

REVIEW ARTICLE

Achieving Health SDG 3 in Africa through NGO Capacity Building - Insights from the Gates Foundation Investment in Partnership in Advocacy for Child and Family Health (PACFaH) Project

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Abstract

As global impact investors gear up to support roll out of the Sustainable Development Goals in the developing world, African CSOs are urged to ensure that governments shift health funding sources away from aid and loans to innovative domestic funding sources which prioritize health. To do so, African CSOs require support to build their capacity for policy and budget advocacy. Governments and development partners have failed to invest in long term capacity building projects for indigenous NGOs and instead support INGOs to push the health advocacy agenda forward. In Nigeria, the Gates foundation has risen to the challenge of building capacity of indigenous NGOs for social accountability in child and family health. The 3 year pilot project - Partnership for Advocacy in Child and Family Health Project (PACFaH) mainstreams capacity building as an effective implementation strategy for 8 indigenous NGOs to deliver on - policy; budgetary; legislative; and administrative advocacy in four issue areas: 1) family planning; 2) nutrition; 3) routine immunization; and 4) reduction of under-5 deaths from diarrhea and pneumonia. This paper documents the achievements of the eight advocacy NGOs in PACFaH, at midterm and notes that while there have been challenges, working through capacity building as an implementation strategy has enabled the local groups in the delivery of evidence based advocacy. (*Afr J Reprod Health 2016 (Special Edition); 20[3]: 55-61*).

Keywords: SDGs, Aid localization, Child and Family Health, Gates Foundation, PACFaH

Résumé

Comme les investisseurs mondiaux d'impact se préparent à soutenir le déploiement des objectifs de développement durable dans le monde en développement, les OSC africaines sont invitées à veiller à ce que les gouvernements changent les sources de financement de la santé loin de l'aide et des prêts à des sources de financement nationales novatrices qui privilégient la santé. Pour ce faire, cependant, les OSC africaines ont besoin de soutien pour renforcer leurs capacités en matière de politique et de plaidoyer budgétaire. Les gouvernements et les partenaires de développement ont échoué dans leurs tentatives d'investir dans des projets de renforcement des capacités à long terme pour les ONG autochtones et soutiennent plutôt les OI NG à avancer le programme de promotion de la santé. Au Nigeria, la Fondation Gates a relevé le défi du renforcement des capacités des ONG locales pour la responsabilité sociale de l'enfant et de santé de la famille. Le projet pilote de 3 ans - Partenariat pour la défense du projet de la santé infantile et familiale (PACFaH) incorpore le renforcement des capacités comme stratégie de mise en œuvre effective de 8 ONG autochtones à tenir bon sur le plaidoyer -sur les plans politique; budgétaire; législatif; et administratif dans quatre domaines d'émission: 1) la planification familiale; 2) la nutrition; 3) la vaccination de routine; et 4) la réduction du décès des enfants de moins de 5 ans du à la diarrhée et à la pneumonie. Cet article documente les accomplissements des 8 ONG de plaidoyer à PACFaH, à mi-parcours et note que bien qu'il y ait eu des défis, en travaillant à travers le renforcement des capacités en tant que stratégie de mise en œuvre a permis aux groupes locaux de livrer le plaidoyer basé sur les preuves. (*Afr J Reprod Health 2016 (Special Edition); 20[3]: 55-61*).

Mots-clés: ODD, localisation de l'aide, santé infantile et familiale, Fondation Gates, PACFaH

Introduction

Sustainable Development Goals (SDGs) and implications for African governments

The Sustainable Development Goals (SDGs) represent a shift away from the old aid architecture of the MDGs. Unlike the MDGs which were based on the premise of a development divide between

the global north and the south, the new SDGs argued that all countries are on a path to development as all countries experienced development challenges. Against this background, the SDGs provided a framework for countries from the global north and south to take responsibility for development in response to local needs and global imperatives such as climate change. Therefore, while the MDGs tasked

countries of the global north to mobilize resources for the countries of the global south, the SDG implementation framework argued that:

"Each country has primary responsibility for its own economic and social development and the role of national policies, domestic resources and development strategies cannot be overemphasized¹."

