Reimagining Technical Assistance

NIGERIA

Status Update

May 2019

About This Document

A Conversation Starter

Human-Centered Design is an iterative process. This document is a snapshot in time, reflecting our evolving thinking and initial insights generated through conversations with stakeholders. Rather than definitive answers, we are presenting readers with raw material -- thoughts, frameworks, and questions -- meant as provocations for further conversation.

Many of the ideas included in this document will inform the agenda and activities of the first Intent Workshop in Abuja. We expect that these ideas will change, evolve, and further develop during the workshop based on input from all key stakeholders *(see note on government voice)*.

Note on Government Voice

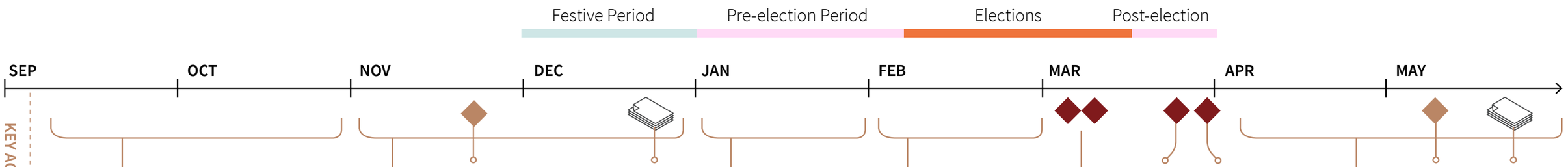
Due to the complex approval process for this project, it has been difficult for us to secure sufficient number of interviews to represent the government voice ahead of the Intent workshop. These initial findings focus on the donor and implementing partner perspectives. We hope that the Intent Workshop as well as follow-up interviews afterwards will help to fill this gap.

Project Status

Timeline & Activities

Key Questions

Overview of Activities



KEY QUESTIONS

- What is technical assistance for child health?
- Who are the actors?
- Who are the key actors in technical assistance and what is their definition of TA?
- What does the Nigeria health system look like?
- What are the different experiences with technical assistance in Nigeria?
- What is our collective vision?
- What are the ingredients for success?
- How does this project link into global trends in global health?
- How can we gather buy in from the stakeholders and ensure this is a government led project?
- How can we link this project with other initiatives of the BMGF Country office?
- How can we integrate this project to other government-led efforts?

TAKEAWAYS

- Global definitions of technical assistance
- Project environment (JSI, Child Health Task Force)
- Creating project Theory of Change
- Landscape of stakeholders and initiatives
- Health system map
- Greater understanding of country context & various TA initiatives
- Clearer definition of project success
- Revised work plan
- Shift in project focus from Child Health to MNCH
- Excitement for this project and nurturing environment for experimentation with TA

Overview of Activities *cont.*

Phone Conversations

Over the course of this project, we had phone conversations with key stakeholders in TA for child health in Nigeria. Poor phone or internet connection were sometimes a barrier. As a result, some of these conversations took the format of formal interviews, while others were less formal introductions to the project.

- *Lead Health Specialist at the World Bank*
- *Chief, Health Nutrition & Population Lead Health Specialist at the World Bank*
- *Teamleader of the MCSP program*
- *RMNCH Advocacy Specialist at MCSP*
- *National Coordinator for Child Health at JSI*
- *Independent consultant*
- *Medical Officer at WHO*
- *Senior program officer at the SOML program*
- *Professor of Pediatrics, Lagos Teaching Hospital*
- *Director of Public Health, Eboyi State*
- *Deputy Managing Director of Programmes at Society for Family Health*
- *Country Directory at r4d*
- *Deputy Director at Palladium*
- *Country Technical Coordinator / Country Director at Solina Health*
- *Project Manager at Solina Health*
- *Country Technical Coordinator / Country Director at Malaria Consortium*

In-person Meetings

During the week of 22 - 29 March, the JSI and the Sonder team visited Abuja to meet with the country office of the Bill & Melinda Gates Foundation, several TA providers and representatives of different departments at the FMOH. Aim of this visit was to socialize the initiative among key stakeholders and invite participation in the process through conducting interviews and participation at the upcoming workshop. We had meetings with several organizations (named below). The following slides with our emerging insights, questions and frameworks are a result of analyzing and distilling these initial conversations.

The week ended with a meeting at the Ministry of Health, chaired by the Director of Family Health and with presence from different departments: Research & Statistics, Food & Drug Services and Family Health. After a strategic introduction and overview of the National Strategic Health Development plan by the Director of Family Health, the team introduced the project after which the Director and other participants reacted with comments and considerations. The meeting closed with a recommendation to propose this initiative to the Minister of Health for approval after broadening the scope from child health to maternal, newborn and child health and health systems strengthening citing the need for it to be endorsed and facilitated by other departments not merely through the Family Health department.

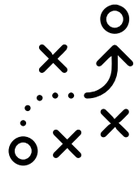
- *BMGF Nigeria Country Office staff*
- *Save the Children*
- *CHAI*
- *USAID*
- *WHO*
- *UNICEF*
- *HSDF*
- *FMOH*
- *NPHCDA*
- *Palladium*

Key Questions

Our discovery process seeks to answer questions about the strategic and country context, the people involved, the challenges, and the opportunities. This document will focus on the Nigeria context.

The Country Context

- What is technical assistance?
- What is the current state of technical assistance in Nigeria?
- Who are the key actors and how do they interact?
- What are the different ‘typologies’ of technical assistance?
- What are the emerging trends?



The Strategic Context

- What is this project about and why is it important?
- What problem(s) is it trying to solve for?
- What does the future state success look like?

The People

- Who are the ‘users’ of technical assistance? What differentiates them?
- What are their motivations, needs and frustrations?
- What does technical assistance mean to different ‘users’?
- What are the relational/social/ cultural dynamics at play between different users?
- What are the user experiences with technical assistance?
- What are the desired future ‘pathways’ for technical assistance?

The Challenges

- What are the layers of theory/ themes/metaphor that can begin to tell a story of TA?
- What are all the nuanced insights and quotes from the research?

The Opportunities

- What are the big opportunity areas for change?
- What are the specific ‘How might we’ questions to explore in the next phase?
- What are the emerging ideas and concepts for change?
- What are the guiding design principles / design criteria for evaluating future concepts?

Unpacking TA in Nigeria

What is Technical Assistance?

A key discovery question we have asked stakeholders is: What is Technical Assistance? It is clear that no single definition exists today.

We are interested in learning how the purpose, value, and effectiveness of TA is perceived differently by different actors from national to state governments, donors and implementing partners.

At a high level, there is a shared understanding that TA is about engaging expertise to improve the design and effectiveness of health programs while building local capacity and strengthening the public health system.

There is also a shared understanding that current models of how TA is delivered in Nigeria are not very effective. While millions of dollars are spent on TA in Nigeria annually, mortality reduction is slow.

The definitions of TA we have heard from stakeholders have shaped the spectrum of typologies we have developed in this report. They follow a spectrum from short-term projects to longer-term integrated programs, and from external, agile expertise that works in parallel to the national health system through to more integrated system strengthening initiatives.

What is Technical Assistance? *cont.*

Descriptions of TA from interview participants point to the relationship between TA funders and providers and the Nigerian health system.

"TA should be multi-sectoral, it should look at the states as a unit." –Donor

"The statutory environment that sets up TA providers may impact how TA is delivered. Part of the TA ecosystem is the contracting process; rules, regulations, values and criteria." –Partner

"TA is passing over or transfer of skills and knowledge to those who don't have it in a sustainable manner. When you are done, the people you have worked with will be able to carry on without you. They will be able to plan & make sure they meet their objectives." –Partner

"Government thinks TA is it's money, they come with cup in hand to the partners. "What do you have to give us?" We are coming because we have identified a gap/need that they may not be aware of, so we have to start with advocacy." –Donor

"We are changing the landscape of our approach to TA currently in Nigeria, supporting the government to identify their true needs based on available evidence, prioritizing those needs, and budgeting, and also mutual accountability." –Donor

"A central theme around TA is recognizing that you are addressing/ solving a problem. We start with problem identification, drill down to understand and address possible solutions." –Donor

TA Actors

The below diagram represents our current understanding of the various actor groups in the TA ecosystem in Nigeria. As we continue our conversations with stakeholders, this list may expand.

