CIVIL SOCIETY ORGANISATIONS' ENGAGEMENT WITH THE GLOBAL FINANCING FACILITY IN NIGERIA

THE TASK AHEAD

OCTOBER 2017

Commissioned by MamaYe-Evidence for Action (E4A)

Executive Summary

Progress on maternal health during the Millennium Development Goal period has been slow and there has been a comparative lack of attention to newborns and adolescents. As a result, there is an urgent need to accelerate efforts to end preventable maternal, newborn, child and adolescent deaths and improve the health and quality of life of all women, adolescents and children. The Global Financing Facility (GFF) was launched in 2014 in response to this challenge. The GFF includes extra funding under the GFF Trust Fund, but also aims to leverage and coordinate other sources of funding including domestic financing, donor support, and funding from the private sector.

In 2015, it was announced that Nigeria would receive GFF support. The national GFF governance mechanism is called the Country Platform and it is led by the Federal Government of Nigeria. The single civil society organisation (CSO) representative on the Country Platform is HERFON, the Health Reform Foundation of Nigeria, elected by the Health Sector Reform Coalition. CSOs have an important role to play in GFF not only as implementing partners, but more importantly to influence GFF implementation in Nigeria and hold the government accountable for what it has promised to do under GFF.

This report finds that CSO engagement in GFF has had limited effectiveness to date, but that there are relatively simple interventions that can improve this. Currently, CSOs, particularly at the State level, have very low awareness of the GFF. This is compounded by a lack of information-sharing by government, and rushed timelines for consultation and review of strategic documents. The CSO representative on the Country Platform also needs guidance to strengthen information-sharing and consultation with other CSOs at the national and State levels. There is also a general lack of transparency in the selection and involvement of CSOs in the implementation of RMNCAH activities, especially at the state level, which diminishes the legitimacy and quality of CSO engagement. In addition, many CSOs at the State level do not normally target State governments with advocacy or accountability activities due to low capacity and insufficient financial resources. Finally, CSO coalitions at the State level generally lack the leadership skills, financial resources and systems to consult, inform and engage their member CSOs.

Many solutions exist. At the country platform level, it is important that there are transparent selection criteria for CSO representatives and that strategic information is shared in a planned and timely way, as outlined in the Minimum Standards for Country Platforms. Much can also be learned from successful CSO engagement mechanisms in other areas, such as the Global Fund's Country Coordinating Mechanism and the Nigeria Service Delivery Innovation Challenge, a GFF-supported initiative that has successfully engaged private sector stakeholders.

At the CSO level, financial resources must be allocated to CSOs and CSO coalitions to enable meaningful engagement; CSO representatives must commit to being inclusive and accountable; resources and technical assistance should be mobilised to build stronger CSOs and CSO coalitions which jointly plan together; and targeted support to CSOs and CSO coalitions on GFF processes will enable better tracking and accountability of GFF investments.

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ASANGO	Abia State Association of Non-Governmental Organisations
BHCPF	Basic Health Care Provision Fund
BMPHS	Basic minimum Package of Health Servicesto
CBO	Community Based Organization
CHR	Community Health and Research Initiative
CSO	Civil Society Organisation
DFID	Department for International Development, UK
E4A	Evidence for Action
FBO	Faith Based Organization
FGD	Focus Group Discussions
FOI	Freedom of Information Act
GAVI	Global Alliance on Vaccines and Immunization
GFF	Global Financing Facility
HCFE & I TWG	Health Care Finance Equity and Investment Technical Working Group
HERFON	Health Reform Foundation of Nigeria
HIV	Human Immuno-Deficiency virus
HSRC	Health Sector Reform Coalition
IDIs	In-depth Interviews
KIIs	Key Informant Interviews
LGA	Local Government Areas
LMIC	Low and Middle Income Countries
M&E	Monitoring and Evaluation
NSDIC	Nigeria Service Delivery Innovation Challenge
NGO	Non-Governmental Organization
OCA	Organizational Capacity Assessment
OCAT	Organizational Capacity Assessment Tool
OVC	Orphans and Vulnerable Children
PHCDA & LG	Abia State Primary Health Care Development Agency and Local Government Health Authority
PHCUOR	Primary Health Care Under One Roof
PMNCH	Partnership for Maternal, Newborn and Child Health
RMNCAH	Reproductive, Maternal, New-Born, Child and Adolescent Health
SOML	Save One Million Lives
SWOT	Strength, Weakness, Opportunities and Threats
TWG	Technical Working Group
UNICEF	United Nations International Children Education Fund
UNFPA	United Nations
WHO	World Health Organization

1. What is the GFF and how is it meant to work?

Background to the Global Financing Facility

As demonstrated by the slow progress made on maternal health during the Millennium Development Goal period and the comparative lack of attention to newborns and adolescents, there is an urgent need to accelerate efforts to end preventable maternal, newborn, child and adolescent deaths and improve the health and quality of life of women, adolescents and children. The plan guiding progress on these issues worldwide is the Global Strategy for Women's Children's and Adolescents' Health (2016-2030). Achieving this plan by 2030 is ambitious, and requires a dramatic increase in Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) financing from both local and foreign sources, as well as more efficient spending of existing resources. The **Global Financing Facility** (GFF) was launched in 2014 in response to this challenge.

