAs (across various sectors),
Kano state government staff	Personal assistants to heads of MDAs
Heads of MDAs	Implementing partners
Personal assistants to heads of MDAs	CSOs,
RMNCAEH+N program officers	Traditional and religious leaders
Ministry for LGA Affairs	Media
Departments of budget & planning	Islamic teachers
Department of finance	Religious women organizations (e.g., FOMWAN and WOWICAN),
Ministry of women's affairs	Professional organizations (such as MWAN, SOGON, APHPN, PAN),
	Ministry of Women's Affairs (staff such as the Director Child health and the gender desk officer),
	RMNCAEH+N program officers,
	Chairman Committee on Health
	Department of Budget & Planning,
	Department of Finance,
	Hisbah (Islamic policy and security agents)
	Members of the academia.
	First ladies at all levels of government,

Table 13: Gatekeepers and Facilitators - Lagos

Gatekeepers	Facilitators
Policymakers - Permanent secretaries (SMoH) and (PHCB)	Ward heads
Directors	Legislative arm of government
District level PSs	Professional women associations (e.g. MWAN)
Market women groups	Women religious organizations (e.g., FOMWAN and WOWICAN)
CSO coalitions	Press/Media
Press/Media	Interfaith CSO
Donors	Market women groups
Implementing partners	Professional women associations (e.g. MWAN,)
Ward Health committee chairmen	Women religious organizations (e.g., FOMWAN and WOWICAN)
Community leaders – Baale	CSO coalitions
Market women groups leaders – Iyalooja	Press/Media
Community women group heads – Iyalode	Donors
Community women group heads – Iyalode	Implementing partners

Key Stakeholders at National level

- Government and key government officials such as the Executive arm of government, as well as senior management staff of health ministries and health agencies at all levels of government.
- First ladies at all levels of government
- Market women groups
- Professional women associations (e.g. MWAN)
- Women religious organizations (e.g., FOMWAN and WOWICAN)
- CSO coalitions
- Press/Media
- Donors
- Implementing partners

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