Moving forward, we aim to more clearly understand the unique goals, motivations, and challenges of each of these actor groups.

** In our current scope, we have focused on the public health sector. In the future, we would like to explore the role private providers play in the TA ecosystem.*

Executive Branch

Federal Government

The federal government sets policies that drive the agenda of the Ministry of Health, funds the MOH, and sanction donor activities in the country.

State Government

The State Government's biggest role in the TA ecosystem is allocating and releasing health funds. They often enter into agreements (MOUs) directly with Donors.

Local Government

Local Governments play a key role in how TA gets implemented. They might influence where a facility is built or exactly who should be trained.

Health System*

FMOH

Federal Ministry of Health is mainly responsible for policy and technical support to the overall health system. They also sanction donor activities in the country.

SMOH

State Ministry of Health is responsible for secondary hospitals and for the regulation and technical support for primary health care services. Most of its funding comes from the State Government.

NPHCDA

The National Primary Healthcare Development Agency sits within the Ministry of Health. However, it often acts independently or in parallel with the FMOH. State Primary Healthcare Boards (SPHCB) fall under the NPHCDA.

Healthcare Providers

Providers at the primary level are mostly the recipients of TA. Providers on the secondary and tertiary levels are likely to both receive and provide TA.

Donors

Private Foundations

Private Foundations are a major funder of TA in Nigeria. They work through Implementing Partners to deliver on a set strategy.

Foreign Governments

Unlike Private Foundations, Foreign Governments often have to follow specific protocols to engage with the Nigerian government. Their processes are usually slower and more top-down. Their agenda is largely set by their country's own legislature.

Implementers

Professional Associations

On the national level, Professional Associations, mostly made up of Providers, play a key role in working with the government to set guidelines and strategic health plans, and ensure such plans and guidelines are disseminated to the subnational level. They are also providers of TA.

Implementing Partners

Implementing Partners are funded by donors to execute a specific program or project. They work directly with all local stakeholders and are major providers of TA.

Health Advocates

Health advocates function very similarly to Implementing Partners. What sets them apart is that they have a country strategy and only seek funding for work that fits under that strategy. They use the data collected at the subnational level to advocate for changes at the federal level.

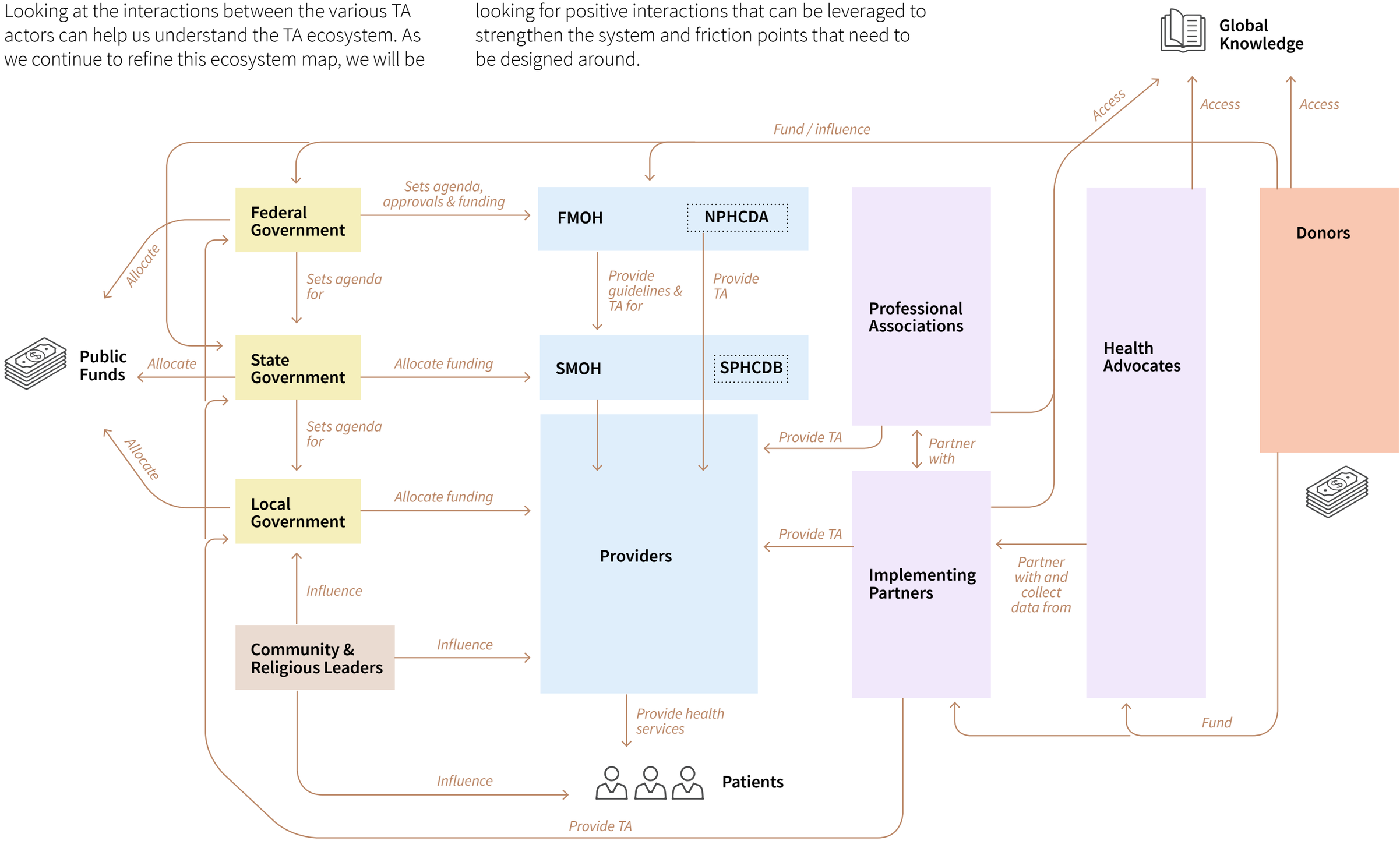
Community

Community & Religious Leaders

Community and Religious Leaders hold a tremendous amount of influence over both the patients as well as the local governments. Implementers must engage them to get approval and feedback.

TA Actors *cont.*

Looking at the interactions between the various TA actors can help us understand the TA ecosystem. As we continue to refine this ecosystem map, we will be looking for positive interactions that can be leveraged to strengthen the system and friction points that need to be designed around.



Current State of TA in Nigeria

Below are examples of some of the TA-related activities we heard about from participants in Nigeria. Some examples are specific initiatives, while others represent models followed by multiple organizations.

Theses examples range from current status quo projects, to initiatives that are pushing to innovate how TA can be delivered. Our focus is on understanding strengths and weaknesses of each approach.

It is important to note that these are based on participant's own descriptions of the projects & have not yet been fact checked. *For more details, please see the Case Studies section of this report.*

TA Initiatives:

1

Traditional Implementation (MCSP, USAID)

A traditional project model where global and national objectives are delivered at the local level.

2

State-level MOU (USAID)

State-level government is involved in every step of the process. Governor signs MOU with commitment to allocate funds.

3

Advocacy Model (Save The Children)

Organization sets a national agenda, secures funding for projects on the state level, and uses evidence to advocate for federal changes.

4

Small Scale Test (CHAI)

A design approach is used to better understand the problem, develop possible solutions, and validate solutions.

5

Grant Optimization (Niger State, BMGF)

An effort to harmonize BMGF grantee work & increase collaboration in Niger state.

6

Program-for-Results (SOML, WB)

Performance-based state-level funding. States become eligible for additional funding only if they meet specific targets.