The GFF includes extra funding under the **GFF Trust Fund**. This funding is provided by the World Bank and the governments of Canada, Norway and the United States. The goal of the GFF is to leverage and coordinate even more funds, including domestic financing from the governments of recipient countries, other donor support, and the private sector. At the international level, the main GFF governing body is the **Investors Group**, composed of senior representatives of recipient and donor governments, UNICEF, UNFPA, WHO, the World Bank, GAVI, Global Fund, PMNCH, non-governmental organisations and the private sector. Nigeria is one of eight countries out of the 62 countries eligible to receive funding from the GFF Trust Fund announced as "second wave" countries at the GFF launch in July 2015 alongside Bangladesh, Cameroon, India, Liberia, Mozambique, Senegal, and Uganda. The Democratic Republic of the Congo (DRC), Ethiopia, Kenya, and Tanzania were the "front runner" GFF pilot countries.

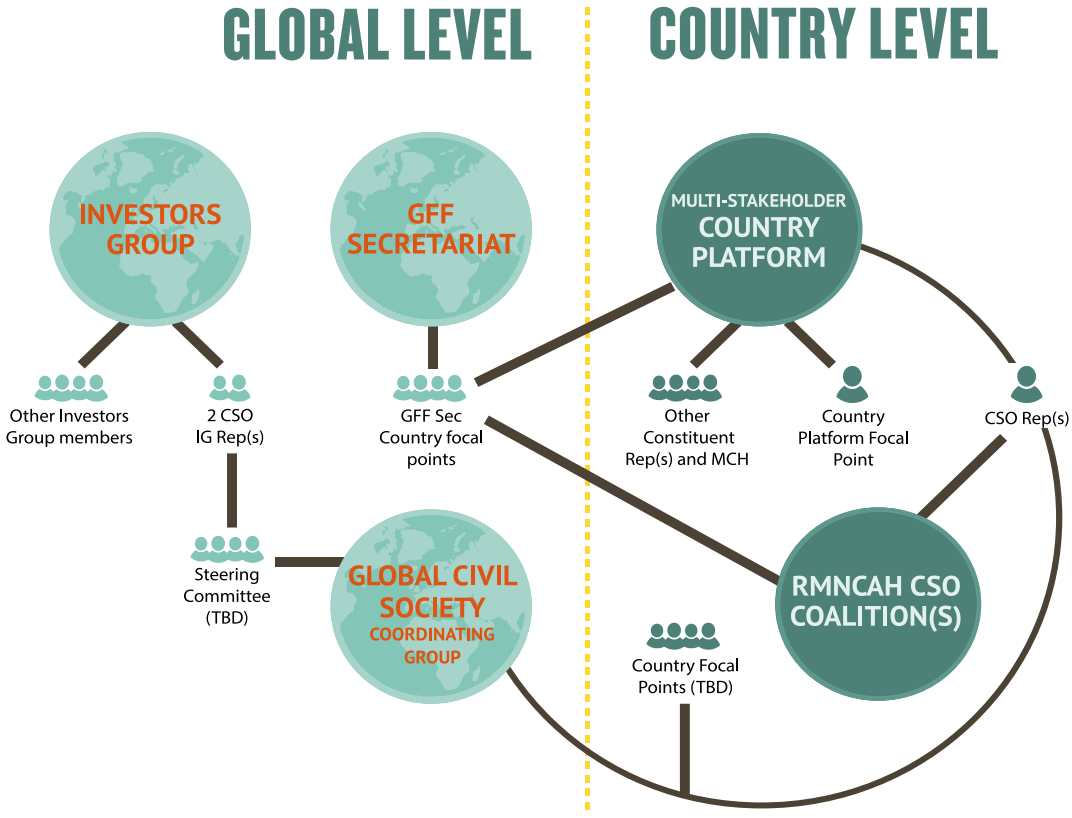


Figure 1: Structure of GFF at global and country level[1]

[1] Adapted from Annex 1: Communication Channels & Entry points for CSOs in GFF. Civil Society Engagement Strategy, Firth Investors Group Meeting, April 24 2017. Available here: https://www.globalfinancingfacility.org/sites/gff_new/files/documents/GFF-IG5-5%20CS%20Engagement%20Strategy.pdf