At the 10th session of the African Economic Conference held in Kinshasa, in November 2015, African policy makers endorsed the new global thinking on development by putting the responsibility for sustainable development squarely on African governments. They argued that development financing should shift from foreign aid to national governments, which, they argued, must become more efficient in mobilizing private sector funding through taxation and innovative financing plans. The conference noted that in Africa:

"At least \$4 trillion is needed annually to finance SDGs. There is a lot of potential to mobilize resources locally, said Kapil Kapoor, the Director of Strategy and Operational Policies, African Development Bank. Kapoor underscored the need to intensify efforts to mobilize domestic resources to finance SDGs²."

Similarly, the ministerial statement of the Eighth Joint Annual meetings of the African Union Specialized Technical Committee of Finance, Monetary Affairs, Economic Planning and Integration meeting held in Addis Ababa from 30th-31st March also noted that: "While official development assistance has been helpful, it is a fragile platform on which to base a structural transformation agenda, calling for domestic mobilization of funds through taxes, sovereign and pension funds and other financing mechanisms³."

While governments were challenged to improve their technical capacity to support implementation of the SDGs, non-state actors such as NGOs were also challenged to improve the technical quality of their social accountability role and to work within broad partnerships of non-state actors.

SDGs implications for African NGOs

SDG expectations for African Civil Society Organizations (CSOs) built upon learnings around

the social accountability models anchoring the MDG period. The new social accountability framework argued for a strong watchdog role for NGOs which were expected to work within civil society partnerships including community and faith leaders, professional associations and social movements to hold government to account on SDGs. CSOs were to be "meaningfully involved in developing, implementing and monitoring progress" on the SDGs⁴. Thus the Financing for Development Conference (Addis Ababa Ethiopia) saw CSOs as contributing to an enabling SDG policy implementation environment. This environment was to be shaped by the rule of law, civil society, combating corruption and the independent media. The African Ministers of Health, Finance, Education, Social Affairs, Local Governments attending the Ministerial Conference on Immunization in Africa, in Ethiopia, Addis Ababa 24th to 25th February 2016 made a strong case for government to work "with communities, civil society organizations, traditional and religious leaders, health professional associations and parliamentarians as a key strategy to ensure adequate domestic mobilization for immunization⁸."

SDG 3 and the grand convergence in global health

Sustainable Development Goal 3 is particularly significant to public and reproductive health communities of practice. SDG3: "ensure healthy lives and promote well-being for all at all ages", is elaborated through three important mortality reduction targets to be achieved by 2030. They are: 3.1—by 2030 reduce the global maternal mortality ratio to less than 70 per 100,000 live births 3.2—by 2030 end preventable deaths of newborns and under-five children 3.3—by 2030 end the epidemics of AIDS, tuberculosis, malaria, and neglected tropical diseases and combat hepatitis, water-borne diseases, and other communicable diseases. While all 17 SDGs are purported to be of relevance to all countries of the world, the mortality reduction targets of SDG 3 set to be achieved by 2030 are of direct relevance to high health burden countries of the global south⁸. Underpinning SDG3 targets is a strong evidence base with robust data pointing to the fact that the health gap between countries of the global south and the global north can be closed by 2030 with adequate and strategic mortality reduction investments in the developing world⁸. Emerging

evidence suggests that government investments in family planning, reduction of maternal and child mortality are critical if the convergence in global health indicators between the developed and developing world is to be achieved. Expansion and increased uptake of family planning services as well as reduction in maternal, neonatal and child mortality are important pathways for achieving the central SDG target of eradicating extreme poverty by 2030.

SDGs roll out in Nigeria

As Nigeria rolls out the SDGs, indigenous NGOs have so far been integrated into broad discussions on priority setting. However, no formal mechanisms have been established for incorporating their voices into SDG implementation and no programs have been proposed to equip indigenous groups to fulfill their role in SDG implementation. Despite learnings from the MDGs Endpoint Report, consultation with indigenous CSOs has not translated into a plan of action with built-in capacity building provisions. Two important Nigeria SDG launch activities are indicative of this situation. The first is the Social Good Summit⁷ held in Abuja on 30th November 2015 and the second is the National Stakeholders' Retreat on Implementation of SDGs, convened under auspices of the Office of the Senior Special Assistant on SDGs, Princess Adekoke Orelope-Adefulire in Abuja on 1st September 2016. At the Social Good Summit, the NGOs present rallied around the theme - New Goals. New Power. New Technology - to call for an institutionalized mechanism for effective implementation of the SDGs.