7

Cross-donor Coordination (4Gs, BMGF)

Survey of existing work plans from 4 major funders. Looking for overlaps, gaps, and ways to better coordinate in the future.

8

Gov-dependent TA (IHP, USAID)

Provides TA support to projects already funded by the government. No funds are given for training cost etc.

9

Technical Support Unit (NPHCDA)

A system to coordinate the identification & fulfillment of TA needs within the NPHCDA

10

Strengthening Local Partners (r4d)

Building capacity in local organizations to provide TA to the government.

11

TA Hub (BMGF)

A temporary agency model. States with funding for a particular TA initiative are connected with best suited partners. The hub also manages the project.

12

Integrated MOU (Kaduna State)

Multiple donors sign a single MOU with the state to ensure better coordination, clear roles & responsibilities, and more efficient use of funding.

13

Training the Trainers (IMCI, WHO)

National level effort to train the trainers (one in each state). Then it's up to the state to organize the "step-down" training.

TA Typologies

In the following section, we are exploring a set of dimensions that could lend a perspective on defining technical assistance.

Highlighting the different dimensions of technical assistance in a variety of ways helps capture our multi-layered understanding of the system thus far. It also helps us explore which of these dimensions resonate the most and can be useful tools or conversation-starters with stakeholders.

We are calling these different categorizations typologies.

By identifying the different typologies, their specific characteristics, advantages and disadvantages, we can more specifically target our ideation to these typologies later in the design process.

On the following slides, we have mapped the initiatives presented on slide 13 (number 1 to 13) to the different dimensions identified. The brown number circles highlight where an initiative falls within a dimension.

TA Typologies: *Time*

TA is implemented along a continuum between fast response to health crisis and longer term, strategic improvements of national health systems.

Emergency response

- Expertise & Leadership
- Advice

Project

- Solution development
- Innovation
- Activities
- Training
- Reporting
- Catalytic

Program

- Coordination
- Integration
- Cross-sector
- System strengthening
- Continuity
- Scale

Strategy

- Data
- Problem diagnosis
- Advocacy
- Learning
- Strategy
- Coordination
- Communication

Reactive ⟷ **Strategic**

1 4 13 2 10 9 3 6 8 11 12 5 7

TA Typologies: *Capacity*

TA can provide needed expertise through external resources brought on for the duration of a project, by filling capacity gaps, or by investing in longer-term capacity building on the ground.

Bringing in capacity

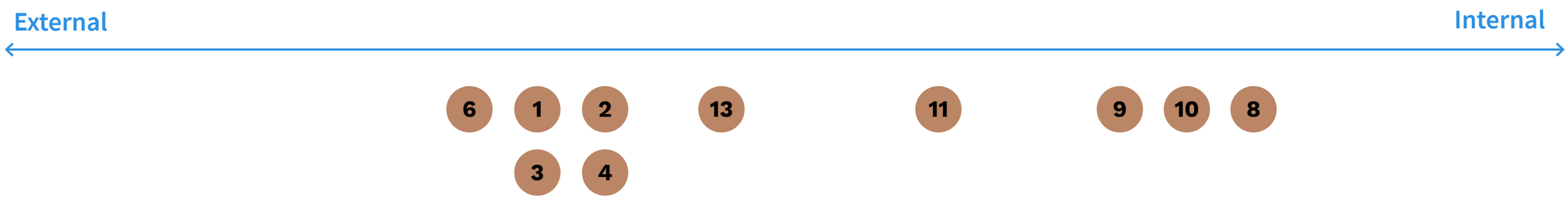
Capacity temporarily provided by international NGO's and consultants who fly in & out for the duration of the project.

Filling capacity gaps

Capacity is built locally to meet specific project needs.

Building capacity

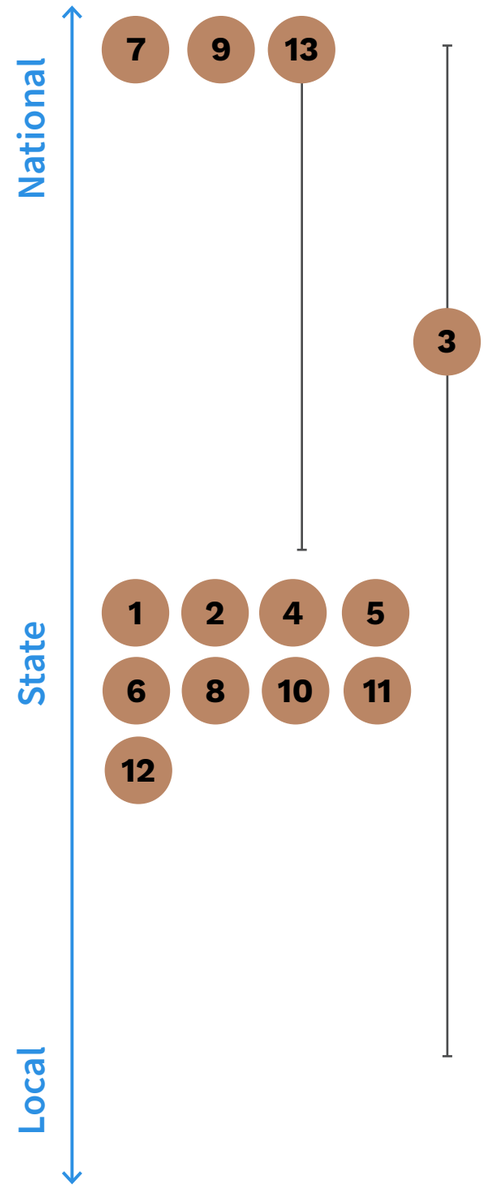
Capacity is built and sustained within local service structures.