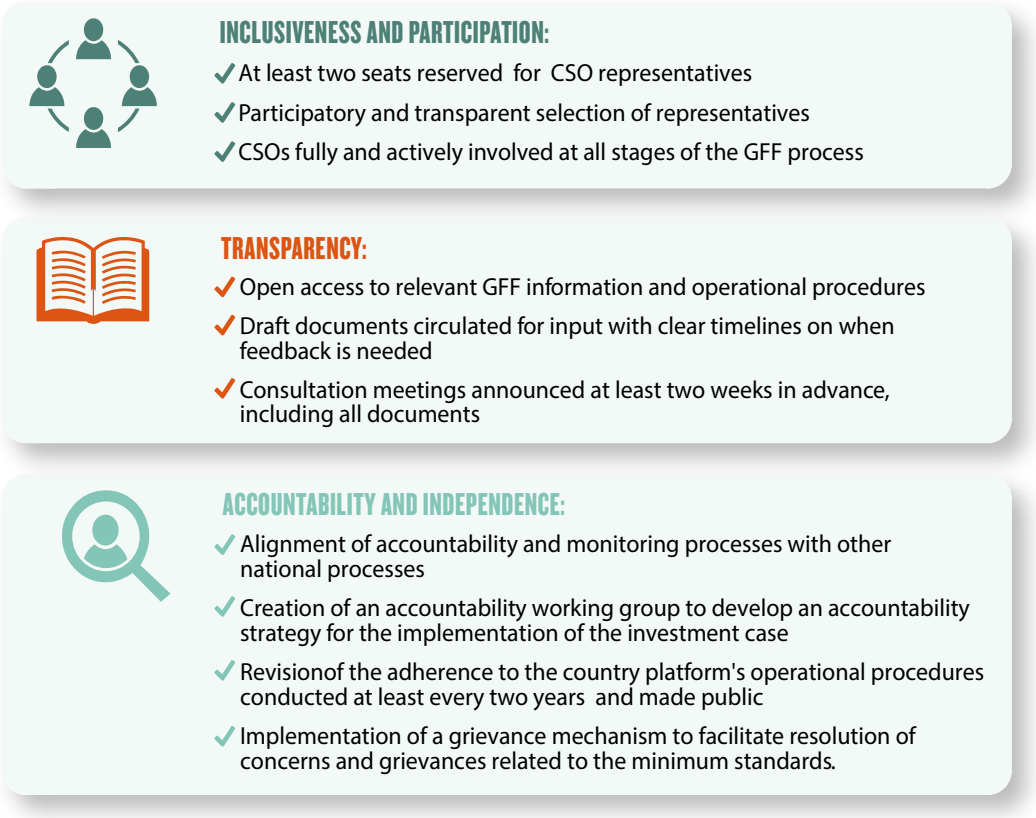
At the country-level, the GFF is managed by a **Country Platform**. Country Platforms are under the leadership of national governments and include donor partners, private sector stakeholders, and civil society organisations (CSOs). In order to guide operations of the GFF in-country, the Country Platform must produce two documents: an **Investment Case** and a **Health Financing Strategy**. The Investment Case is a description of the improvements that a country wants to see with regard to RMNCAH and a prioritised set of investments required to achieve these results. The Health Financing Strategy is a plan to ensure that the health sector is fairly and sustainably financed over the long-term, to accelerate progress on RMNCAH and universal health coverage. It considers all sources of health financing, including domestic resource mobilisation. The Country Platform is intended to ensure inclusiveness and transparency in GFF processes at the country level, thereby enabling accountability for the commitments made in the Investment Case and the Health Financing Strategy.

Minimum Standards for CSO Engagement in the Global Finance Facility

Civil society has a critical role to play in GFF processes, bringing unique community-based knowledge, access and expertise to make the GFF operations and results achievable. They are also important in keeping the government and other GFF partners accountable for the actions outlined in the Investment Case. The GFF established minimum standards to which countries are expected to adhere to ensure that the Country Platforms embody the principles of **inclusiveness and participation, transparency, independence, and accountability**. Adhering to these principles is particularly important to ensure that civil society organisations are able to engage effectively in GFF, particularly in their accountability role.

The minimum standard principles are described in the diagram below and can be accessed online at this address: https://www.globalfinancingfacility.org/sites/gff_new/files/GFF%20Country%20Platform%20guidance%20note.pdf

Figure 2: GFF Minimum Standards for Country Platforms[2]



[2] Adapted from Box 3. Recommendations for effective CSO engagement in RMNCAH country platforms, Civil Society Guide to the GFF, Suzanna Dennis, October 2016. Available here: http://pai.org/wp-content/uploads/2016/10/CS-GFF-Guide-2.pdf

2. How does the GFF work in Nigeria?

Governance

Nigeria was announced as a second-wave GFF country in July 2015. Addressing the urgent RMNCAH needs of affected populations is one of the three key priorities of the government.

Country Platform

The GFF Business Plan instructs that a multi-stakeholder Country Platform, led by the Federal Ministry of Health, should be in place to ensure meaningful engagement and transparent decision -making at all stages of elaboration, implementation, monitoring and review of the RMNCAH Investment Case and Health Financing Strategy. Where such platforms already exist, the Business Plan encourages countries not to set up parallel GFF platforms but instead expand upon existing ones to incorporate the characteristics of the Country Platform.

In Nigeria, the Health Care Financing Equity and Investment Technical Working Group (HCFE&I TWG) initially doubled as the GFF Country Platform[3]. The HCFE&I TWG had over 100 members comprising donors, government, private sector and civil society representatives. In November 2016, the Federal Ministry of Health (FMOH) dissolved the HCFE&I TWG and a new multi-stakeholder Country Platform was established with a smaller membership, comprising donors, bilateral and multilateral organisations (World Bank, WHO, UNICEF), key department heads of the FMOH, the private sector and the **Health Sector Reform Coalition (HSRC)** as the CSO representative. There is only one CSO representatives on the Country Platform despite the minimum standards indicating there should be a minimum of two.

The GFF Business plan advises that a national RMNCAH CSO coalition be established to support the implementation of the GFF at country level. The role of the coalition is to share information, support implementation and build capacity from the national to the sub-national level. The HSRC has taken up this role by default since it is the largest health sector coalition at the national level. The HSRC is a loose coalition of 41 CSOs in the health sector with over 100 individual members. The HSRC earned recognition by government as a rallying point for CSOs in the health sector in part because the heads of the coalition have often been retired government officials with influence to actively bridge the gap between CSO coalitions and government and the motivation to involve government in its activities.