Despite the presence of local NGOs at the Social Good Summit, international NGOs such as Save the Children shaped the discussions and influenced the priority setting⁷. This was largely due to the fact that support for the SDGs is the principal goal of many international development partners as they work across the multiple countries on humanitarian and development programs. Thus international development partners have deployed financial and human resources to studying SDG issues and challenges in Nigeria, they have set priorities, developed work-plans and have mapped out thoughtful strategies for implementation.

For the local Nigerian NGOs, however, this is not the case. Few local groups were incorporated into the MDG process and even fewer were consulted as Nigeria developed its

transition strategy from MDGs to SDGs. Most of these processes were directed by government agencies with the support of consultants. This is not surprising due to the capacity challenges and the dearth of unrestricted capacity building support resources for indigenous Nigeria NGOs. Even in cases where funding agencies such as USAID support capacity building interventions for Nigerian CSOs, the emphasis is more on the outputs and outcomes the local groups are expected to deliver rather than NGO systems strengthening and staff empowerment.

Nigerian CSOs and the challenge of achieving SDG 3

Given the absence of a national CSO capacity building strategy and the proxy investments by donor agencies in local branches of International NGOs (INGOs), indigenous groups struggle to evolve into a truly professional third sector with capacity to contribute national planning and development. To be sure, indigenous NGOs such as Society for Family Health applying business models to service delivery seemed to have achieved greater success than other NGOs in behavioral change, research, good governance and advocacy. Not surprisingly, the first generation research and policy advocacy centers such as the Development Policy Centre of Ibadan; the Claude Ake founded Centre for Advanced Social Sciences in Port Harcourt and the Centre for Research and Development incubated by the development Research and Project Centre in Kano are now all mothballed or disbanded.

A 2014 landscaping of CSOs in Nigeria conducted by the DRPC for the Bill and Melinda Gates Foundation found that the NGOs most challenged to perform in Nigeria are the advocacy groups which are not expected to deliver insecticide treated nets or safe water but to make a cogent and convincing case to governments to deliver such services. This is a more difficult task requiring policy analysis, budget tracking, opportunity cost and development planning tools linking health to development. USAID Nigeria addresses the weak advocacy capacity of Nigerian NGOs below:

Few of the Nigerian organizations that USAID supported in the past have demonstrated the power or capacity to influence the national government on par with their civil society counterparts in South Africa, Kenya, or Ghana. Only the trade unions under the mantle of the NLC

have shown the ability to influence government policy consistently⁸. The landscaping study found that indigenous CSOs often confused awareness creation with advocacy; they lacked the capacity to analyze and track budgets; were inexperienced in developing policy and issue briefs; had challenges working with the media; and were not quite skilled in building and nurturing multi-stakeholder coalitions.

Despite challenges, indigenous Nigerian NGOs are well acquainted with the grassroots and they have excellent communication channels from the grassroots to the policy makers and the converse. While it must be admitted that many of these groups are perceived as partisan and often frame advocacy statements in seemingly political language, in general, the potential for CSOs becoming active development partners far outweighs the fear of politicization. It is therefore valuable and important to improve the technical capacity of indigenous CSOs so that their contribution to the development conversation around the SDGs is technical, fact-derived and brings grassroots science to the public policy space.

But how can the capacity of indigenous CSOs be developed, where should the resources come from and who should do it? The likely answer to this question is that local CSOs should set aside their own resources to strengthen their systems, and expand their technical capacity to be helpful to Federal, state and local governments. This they can do by writing proposals to the development community or by self-funding through levying members or staff. This is unlikely to happen. More feasible options are that the international development community and/or the apex government agency with responsibility for national planning - that is, the Ministry of Budget and National Planning should expand their scope of activities and design a targeting capacity building intervention for indigenous Nigerian CSOs.

NGOs capacity building programs in Nigerian

Nigeria's return to elected governance in 1999 saw major development partners the Ford, Packard and MacArthur Foundations invest in leadership development programs for civil society leaders in NGOs, FBOs and CBOs.

Multilateral partners such as the World Bank and USAID particularly supported health focused NGO working in HIV/AIDS

programming. These included World Bank HAF intervention and USAID funded programs implemented by Family Health International. The early years of the Jonathan administration, also saw the Federal Ministry of Budget and National Planning empowering indigenous NGOs led by the Centre for Health Science Training, Research and Development (CHESTRAD)⁹ to participate in global conversations on the future of development assistance and through formalizing consultations within the Ministry. Recent NGO capacity building interventions include the USAID funded Chemonics Strengthening Advocacy and Civic Engagement (SACE) program and the DFID funded State Accountability and Voice Initiative (SAVI) intervention.