Not applicable initiatives: 12 5 7

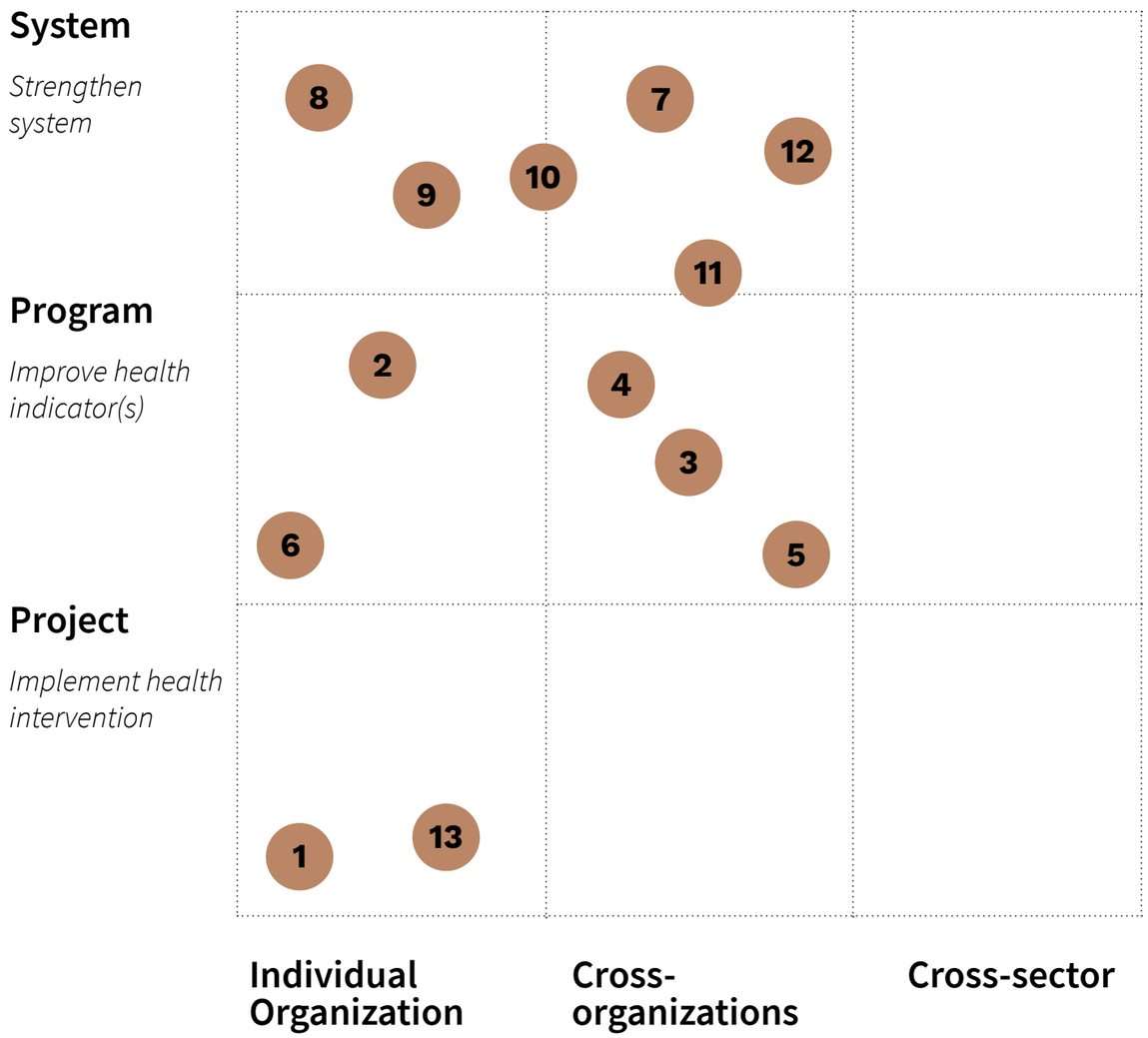
TA Typologies: *System Level*

TA can be implemented at various levels of the health system. Currently, projects implemented on the federal level tend to be more strategic in nature. Those on implemented on the state level tend to be more operational.



TA Typologies: *Scope*

We can also differentiate TA initiatives by the scope of their engagement across two dimensions: level of engagement and level of collaboration. More traditional TA models tend to sit in the bottom left corner, while more innovative solutions lie in the outer quadrants.



Emerging TA Trends

There is an increasing sentiment in Nigeria's technical assistance community that the current status quo is not working. Data shows that despite huge investments made in the country over the years, not much progress has been made to improve the health system. Many are looking to innovate.

We have documented some of those innovative efforts in the Case Studies section of this report. Here, we want to give a snapshot of the major trends that have bubbled up from our conversations with stakeholders.

"For 16 years we tried to change the system in Bauchi and Sokoto state, the RMNCH landscape, through a project-driven approach. We did not move the needle. Rather the needle was going backwards."

Putting ownership back in the government's hands

Eager to meet aggressive targets and frustrated with the challenges of working with complex, bureaucratic systems, many TA actors opted instead to create parallel systems meant to side-step systemic issues.

While effective in providing urgently needed relief in the country, the strategy has chipped away at the already struggling public sector. It has created an over-reliance on donors and partners to conduct core government business and has drained government offices of some of their most talented civil servants who saw opportunities to earn more in the parallel organizations.

Government ownership and institutional strengthening are now seen as a key for achieving long-term, sustainable progress.

Many donors have shifted away from working on the national level to engaging directly with individual states. Governors are routinely involved in the design of health programs. Official MOUs are signed with the state, ensuring commitment and accountability from both sides.

Donors are also increasingly willing to slow down, prioritizing long-term capacity building over reaching short-term targets. USAID's Integrated Health Program (IHP), for example, relies entirely on the government to organize and fund their own activities, with TA support strictly complimentary.

These shifts, however, have put pressure on donors to rethink how grants are structured and evaluated. Understanding how to manage government-dependent timelines and defining more appropriate deliverables will be key for success

Relevant Initiatives: **2** **8** **9**

Emerging TA Trends *cont.*

Leveraging local wisdom

International donors and implementers come into Nigeria with deep technical expertise. They have access to a wealth of global knowledge and best practices. Being able to apply these recommendations to achieve the desired outcome, however, often requires a nuanced understanding of the local context. Global strategies must be modified to fit local realities.

Many organizations are now engaging local stakeholders in a co-design process before any implementation takes place.

Some organizations are also recognizing the value of local organizations who understand local cultures and can engage with the government on a long-term basis. R4d, for example, is experimenting with partnering with local partners to build their capacity through the duration of the project.

Relevant Initiatives: **4** **10**

Re-thinking training approaches

There are many issues around conducting effective training. Since training is usually evaluated on number of people trained, not the impact it has, many projects do whatever necessary to deliver on targets set by donors. Per diems and opportunities to travel often incentivise the wrong people to get trained. Lack of coordination between organizations also leads to more trainings than necessary, taking key people out of their jobs. Lastly, high staff turnover frustrates most efforts to build lasting capacity.

The Integrated Health Program (IHP) is working with local Professional Associations to ensure a more sustainable capacity building and moving away from taking HCWs out of their facilities through on the job training.

The BMGF Grants Optimization project is creating stronger guidelines around training for grantees and developing systems to help better track who is getting trained and how often.

Relevant Initiatives: **5** **8**

Greater collaboration across donors and partners

The TA ecosystem is extremely fractured. Lack of transparency and coordination across organizations leads to duplicate efforts in some areas, and big gaps in others.

Sadly, many system actors might actually benefit from this fractured system. States might get double the funding, staff might collect more per diems for attending workshops and trainings they don't need, and implementing partners might secure additional work to keep their staff employed.

Stagnant progress in the country has created a new push to do better. Kaduna state's Integrated MOU and the Technical Support Unit at the NPHCDA are examples of a government-led efforts. The 4Gs and Grant Optimization work at the BMGF NCO are donor-led efforts. The TA Hub is an independent organization approach.

Relevant Initiatives: **5** **7** **9** **11** **12**

TA Case Studies

1. Top-down Implementation (MCSP, USAID)

2. State-level MOU (USAID)

3. Advocacy Model (Save The Children)

4. Small Scale Test (CHAI)

5. Grant Optimization (Niger State, BMGF)

6. Program-for-Results (SOML, WB)

7. Cross-donor Coordination (4Gs, BMGF)

8. Government-dependent TA (IHP, USAID)

9. Technical Support Unit (NPHCDA)

10. Strengthening Local Partners (r4d)

11. TA Hub (BMGF)

12. Integrated MOU (Kaduna State)

13. Training the Trainers (IMCI, WHO)

About the Case Studies

In this section, we focus on detailed case studies of TA activities we heard about from stakeholders in Nigeria.

Some are specific initiatives, while others represent models followed by multiple organizations.

Theses examples range from current status quo projects, to initiatives that are pushing to innovate how TA can be delivered. Our focus is on understanding strengths and weaknesses of each approach.

Each case study consists of two sections. The first page focuses on the characteristics as well as the advantages and disadvantages of each approach. The following page(s) contain a more detailed summary of what the approach is and how it works.

It is important to note that these are based on participant's own descriptions of the projects & have not yet been fact checked.

1 Traditional Implementation (MCSP, USAID)

A traditional top-down project model where global and national objectives are delivered at the local level.

CHARACTERISTICS:

- Shorter-term
- Health results are prioritized
- Bringing in outside capacity or filling specific capacity gaps

ADVANTAGES:

- Pinpoints mission/country needs and finds a way to get experts to the table to respond to that need.
- Pooling knowledge and trying to effectively utilize that knowledge most efficiently to address countries' needs.
- There is a defined process that tries to include multiple stakeholders with end user in mind.
- Opportunity to support government when they don't have in-house expertise
- Can work at different levels in a country (national, district, community)
- Cross country learning – learning within country to direct change in the future (infrastructure support, strengthen system, etc.)