From the HSRC, the immediate past Executive Secretary of the Health Reform Foundation of Nigeria (HERFON), was nominated in 2015 to be the CSO representative on the initial Country Platform (then HCF&I TWG). When the former Executive Secretary moved on to a higher national assignment, the role of CSO representative was automatically extended to the new HERFON Executive Secretary.

To date, only two national GFF meetings have been convened by HERFON since 2015, due to funding challenges experienced by HERFON. There has been little consultation with the full HSRC membership about which CSO should represent the HSRC and how CSO views will be channelled through HSRC to the Country Platform.

Health Financing Strategy and Investment Case

The government led the process for developing the Health Financing Policy and Strategy and invited wide consultation with multi-stakeholders, including CSOs. The Health Financing Policy and Strategy was validated by stakeholders in June 2017. The Reproductive, Maternal, Newborn, Child, Adolescent and Nutrition (RMNCAH +N) Investment Case was open for consultation to partners and CSOs in March 2017. However the window for stakeholders, including CSOs, to engage in an effective consultation and review of the RMNCAH +N Investment case was only two days and therefore few CSOs were able to take advantage of this

[3] The TWG was constituted in 2015 to operationalise the National Health Act and was saddled with the responsibility of developing the National Healthcare Financing Policy and Strategy.

opportunity. The RMNCAH +N Investment Case is still at the finishing stages with the Federal Ministry of Health prior to validation and subsequent dissemination. The RMNCAH + N Investment Case and the Health Financing Policy and Strategy are currently not accessible online[4] and can only be requested from the Ministry of Health.

Strategy

GFF activities are highly linked to wider government health priorities and programmes in primary healthcare: The Basic Minimum Package of Health Services, the Nigeria State Health Investment Project, and the Nigeria Service Delivery Innovation Challenge.

Basic Minimum Package of Health Services

Nigeria's National Health Act of 2014 promotes a Basic Minimum Package of Health Services (BMPHS) to be delivered through a combination of public and private funding. Nearly all of the nine interventions in the Basic Minimum Package align with GFF priority areas: six are focused on maternal and child health, and one is for malaria. This Basic Minimum Package is meant to be piloted in three states: Osun, Abia and Niger and funded through the Basic Health Care Provision Fund (BHCPF). The BHCPF will be pilot tested in rural-poor communities of the 3 states to work out operational details and establish the institutions and mechanisms needed for broad success[5].

The BHCPF includes not less than 1% of all revenues from the federal government, as stipulated in the National Health Act. The BHCPF also includes donor grants and $20 million in funding from the GFF Trust Fund to support implementation of the BMPHS in the 3 pilot states. As of the time of writing, the pilots have not yet started.

Nigeria State Health Investment Project

The Nigeria State Health Investment Project (NSHIP)/performance based financing (PBF), implemented by the National Primary Health

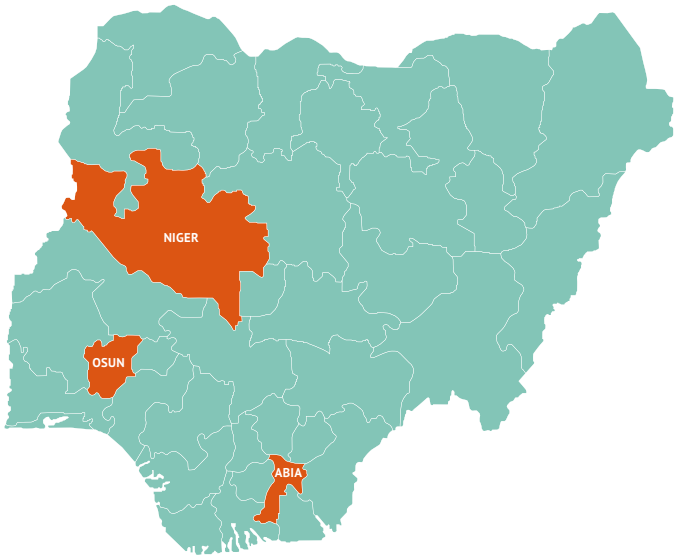


Figure 3: The Basic Minimun Package will be piloted in Osun, Abia and Niger

Care Development Agency is primarily focused on RMNCAH interventions at the primary healthcare level. Services purchased include antenatal visits, deliveries, caesarean section (at secondary level), family planning, voluntary counselling and testing (VCT), prevention of mother-to-child transmission (PMTCT) of HIV, immunisation and sexually transmitted infections (STI). PBF also pays for improving the quality of RMNCAH services thereby driving increased coverage and quality of services. This project is funded by the World Bank and implemented in five North East states, which will receive additional funding from the GFF to increase coverage and quality of services.