Investing in the PACFaH project and SDG 3 - the gates foundation experiment

The Partnership for Advocacy in Child and Family Health (PACFaH) project, funded by the Gates foundation in November 2014 was designed within the parameters of big conversations round the role of CSOs and the SDGs, especially SDG 3. PACFaH gave leadership to 8 indigenous NGOs in the advocacy space. The project mapped out a strong social accountability role for these groups and linked them to a broad civil society space which included the media, FBOs and CBOs. PACFaH went further to frame the advocacy task in SDG terms of domestic mobilization.

Where PACFaH differed from the typical SDG paradigm, however, is that the design purposefully mainstreamed capacity building as the implementation strategy to enable NGOs to fulfill the social accountability mandate of the SDGs. The project therefore drew from the Gates funded CSO Nigeria landscaping study to identify key technical and organizational performance gaps around which capacity building components were built as objectives into PACFaH. Technical capacity building components were in the areas of monitoring and evaluation; communication for advocacy; coalition building; budget work; and advocacy materials development. Organizational capacity building component were in the areas of human resource management; project management; board development and governance; institutionalization; and systems strengthening.

PACFaH implementing partners were the Development Research and Projects Centre, the prime recipient and capacity building provider for seven leading health NGOs. The seven groups were the Civil Society Initiative for Scaling-up

Nutrition in Nigeria (CS-SUNN); Health Reform Foundation of Nigeria (HERFON); Civil Society Legislative Advocacy Centre (CISLAC); Federation of Muslim Women Organizations of Nigeria (FOMWAN); Association for the Advancement of Family Planning in Nigeria (AAFP); Pharmaceutical Society of Nigeria (PSN); and Community Health and Research Initiative (CHR). November 2014 to October 2017 was PACFaH timeline, and nutrition, family planning, routine immunization and childhood killer diseases were the issue areas of focus in child and family health. PACFaH NGOs aimed to hold government accountable for policy commitments in child and family health. The project also aimed to influence government to make adequate budgetary provisions, timely and transparent releases of funds for child and family health commitments; and to remove administrative and regulatory barriers to the efficient implementation of child and family health programs. PACFaH focal states were Bauchi, Kaduna, Kano, Niger, Nassarawa, Lagos and Oyo States. The project also worked at the national level.

The case for CSO capacity building for child and family health

One and a half years into implementation of the project, preliminary findings from mid-term review point to significant achievements in both domains of technical and organizational capacity building. In the domain of technical capacity, data from the project's monitoring and evaluation system, shows that one of the most significant achievement was that NGOs developed the capacity to produce original advocacy products in the form of Issue Briefs, Policy Briefs and Child and Family Health Budget Reviews. Prior to the intervention none of the 7 designed and produced original advocacy materials from primary research carried out by in-house M&E teams.

PACFaH NGOs drew from empirical evidences to develop advocacy asks and messages calling on government to mobilize, allocate, and release domestic funds to meet needs in nutrition; family planning; childhood killer diseases and routine immunization. The NGOs also acquired new skills to develop advocacy training manuals for facilitators and participants which they used to step-down skills to community based organizations in the seven focal states. Another area where NGOs gained new technical skills was

in convening policy dialogues with senior civil servants on the four issue areas. Not only did PACFaH NGOs engage senior civil servants as equals in policy dialogues, they were also equipped to do so through trainings on zero- based budgeting organized by the Ministry of Budget and Planning and through the facilitation of the National Institute for Policy and Strategic Studies (NIPSS).

Feedback from NGO project staff singled out advocacy materials development; master training; advocacy manual development; building of advocacy coalitions; and engaging the media as especially valued technical capacity building activities which motivated NGO staff to perform at a higher level. The prospect of becoming a direct grant recipient of the funding agency and of scaling up PACFaH or replicating the intervention were reported as a further catalytic factor influencing performance.