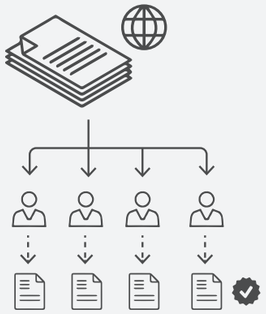
DISADVANTAGES:

- Country context is complex. It takes time for the TA experts to digest context and structure nuances to provide best support.
- Local stakeholders might not fully buy-in to support or be ready for changes that the program will impose.
- Builds expectations. What happens to staff and capacity built when the program ends?
- Not sustainable, short-term solution to a long-term problem. Could achieve more if programs could be over 5-10 years (building capacity and strengthening health systems is a time consuming process.)
- Programs not always designed with M&E at forefront with money to support an iterative learning process.
- Staff turnover
- Conflict between country vs donor needs.
- Data/results over people approach.

1 Top-down Implementation (MCSP, USAID) *cont.*

Program Description Drops

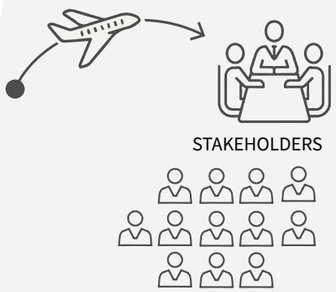
USAID releases a country program description. Tension is high, as the MCSP partners start to fight for a piece of the pie. Each creates capability statements to address program description needs.



"MCSP partners, there are 12 of us, we all start fighting over a piece of the pie. Tension is high. It's kind of a co-collaboration process, we have to create a capacity statement of how our organization can address certain program description need. And then within the consortium it's determined who will take the lead and then which technical organizations will take which piece."

Scoping Visit to Country

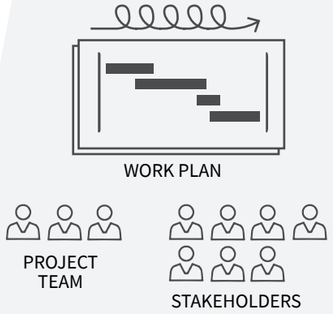
Lead organizations and technical leads identified to go on scoping visit. They learn about past & current programming and identify & meet with stakeholders (government, USAID, partners).



"The team does as much as they can to understand the past context, the present context, and how we will adapt the program to meet the needs of the country. So you meet all the players, sometimes Basics or MCHIP was there before, you learn about that, maybe you already know about it."

Program Designed with Stakeholders

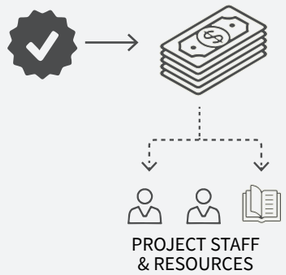
Lead organizations and technical leads work with mission and country stakeholders to propose a work plan. The revision process can last months, sometimes even years.



"And then you basically design a program in collaboration with stakeholders… You're working on a national level and those governments in the country or you're working more sub-national and district level and other partners and stakeholders are involved... whatever it is that you're trying to do. That can be a very lengthy process. In some cases it has taken years. In other cases, it's a couple months, just depending on the scope of the project and the funds involved."

Implementation Starts

Work plan is approved, funds are allocated, and the hiring process begins. Implementation can include national policy TA, training support, revision of guidelines, support to district and community health level.



"You are also trying to hire a bunch of people, like a chief of party, a deputy chief of party. You're amping up the project, funds are allocated and then the implementation can start."

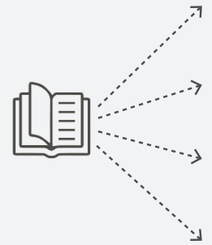
Work plan is Monitored

Once the work plan is implemented, there is quarterly and annual reporting as well as possible TA trips to oversee and support along the way. There are many presentations to the USAID HQ on progress and budget spending.

"And with USAID, there is all this monitoring. So once the work plan is implemented, there is quarterly and annual reporting, there is TA trips, there is approvals, get people to fly out… You know all of this takes a long time, effort, money, and red tape. And then presentations at the missions when you arrive, when you leave what did you do. Then you come back to DC and you have to talk more about what you did and what you're going to be doing and how you are working with people in country to do it. So this TA process is complicated. It's more involved then what people see."

Project is Closed-Out

Once the work plan is completed, project documentation & dissemination (D&D) starts.



"And then hopefully the program has done something, you have monitored your budget appropriately, so the program comes to an end. Which also requires TA towards the ending. And then there is preparing documents that show what you did. So TAs are often involved in that process as well. You know, how did we do it, what's new.."

2 State-level MOU (USAID)

State-level government is involved in every step of the process. Governor signs MOU with commitment to allocate funds.

CHARACTERISTICS:

- Phased approach, state fully owns the project at the end.
- Co-design process with stakeholders
- Greater government ownership
- Filling specific capacity gaps

ADVANTAGES:

- Sustainable, long term financing
- Coordinated planning and direction (reduced fragmentation)
- Government-led
- Accountability enforced
- Transparent and evidence-based process

> *"What I can see from this is that this is addressing a fundamental issue of accountability. There is increased accountability because it's more transparent and there is greater use of evidence around intervention. It's not just 'oh we did that last year so we'll just do it this year.' There is a level of rigor that has come in through the technical assistance and then resulted in increased quality of services and increased coverage."*

DISADVANTAGES:

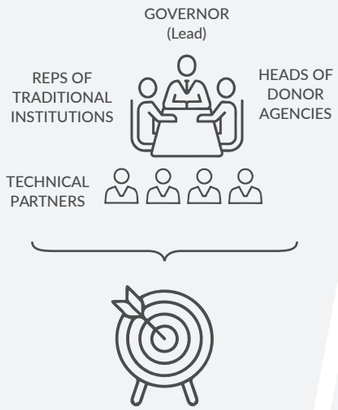
- Cookie cutter approach / need more flexibility
- Over-concentrated at the central level whereas it is a decentralized system
- Shifting goal posts
- At times too aspirational and targets not well understood.

> *"Because it's a multiple state, sometimes the MOUs are almost a cookie-cutter approach. They are all 4 years. And they all have a sliding scale of donor funding at 100%, slide down to 75%, government picks up the 25%, so on and so forth until in the 4th year it becomes 100% government. I think the weakness is thinking that the 4 years is exactly enough for every single state."*

2 State-level MOU (USAID) *cont.*

Needs Are Determined

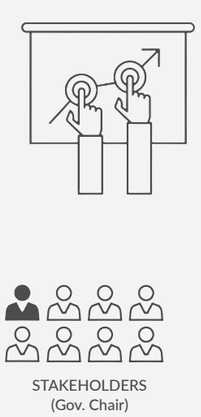
Scanning and initial assessments to determine priorities at state level.



"This helps set the priorities that were formulated in the MOU itself. This is done in multiple states. It is a really important step because it sets the context specific for that particular state and also takes into cognizance the existing resources or interventions that are already in place."

Metrics Are Established

Developing the MOU and performance metrics for each state.



"This is government led, so the government is in the driver's seat and it is at the highest level of the government. In this case, this is at the state level. So the governor is the signatory and part of this MOU. In this case, there is also a representatives of the traditional institution, so that there is that link to communities or informal authorities. And I think that's an important reflection of the context that this is being implemented in."

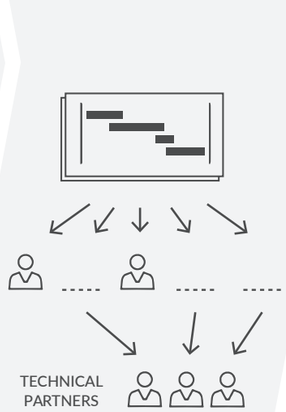
Planning Starts

Accountability framework is set and harmonized planning and budget process begins.

"And then there is the development of the accountability framework. And you also move into harmonized planning and budgeting process. It's around this period that the technical assistance needs are identified."

TA Needs Identified

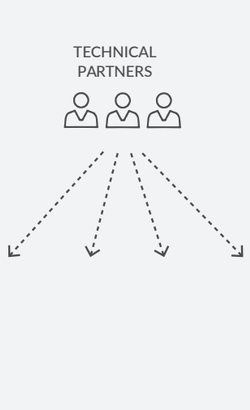
Identification of TA needs based on project plan and available resources in the state.