Nigeria Service Delivery Innovation Challenge

In addition, the Federal Ministry of Health is pioneering an integrated approach to health service delivery in partnership with the private sector for improved RMNCAH service quality and coverage. The Nigeria Service Delivery Innovation Challenge (NSDIC) was a competitive process to stimulate innovations in primary health care service delivery in the conflict-affected North East States. This partnership between the Federal Ministry of Health, the Private Sector Health Alliance of Nigeria, the Health Care Federation of Nigeria, the International Finance Corporation, and the GFF

[4] Correct as of time or finalising this report in October 2017

[5] "The States were selected based on geography; presence of a functional State Supported Health Insurance Scheme (SSHIS) and State Primary Healthcare Development Agency (SPHCDA). This is to enable disbursement through the two "gateways" for the funds. The pilot of the BMPHS with the GFF Grant, will generate a 'proof of concept' and inform learning towards the scale up of the BMPHS implementation in all the states of the Federation in 2018" (FGON, draft Investment Case, 2017).

was launched in December 2016. The NSDIC builds on the public sector's understanding of problems, the private sector's platform for innovators and civil society's expertise to collaborate in addressing four priority health systems challenges:

1. Increasing coverage of RMNCAH interventions in North East Nigeria;
2. Improving quality of care;
3. Increasing the availability of life-saving commodities; and
4. Strengthening the availability, timeliness, and quality of the civil registration and vital statistics (CRVS) system.

A total of 65 submissions were received and reviewed with a shortlist of nine innovative service delivery models going through to the second round, out of which three emerged with the highest scores. These three service delivery innovations are to be incorporated into Nigeria's Investment Case and are likely to receive GFF Trust Fund support for scale-up.

3. How are CSOs in Nigeria currently engaging with the GFF?

Common challenges for CSO engagement with GFF at the national and state levels

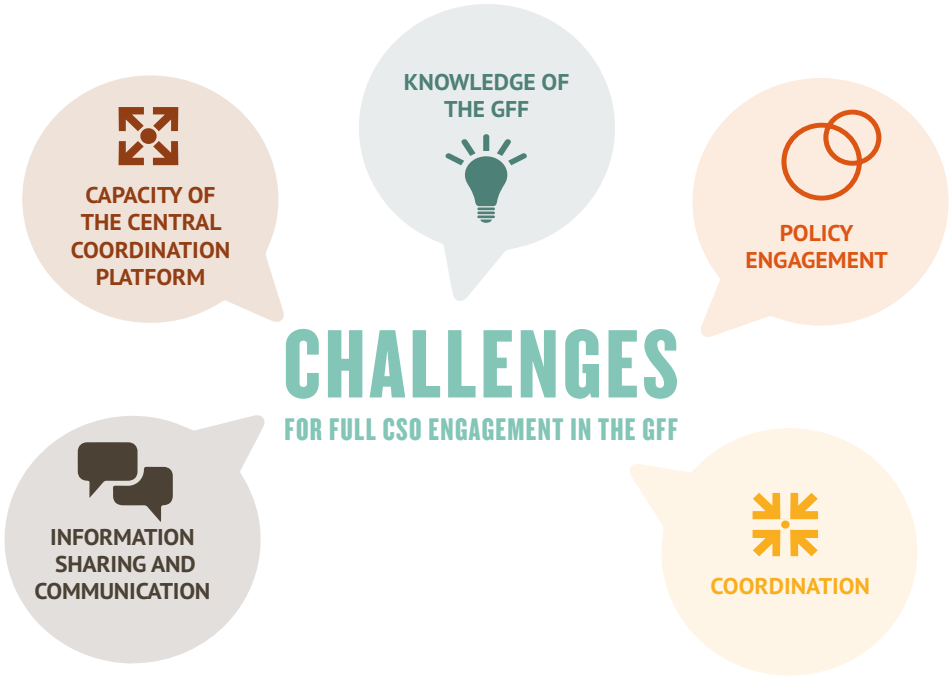


Figure 4: Overview of challenges for full CSO engagement in the GFF

LOW CAPACITY OF CENTRAL COORDINATION PLATFORM

As mentioned above, HERFON (the secretariat of HSRC) has only been able to convene two national-level meetings with CSOs on GFF. One of these was a meeting with the Minister of Health and the other was a departure briefing meeting with CSOs prior to the April 2017 GFF meeting in Washington. Both meetings were supported by CHR, another member of HSRC.

HERFON has also lacked the capacity to engage with CSOs at the state level. As explained by the HERFON Executive Secretary: "The role that HERFON enjoys at national level by being the (GFF) Secretariat does not translate directly to the State level". While there is a HERFON presence at the State level via HERFON State Coordinators, these State Coordinators are individuals that do not necessarily represent any CSO and most of them are not known in their States' as coordinating any CSOs; in addition, HERFON lacks the capacity and finances to engage with them regularly. As a result, HERFON is not able to mobilise CSO groups for collective action at the State level. With additional financial and technical support, such coordination may be possible: for example, HERFON already coordinates CSOs in the 14 DFID-supported States to hold State governments accountable for primary healthcare activities.

> **"The role that HERFON enjoys at national level by being the (GFF) Secretariat does not translate directly to the State level".**

CHR also supported and facilitated the emergence of a 15 member GFF CSO working group with 3 of its members drawn from each of the three pilot states. Since not all CSOs in HSRC have an interest in the GFF, a terms of reference (ToR) was communicated to all members inviting them to indicate their interest in joining the GFF CSO working group. The ToR

identified CSOs working in health financing, professional bodies and media as potential members of the working group; local and international development partners and INGOs were identified as members with no voting rights but who could provide technical and financial support. The mandate of the working group to strengthen CSO engagement in the GFF in Nigeria would have been stronger if there had been more opportunity for the broader HSRC membership to participate in developing its ToR.