In the domain of organizational capacity building, all seven groups recorded an increase capacity in project; financial; monitoring and evaluation; and human resource management capacity. Capacity to monitor and evaluate project activities emerged as the most challenging yet most significant area in which PACFaH NGOs reported increased capacity. While 6 of the 7 PACFaH NGOs were engaged in monitoring and evaluation (M&E) of health advocacy projects prior to PACFaH; none had M&E skills in all the areas of advocacy - broad based constituency mobilization including the media; scientific evidence generation; tracking uptake of knowledge briefs by advocacy targets; convening advocacy capacity building workshops; budget work; and leading multiple coalitions in face-to-face advocacy to the executive and legislature. PACFaH NGOs were trained and mentored to develop M&E tools and analyze M&E data on all advocacy components which looped back into project work plans.

An important challenge, however, was that PACFaH NGOs were, slow to adopt new systems and approaches under organizational capacity building components of the project. The NGOs were therefore slow to replace financial management systems which pool personnel budget of multiple donor projects with project specific accounting systems. They were also slow to put in place consistent project management systems linking staff levels-of-effort, job descriptions and remuneration. Moreover, the need to recruit new PACFaH-specific staff instead of assigning

existing core NGO staff introduced a level of uncertainty into the NGOs. Compliance with work plans also proved to challenge as PACFaH NGOs sought to respond to quick-wins opportunities to the disadvantage of approved work plan. The project found that the more mature the NGO and the larger its grant portfolio prior to the PACFaH project; the lower the uptake of organizational capacity building guidelines and systems.

Conclusions

Capacity building for SDG3

Half way into the PACFaH project's timeline, roughly 45% of intermediate investment outcomes have been realized and 60% of intermediate investment outputs were also achieved¹⁰. Examples of high level intermediate investment outcomes achieved are - creation of dedicated budget line items for nutrition in the 3 PACFaH Nutrition Focal states with allocation of funds to Nutrition in 2 to 3 states, allocation and release of routine immunization particularly in Bauchi state. In addition, the project has recorded increased budgetary allocation for family planning at state levels; improved knowledge of and compliance with national policies within the executive; and the incorporation of the Pharmaceutical Society of Nigeria (PSN) on the National Essential Medicines Coordinating Mechanism (NEMCM) of the National Primary Health Care Development Agency (NPHCDA) with a high level National policy dialogue led by the organization contribution significantly to proposed policy in child and family health.

Commitments from high level advocacy targets include affirmative statements from the Federal Minister of Budget and National Planning in response to a PACFaH advocacy visit on 14th July 2016 that:

"We shall ensure that the allocations for Health in the 2017 Budget shall be substantially increased. It may not be up to the 15% (in line with the Abuja 2001 declaration) that you are requesting for; however, it shall be more than the allocation in the 2016 budget.... This administration is committed to deliver Universal Health Coverage (UHC) for all Nigerians. There shall be increased investment across all facet of Healthcare delivery

in Nigeria.... Routine I Immunization as well as the eradication of Polio shall be given necessary attention by this administration....This Ministry is the Secretariat for Nutrition program in the Country. We shall ensure that Malnutrition and other negative Nutrition related indices are eliminated from the Country...We shall ensure that all the requests made by the PSN and PACFaH team are well addressed¹¹."

Representatives of the Project have also been nominated by key Government actors to play significant roles and contribute to policy implementation direction for improved outcomes in health care funding.

Significantly, intermediate investment outputs such as advocacy manuals, issue briefs, tool kits and policy briefs were also achieved. Hundreds of copies of outputs were produced and disseminated. However, it must be noted that substantial challenges remain in the quality of such outputs and in the ability of the PACFaH NGO partners to track uptake of these documents. Overall, PACFaH capacity building activities facilitated access; strengthened indigenous NGOs ability to conduct evidence based advocacy; created an environment of learning; and challenged local NGOs to aspire to standards of performance and institutionalization.

The experience of the PACFaH points to the utility of investing in CSO capacity building in Nigeria to keep government responsive, accountable and in healthy dialogue with the third sector. The PACFaH experience challenges government and the international development community to recognize that Nigerian CSO activism around the SDG health goal cannot be guaranteed without investing in training, mentoring, networking, and facilitating institutional and technical capacity building. PACFaH demonstrates that while there is no quick fix in the domain of social accountability, local NGOs do have an excellent track record at accessing decision makers and initiating follow up advocacy visits. But perhaps the most significant lesson of the PACFaH project for the development community poised to support roll out of the health SDG, is the necessity to invest in capacity building of indigenous advocacy NGOs as a precondition for reducing the health burden and sustainable development¹².

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