"So you have set the priorities, you've set your planning, and you've set your budget, and then you are able to identify.. 'I already have the resources, I already have the technical expertise to do things I have in my plan, or I don't.' So this is where the draw-down on technical assistance is actually elevated."

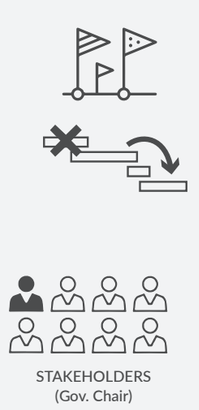
Partners Deliver TA

Technical assistance is delivered by the technical partners.



Progress Is Reviewed

Regular project reviews monitor the progress and course corrections are done as needed.



"There are regular reviews. I think this is important. And course corrections. So if they started a particular intervention or approach, they can course correct it based on what they see during the rollout."

Financials Are Audited

Final financial audits are conducted.

"There are also financial audits. Because this type of MOU includes basket funding, so I think this is an important part of the steps."

3 Advocacy Model (Save the Children)

Organization sets a national agenda, secures funding for projects on the state level, and uses evidence to advocate for federal changes.

CHARACTERISTICS:

- Organization sets the priorities, advocates to government.
- Agenda is informed by local needs, but driven by the organization's priorities.
- Short-term projects, part of a long term strategy.

ADVANTAGES:

- Focus on a single demographic creates a more focused scope.
- Clear priorities informed by global evidence, exposing local governments to information they might not normally have.
- Supports data-driven decision making.
- Multiple partners are engaged at the local level.
- Circumvents the fragmentation between federal & state MOH.

DISADVANTAGES:

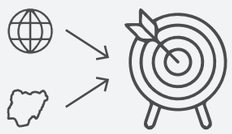
- Scope is limited to a specific demographic.
- Still mostly top-down approach.

3 Advocacy Model (Save the Children) *cont.*

ADVOCACY PROCESS

Local and international priorities are assessed

Global data is combined with a survey and a situational analysis to identify key issues for the country.



Pneumonia is now the #1 killer in Nigerian, no longer malaria. Why is this problem not visible? There is no Pneumonia champion. Pandemic nature of some diseases makes them more important globally. If there is a global champion, it is more visible locally as well. Because Pneumonia already occurs everywhere & can be manages with proper care, it is only a developing country issue.

"We are dependent on funded projects but have our own strategy. Every few years, we do a survey — what are the critical issues (do research, get data, talk to children), and situational analysis. Then we have to prioritize. Then we seek funding to support our strategy. Communities are part of developing this 5 year plan. The projects are at the primary level. We use our experience of working in the community to inform our plan."

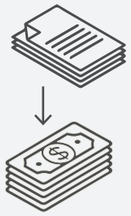
5 year plan is developed

Issues are prioritized and a 5 year strategy is set for the country.

"Each organization has its own expertise. When we do country studies, we check what are the problems and who are the actors. Are there actors who are better in an area than we are? If yes, we leave it up to them."

Funding is secured for project that fits the plan

Organization seeks funding for projects that fall within its overall strategy.



"When we get specific projects, we have to do specific assessment. Situational analysis. For example, for Pneumonia. We did a consultative meeting with the government and civil society. What are the gaps, challenges. Validate that with the research institute to triangulate anecdotal data. Work with the government, develop a plan. Get the buy-in along the way."

"Selecting the states: look for big gaps. Also use different political systems (ex Lagos & somewhere up north). Generate evidence and feed it to the federal level. We don't go to every state. We can't. Presence is guided by the situational analysis. Where do we need to go to collect the evidence? Where can we have the most impact?"

Project-specific needs are assessed

A project-specific needs assessment is conducted. Best states for implementation are selected based on health indicators and political data.

Implementation starts

Use a mix of internal and external resources to implement project.

"For ownership, you have to have a roadmap. By the end of the project it is part of the government plan. We have successful stories for getting into the gov plan and into the budget. But the issue is releasing the funds."

Data is collected

Collect extensive data to measure the effectiveness of the intervention.

Advocacy is a big part of the work. Selecting states where they can collect the right kind of evidence to have impact on the federal level is key. Working on the federal level does not bring results. But if they can generate results locally, they can influence the federal policy.

Data is used to advocate

Use locally collected data to advocate on the federal level.

Policy influencing happens on the federal level. But you are more productive and effective if you go below the federal level. You have to work where you can make a difference, then use the evidence to influence policy. ex. Small cash transfer program — attracted attention and now we have influence on the national level.

4 Small Scale Test (CHAI)

A design approach is used to better understand the problem, develop possible solutions and validate solutions.

CHARACTERISTICS:

- Agile & iterative
- Emphasis on government ownership of the final solution

ADVANTAGES:

- The process is fast and flexible
- Encourages innovative approaches
- Less investment required than regular projects

DISADVANTAGES:

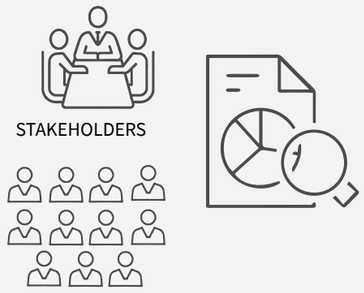
- Government must participate to develop shared ownership for the problem and the solution
- There is a need to recognize this project as a first step that still requires adoption and scale

4 Small Scale Test (CHAI) *cont.*

CHAI PROCESS

Problem identification

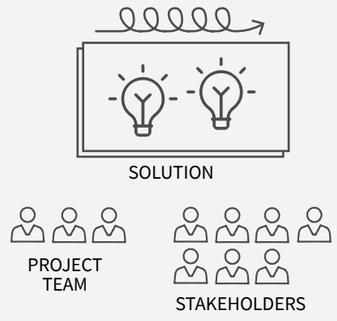
Starts with problem identification and drills down to understand what is happening.



"A central theme around TA is recognizing that you are addressing/ solving a problem. We start with problem identification, drill down to understand and explore possible solutions."

Design Possible Solutions

Process is agile and flexible. Possible solutions can be tested and evolve over time.



"TA needs to work with government to think through the viability and effectiveness of solutions."

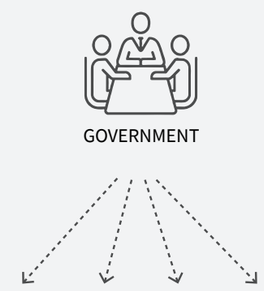
Small scale test/ validation of solutions

Proof of concept can be tested at a small scale in a short timeframe.

"We identify gaps and solutions together with government to ensure that the government has ownership."

Government takes ownership over problem & solution

The long term ownership of the problem and the solution sits with the government.



"These problems are owned by the government, so the government needs to work towards owning the solution."

5 Grant Optimization (Niger State, BMGF)

An effort to harmonize BMGF grantee work & increase collaboration in Niger state.

CHARACTERISTICS:

- Promotes coordination and de-fragmentation of BMGF projects on the state level.
- Strengthens existing government protocols rather than creating parallel ones.

ADVANTAGES:

- Harmonizes the efforts of all BMGF grantees working in a particular state.
- Leverages existing infrastructures set up through the MOU process.
- Partners will be able to come to the government with a single voice, making negotiations more effective.

DISADVANTAGES:

- No consistency across states (yet).
- Donor-level: Not currently addressing the inconsistencies between different donors.

5 Grant Optimization (Niger State, BMGF) *cont.*

BMGF NCO

"The foundation does not impose many rules on the grantees. We take a hands-off approach."

"We know that the number of projects is a problem for the state. They are in meetings all day with our grantees."

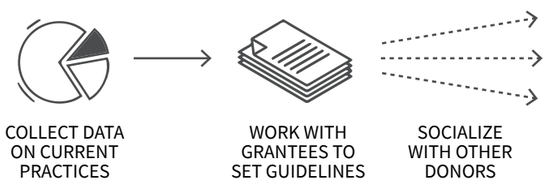
Harmonizing BMGF grantee work & increasing collaboration

GRANTEE

"BMGF needs to take a more active role to help us work with the government more effectively."