LOW KNOWLEDGE OF GFF AMONG CSOs IN NIGERIA

A major challenge among CSO leaders across the three BMPHS pilot States (Osun, Abia and Niger) is a lack of understanding about the GFF. For example, the civil society groups interviewed at the State level did not know of any CSO representation in GFF processes. One respondent linked the lack of information at State level to ineffective mobilisation at the national level: "Most CSOs are not informed about the GFF nor its processes in Nigeria because, even some of the national networks/coalitions of CSOs' on specific health area are not engaging with the GFF" – Civil society representative, Osun State. On the other hand, knowledge about RMNCAH among the civil society groups was relatively high, especially in the area of sexual and reproductive health.

"Most CSOs are not informed about the GFF nor its processes in Nigeria because even some of the national health-specific CSO networks and coalitions are not engaging with the GFF".

Civil society representative, Osun State

WEAK CAPACITY FOR ENGAGEMENT OF STATE-LEVEL CSOS AT THE POLICY AND PLANNING LEVEL

There is limited capacity among CSOs and their networks or coalitions in the focal States to engage in policy processes at the executive or legislative levels, or to conduct budget tracking. Apart from a few CSOs that participated in the legislative processes of the States' Primary Health Care Development Bill because their funders requested for such engagement, the majority of the CSOs were not aware and did not engage in legislative advocacy processes. This has led to a situation where civil servants conversant with the PHCDA Act form NGOs in order to represent CSOs on the board of the PHCDA.

WEAK INFORMATION SHARING AND COMMUNICATION MECHANISMS

At the State level, some civil society stakeholders reported that they have had no information about GFF, while others suggested that GFF information is difficult to access in the States where it is available. There has been little or no communication on GFF to the CSOs and the general public which means that government and its agencies are not held to account for how they manage GFF related projects. It seems very challenging to obtain information on the GFF process without personal relationships with government officials or international development partners involved in GFF-related activities.

Most State level CSOs were not aware of any calls for CSO engagement or the criteria for such engagement, pointing to a lack of transparency in CSO selection for participation in GFF mechanisms. In most cases, the only engagement CSOs have had with GFF relates to the implementation of health projects (mostly behaviour change activities at the community level), and not to government-orientated advocacy and accountability activities.

Where CSOs have requested information there is a lack of response, feedback and follow-up to some CSOs' requests by government agencies at both State and federal level. There is some suspicion at State Ministry of Health level about requests for information by CSOs about GFF-related activities. Some additional information-sharing and mobilisation efforts targeted at CSOs have been led by bilateral and multilateral agencies (World Bank, USAID, GAVI, Global Fund etc.), E4A, PMNCH, and the African Health Budget Network at international,

national, and State levels. However, the fact that these efforts have been disparate and uncoordinated means that sustained information sharing and targeted capacity building is still lacking.

POOR COORDINATION

Although the GFF Secretariat, based at HERFON, has facilitated the development and sharing of a terms of reference targeting about 15 identified organisations to bring together a GFF working group of CSOs and external development partners at the national level, there is not yet any consensus built on respective roles. This translates to a lack of harmonisation of different partners' actions on CSOs' GFF engagement in Nigeria.

At the State level, CSO engagement is mostly restricted to those CSOs or coalitions that work directly with the State Primary Health Care Development Agencies or with the State's Coalition of NGOs, where these exist. In Niger State, the Niger State Network of NGOs' has been instrumental in driving civil society engagement and collaboration on primary healthcare activities, coordinated by the Niger State Primary Health Care Development Agency. In Abia and Osun States, engagement between the States' Primary Health Care Development Agencies and CSOs has been restricted to individual CSOs. There is little or no involvement of RMNCAH-focused CSO coalitions in interactions between CSOs and the State-level governments.

In Niger State, the Niger State Network of NGOs' has been instrumental in driving civil society engagement and collaboration on primary healthcare activities, coordinated by the Niger State Primary Health Care Development Agency.

State-specific challenges and opportunities for CSO engagement with GFF

Some civil society networks and coalitions in the States could take a leadership role to facilitate GFF engagement at the state-level. The Network of NGOs in Abia, Niger and Osun States have a history of bringing together different stakeholder groups to implement and monitor health sector programmes, and facilitate dialogue on policy or social issues between governments, development partners, beneficiaries and other stakeholders. However there is a lack of technical competencies required for GFF engagement among these networks.

SUMMARY OF OSUN STATE CSO COALITIONS' SWOT ANALYSIS

S Osun State has a CSO network on malaria; on HIV & AIDS; on family planning, and on SRH, with some structures for mobilisation. Osun State's strengths also include an acceptable level of capacity and the relatively cordial relationship among CSOs in the State. The strongest and most comprehensive network is the Network of NGOs, which has recently been dormant despite past successes. Resuscitating the Network of NGOs in Osun State is seen as a viable option for galvanising CSOs for GFF response.

W A network bringing together all health-focused CSOs does not exist; CSOs' involvement in policy and budgetary processes, as well as their knowledge of GFF, is very low.

O Opportunities include a government policy in favour of Public-Private-Partnerships and a number of highly skilled persons in the State who could contribute to the capacity development of the State CSOs' through training or mentoring.

T Despite the Osun State Primary Health Care Development Agency accessingGFF-related funds, it has only engaged with one CSO in the State.

SUMMARY OF ABIA STATE CSO COALITIONS' SWOT ANALYSIS

S The CSO networks in Abia State have strong mobilisation skills and in-depth knowledge of the State and its environment, as well as a cordial relationship between the CSOs and the communities. Their RMNCACH knowledge is high. The activities of CSOs are coordinated by the Abia State Association of Non-Governmental Organisations (ASANGO).

W Knowledge of GFF is completely new and foreign to CSOs coalitions in Abia State. CSOs' policy engagement is weak.

O The CSO networks in Abia State work on different thematic areas of health with different government agencies. CSOs currently engage with, and have representation on, the Saving One Million Lives (SOML) steering committee initiative, as well the Abia State PHCDA and LG Health Authority.

T Government agencies managing GFF do not necessarily engage with existing, established CSO coalitions. There is low transparency around the government's budgets and activities. The Abia State government tends to perceive CSOs as instruments of the opposition party.

SUMMARY OF NIGER STATE CSO COALITIONS' SWOT ANALYSIS

S There has been successful collaboration among the Niger State CSOs' coalitions in the past, as demonstrated by their joint advocacy resulting in an increase of the State's budgetary allocation to health from 8% to 11% of the total budget. The most active are the Niger State Coalition of NGOs as well as the State chapters of national CSO coalitions such as the Association of Civil Society on Malaria Control, Immunisation and Nutrition (ACOMIN), and Federation of Muslim Women Association of Nigeria (FOMWAN). CSOs have also been involved in some RMNCAH related activities in the State including advocacy, tracking of health project funds, community mobilisation, sensitisation, community and media dialogue, and legislative engagements on budget and health issues.

W Knowledge about GFF issues was very low. The majority of CSOs also reported a need for updated knowledge in RMNCAH, budget tracking, knowledge management and M&E capacity. The institutional capacity of the CSO coalitions and networks in the State is incapacitated by weak organisation structures and systems. There is also a lack of transparency in CSO leadership and no clear succession plans. This often creates friction and crisis in the leadership and management of the CSO coalitions, as different CSOs battle for control of the CSO groups.

T The Niger State government lacks political will to deliver on health commitments. Successive governments have reversed health policies implemented by previous governments, leading to a lack of continuity that is also seen in the succession of government officials appointed to liaise with CSOs.

O Past collaboration has led to the development of a memorandum of understanding between the CSO networks on health and the State's Ministry of Health.

General capacity constraints observed at the State level

Beyond challenges relating directly to GFF and health advocacy activities, CSO coalitions in the focal states also suffer from a range of capacity constraints that indirectly affect their ability to engage with GFF. The results of the capacity assessments suggest that the following capacity constraints

1. Engagement constraints

i. The CSO coalitions and networks in Abia, Niger and Osun States need clearer institutional structures to promote a shared identity and engagement with member CSOs.

ii. Structures for coordination and collaboration between member CSOs do not exist. As a result, many CSOs operate in information silos.

iii. Members of the CSO networks in Osun State felt left out from the day-to-day decision-making and activities of the CSO network. In Abia and Niger States, only some of the relevant CSOs were involved the CSO networks' activities.

iv. There are no documented structures for mentoring or improving the capacity of CSO members, despite this being a potentially important role for CSO networks to play.

2. Management constraints

i. CSO networks have not undertaken strategic planning. This is partly because of a lack of understanding of the strategic plan development processes, or an unwillingness to engage CSO members in the strategic planning process.

ii. CSO networks do not have mechanisms to measure performance. In many cases, performance management systems do not exist and accountability mechanisms are not complied with except where they are donor driven.

Figure 5: Capacity constraints that may affect CSOs' ability to engage with GFF

3. Leadership constraints

i. There were no sustainable structures for the emergence, selection and effective functioning of the CSO networks' executives.

ii. Many State CSO networks find it a challenge to balance executives' time spent on promoting their individual organisations compared to time spent contributing to the network. This has hampered decision-making at the CSO network level and created frictions among CSO network members and between CSO members and the CSO network's leadership team.

iii. The leadership skills of the CSO networks need to be strengthened, particularly with regards to strategic thinking, financial judgment and organisational leadership and effectiveness.

4. Evidence constraints

i. CSOs lack capacity in data management skills. As a result, reports derived from their health interventions are not prioritised for knowledge sharing and mass education.

ii. The CSOs engage in data gathering and collection, but there is limited capacity for monitoring and evaluation to process and share this data among CSOs.

4. How can we work towards greater and better CSO engagement in Nigeria?

At the Country Platform Level

Clear mechanisms for CSO recruitment

Establishing clear mechanisms for the recruitment of CSOs to the Country Platform is essential for addressing the challenges of CSOs engagement in GFF. Such mechanisms are required to avoid mistrust, clarify CSOs' roles and responsibilities, and ensure that the comparative advantages and skills of civil society are harnessed for the delivery of GFF interventions . Government officials should avoid the hand-picking of 'friendly' civil society representatives, unknown to the wider CSO coalitions. This will ensure that civil society representatives skilled in advocacy and social mobilisation are involved in GFF and not CSO contractors predominantly involved in service provision for implementing organisations, with limited accountability to a specific entity or community.

Clear mechanisms for the recruitment of CSOs to the Country Platform is essential for addressing the challenges of CSOs engagement in GFF.

Sharing information in a timely way

There has been very little information sharing about GFF processes, operations, and opportunities for CSO engagement, in Abia, Niger and Osun States. Concerted effort to reach a range of CSO stakeholders with correct and up-to-date information on the GFF is very important. For the State level CSOs, clarifying the GFF processes and how the State level CSOs' inputs are linked to GFF priorities should be the focus. CSO respondents also observed that GFF processes seemed hurriedly planned, making CSO participation challenging, particularly for those outside Abuja and the State capitals.