1 Standardized travel-related expenses across all grantees

Partners often face the friction between doing the right thing and wanting to meet their targets on time. In order for officials to show up to workshops, they might maximize incentives. Inconsistent per diems & rules about travel reimbursements create unfair competition between grantees. The project is setting guidelines for travel-related expenses for all Niger grantees to follow.



"Inconsistent per diems create unfair competition between grantees. A government official will choose to go where he gets paid more."

2 More effective capacity building (trainings & workshops)

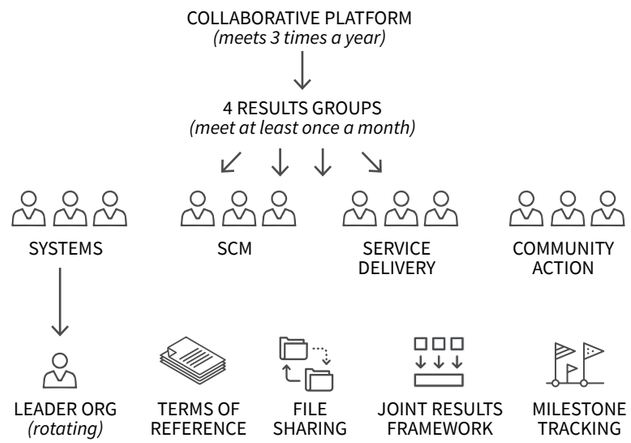
Are the right people getting trained? We don't know how many HCWs are there and what they've already been trained on.

There is a lot of training for the sake of training. They are not well coordinated, especially across grantees.

"Most of the work we do manifests itself in some form of training. But how effective is it?"

3 A Collaborative Platform for Grantees

The Collaborative Platform will create infrastructure for cross-grantee coordination.



"We need to come to the government with one voice. We need to agree on priorities together."

6 Program-for-Results (SOML, World Bank)

Performance-based state-level funding. States become eligible for additional funding only if they meet specific targets.

CHARACTERISTICS:

- Filling capacity gaps at state level
- Emphasis on data-driven decision making
- Improved accountability
- Top-down

ADVANTAGES:

- Improved accountability, since states don't get extra funding unless they deliver on their targets.
- Supports data-driven decision making.
- Builds capacity to read and act on data at the state level.

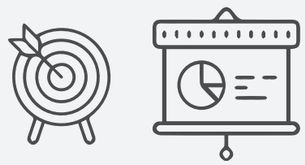
DISADVANTAGES:

- Institutional change is slow, the indicators are not moving as hoped.
- Issues with staff motivation and turnover leads to an over-reliance on TA consultants to do the necessary work at SMOH.
- Forces states to learn & use WB health indicators in order to qualify for funding.
- Issues with recruiting enough local consultants with the right skillset.

6 Program-for-Results (SOML, World Bank) *cont.*

Targets for key health indicators are set.

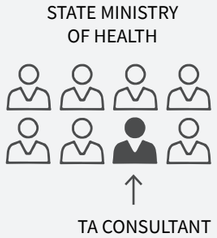
Local and global data is reviewed to set national national targets for key health indicators.



"The role of the TA is to generate the local capacity to generate data. To drill down to determine problems. The first we did within each state was to determine their own capacity for analyzing the data at hand."

State needs are assessed & TA consultant is embedded

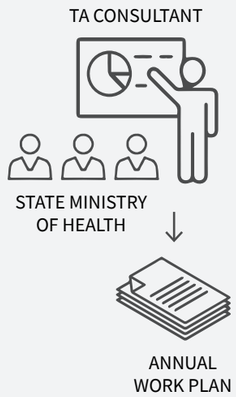
A TA consultant is embedded on the state level to help build capacity with the focal person at SMOH.



"A local TA person is engaged within each state, and it was designed specifically to have capable people of managing and assisting stakeholders at the local level to assess and then address their out TA capacity."

Annual work plan is developed

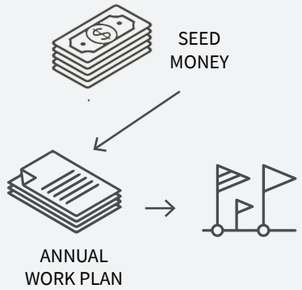
Consultant advises SMOH to strengthen ability to analyze data, monitor indicators, & set up appropriate interventions. They work to develop the annual work plan.



"Compare data sets, including the national household survey. TA brings all data to the table, triangulates it, and finds solutions."

Seed money is released & work plan is implemented

SMOH uses seed grant money to implement the work plan and works towards improving key health indicators.

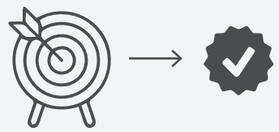


"The generation of annual operating plans is done with all stakeholders in one room. This leads to identifying gaps in funding, and then the opportunity for mobilization of additional funds to address such gaps."

"1.5 million dollars as "seed money" was given to each state, to use after developing their annual work plans, which were developed in partnership with World Bank."

Targets are met by the state

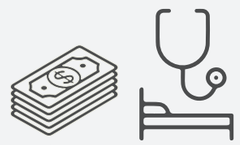
Key indicators are monitored to evaluate if the state has reached its targets.



"The results have not been great. Indicators are not moving. It's a motivation issue."

State qualifies for additional funding

Based on met targets, the state qualifies for additional funding from the program.



For states this is not guaranteed additional funding, or the foundation of their funding, it needs to be seen as supplementary based on performance.

7 Cross-donor Coordination (4Gs, BMGF)

Survey of existing work plans from 4 major funders. Looking for overlaps, gaps, and ways to better coordinate in the future.

CHARACTERISTICS:

- Country-level scan of all existing activities across the 4Gs.
- Short-term intervention

ADVANTAGES:

- Jump-starts a conversation on how the Gs might collaborate/coordinate better.
- Will identify any major duplications and gaps in work plans.
- Engaging with existing country partner coordination groups.

DISADVANTAGES:

- Acquiring and reviewing work plans is extremely time consuming.
- Does not address the root cause of the problem.

7 Cross-donor Coordination (4Gs, BMGF) *cont.*

Huge amounts of money is being funneled into Nigeria through 4 major verticals — GAVI, GF (HIV, TB, Malaria), GFF (RMNCH), Global Polio Eradication Initiative (GPEI). Since each organization is working with a different parastatal of the government, not much is being done to coordinate activities and avoid duplicative efforts across these organizations.

"They bring a ton of money to Nigeria, but we don't have a clear picture on how they work. No clear visibility into the overlap. Because they are all tied to different parastatals in the government, they don't talk to each other. We are doing analysis to see what they are actually doing by reviewing all of their work plans."

"Government officials benefit from the fragmentation. More activities means more workshops, more per diems..."

Challenges project is trying to address:

- Limited program awareness and transparency across the 4 Gs.
- Each donor has their own tools, all of them are different.
- Each G has their own fund counter-pay from the government. When you add them all up, can the government actually afford to pay all of it? The government is in deficit. We need to be more realistic about the expected contributions.
- Lack of government coordination and transparency around management of funds.

Current efforts:

- Looking at all health systems activities
- Harmonizing of accountability frameworks
- Active cross-representation and coordination across the 4 Gs. (mid-term goal)
- Leveraging of existing country partner coordination groups to coordinate Gs (DPG-H, HPCC)

8 Government-dependent TA (IHP, USAID)

Provides TA support to projects already funded by the government. No funds are given for training cost etc.

CHARACTERISTICS:

- State-led
- Building capacity / system strengthening
- Prioritizing long term capacity over short term health outcomes

ADVANTAGES:

- TA is fully integrated into existing state-level work, only supporting projects that the government is willing to fund.
- Challenges the dependence on donors to get things done.
- Rebuilding capacity within state to do work that is currently exclusively done by donors and implementing partners.

DISADVANTAGES:

- Relies fully on state government to allocate and release funds on time. This introduces a lot of project risks, especially around timelines.
- Pushback from the government, because there is no funding allocated to it.
- Mismatch between what is being done & what is being evaluated. There has been push back on “giving credit” for impacting health indicators when all they are proving is TA, not the actual project funding.