Making adequate time for consultation and reviews of policy documents at the national Country Platform level is therefore essential for adequate CSO engagement. This can be achieved by producing a yearly timeline of activities and disseminating this widely to RMNCAH CSOs.

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Learning from existing guidelines and systems

The main challenges confronting CSO engagement with GFF in Nigeria (i.e. information sharing, representation and engagement) could be addressed by adherence to the GFF Minimum Standards for Country Platforms (see section 1). Detailed approaches and recommendations that can be adapted to Nigeria's context are highlighted in this document.

The Global Fund Country Coordinating Mechanism (CCM) in Nigeria could be an interesting model for the Country Platform to follow. It has devised a transparent and inclusive process for engaging CSOs and affected communities, which is based on transparent communication, strong linkages and a respectful partnership between civil society, government, and other stakeholders. As mentioned above, the GFF's engagement with the private sector through the Nigeria Service Delivery Innovation Challenge has worked well in engaging those stakeholders and could be adapted for civil society (at least with regards to service delivery).

At the CSO level

Provision of financial resources for CSO engagement

The lack of financial resources for CSOs to participate in GFF responses was repeatedly highlighted as a barrier to their engagement in GFF across all States. Most CSOs lack the resources to cover the time and expense of participation in the evolving GFF processes, meaning that participation is not remunerated. As a result, better-resourced national NGOs and INGOs have more opportunities for GFF

engagement, which de-legitimises CSO engagement. In addition, resources must be allocated to the coalitions in charge of coordination at the State or national levels to enable joint organisation, information sharing, and strategic planning regarding GFF (RMNCAH) priorities.

Inclusive and accountable CSO representation

The GFF's minimum standards of inclusiveness and participation, transparency, independence, and accountability should also be applied within the national and State CSO coalitions. One of the most effective ways to ensure positive outcomes for GFF is to plan and co-design GFF actions together to ensure open dialogue. Unfortunately, this is often overlooked, meaning that some critical partners end up feeling side-lined. This underscores the need for the GFF secretariat to engage tactfully with stakeholders in order to ensure partners' buy-in at the State and national levels. The leadership and management teams of CSO coalitions must also be held responsible and accountable to their members and their stated strategic focus. Finally, CSOs should also be resourced to mobilise broader groups of community-based civil society groups like CBOs, FBOs and other social networks.

"One of the most effective ways to ensure positive outcomes for GFF is to plan and co-design GFF actions together to ensure open dialogue."

Resources and technical assistance for joint strategic planning

CSO coalitions on RMNCAH must develop and implement joint strategies for advocacy, networking, information sharing and capacity strengthening. This requires creating a space for civil society leaders at the national and State levels to identify and advocate for common GFF priorities and interests. Technical assistance and financial resources to enable this coordination is also necessary. Supporting CSOs to develop a strategic plan for GFF and agreeing on indicators for success and deliverables would be helpful.

Training and mentoring

Developing the capacity of CSOs and CSO coalitions for programme design and management is a major requirement for the scale-up and sustainability of GFF response. It demands supporting civil society to acquire skills related to planning, organising, resource tracking and policy influencing, as well as developing the systems and strategies for achieving short and long-term GFF targets.

In addition, strengthening the leadership capacity of civil society networks should be a priority. This will ensure the emergence of civil society movements led by trusted and empowered 'comrades' willing to build the necessary systems and structures for GFF engagement. While such efforts will not be successful overnight, short-term fixes will not be sufficient to ensure valuable CSO engagement with GFF.

5. Study background and methods

Civil society engagement and involvement in GFF in Nigeria has been varied and limited up until now. To better understand civil society engagement in the GFF, MamaYe-Evidence for Action (E4A) commissioned a mapping of civil society engagement in GFF. The aim was to provide insights into the successes and constraints in civil society engagement in GFF, as well as documenting ways of enhancing civil society participation.

This report was produced from an on-site and a desk-based analysis of CSOs' understanding of GFF, their roles in GFF advocacy, and the required skills and knowledge for meaningful engagement in the development of national plans. The assessment focused on the national level and on three focal states: Osun State (South-West zone), Niger State (North CENTRAL zone) and Abia State (South-East zone), which have been selected to implement the Basic Minimum Package of Health Services (BMPHS) in Nigeria with support from the GFF.

The States were selected based on geography; presence of a functional State Supported Health Insurance Scheme (SSHIS) and State Primary Healthcare Development Agency (SPHCDA). According to the Federal Government, the pilot of the BMPHS with the GFF Grant, will generate a 'proof of concept' and inform learning towards the scale up of the BMPHS implementation in all the states of the federation in 2018.

The assessment methodology involved a desk-based review of relevant information on GFF and participatory interactive sessions with individuals, CSOs and their networks. A total of 4 Focus Group Discussions – one at national level and one in each of the three focal States - and 3 Key Informant Interviews were conducted, involving 55 persons in total. The focus group discussions were conducted with CSO representatives from urban and rural areas. The key informant interviews were conducted with the heads of the focal States' Primary Health Care Development Agency to elicit information on health financing and CSOs' roles in health resource monitoring, as well as their experiences in working with CSOs' networks.

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