8 Government-dependent TA (IHP, USAID) *cont.*

"This project is trying to work alongside a gov-led process, but not bringing in any of the usual incentives... They are very used to a certain way.. take the workers, put them in a hotel, give them per diem etc."

"Normally we would finance all of this and not even involve them. Now we are saying we will work with your plan and you will finance the activities. We will just support. But they are saying that the budget has not been released... States have challenges. They don't have a budget for a vehicle. But it can't be funded by the project."

"Training approach will be different from the current Nigeria model. Not taking workers out of facility. Training will be done on site using professional associations receiving grants. We are institutionalizing knowledge at the local level."

"Because we already know government can't do everything. Local members of the professional associations are still part of the system. They will be getting a lot of the training."

"Sometimes its lack of awareness of what capacities gov needs to have... Donors have led the activities. Now the government agencies don't even have an idea of the scope of this effort. In the past, it used to be there. There is no infrastructure to get stuff done anymore... Once they have a clear idea of the scope of the work, maybe they will appreciate the TA coming in more."

"[There are] huge delays in the allocating funds. It's the biggest challenge because we are not allowed to budget for the activities ourselves. Our timeline has been shrunk to 3 months. Normally we would identify key activities and then fund them. Now we have to wait."

9 Technical Support Unit (NPHCDA)

A system to coordinate the identification & fulfillment of TA needs within the NPHCDA

CHARACTERISTICS:

- Addressing local priorities
- State-led, gov-owned
- Building capacity / system strengthening
- De-fragmenting the system / improving coordination
- Stronger monitoring / transparency

ADVANTAGES:

- States own request process, making them more likely to get the TA they actually need
- Better coordination at national level means resources are used more effectively
- Standardized M&E process and data collection
- Capacity building for internal government TA resources

DISADVANTAGES:

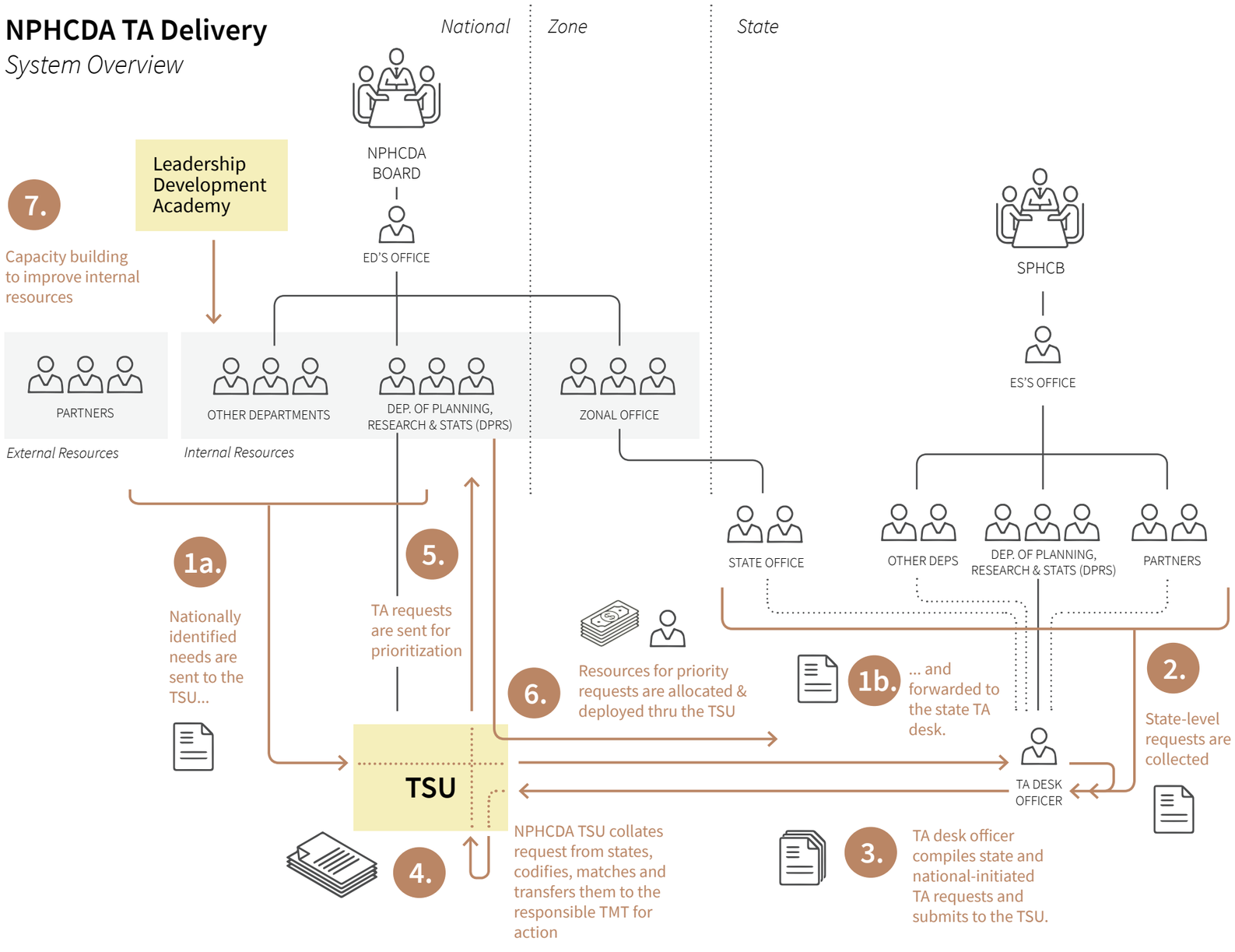
- The centralized process is very slow, there is a long gap between when states request for TA and when they actually get it.
- Difficult to enforce using the platform for all requests. Parallel, informal request systems still exist.

9 Technical Support Unit (NPHCDA) *cont.*

The NPHCDA has a mandate to provide technical support to states, LGAs, and other stakeholders in the delivery of PHC services. Limited technical capacity, funding, and no system for coordination and tracking have hampered the agency's ability to effectively deliver on this mandate. The Technical Support Unit (TSU) was created to address these issues.

Key features:

- Ownership over all TA requests is given to the states, even if the need is originally identified at the federal level.
- All TA requests are coordinated through a single communication channel and prioritized at the national level through a standardized procedure.
- TA requests are fulfilled according to priority level, using a mix of internal & external resources.
- Additional internal capacity is built through the Leadership Development Academy.
- TA delivery is monitored to assure quality.
- Money spent engaging technical consultants is being channeled through the TSU to provide technical services to the states free of charge.



9 Technical Support Unit (TSU) (NPHCDA) *cont.*

TSU PROCESS

State's TA needs are identified

TA requests can come from either the state or the national level.

- State level: TA needs initiators (SPHCB ES, heads of TMTs, Program officers, partners, etc.) communicate capacity gaps to **SPHCB TA desk officers.**
- National level: TA contact persons in departments within the NPHCDA fill out the TA request template and transmit to the NPHCDA TSU.

An aggregated TA request is submitted by the state

But regardless of where the requests are initiated, they will be submitted at the state level.

- TA desk officers will compile state and national-initiated TA requests and submit to NPHCDA to TSU.
- All requests are submitted using the **TA request template**, which captures the problem to be addressed by TA, programs or PHC building block affected, required technical support, and expected output from TA.

TA requests are collated

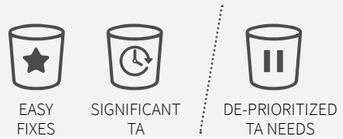
NPHCDA TSU collates request from states, codifies, matches and transfers them to the responsible TMT for action.

TA requests are prioritized

NPHCDA TMT prioritizes requests, prepares fulfillment plan & obtains approval to fulfill the requests.

TA request are categorized into:

- **Easy fixes** (can be immediately fulfilled without significant planning or resource commitment
- **Significant technical support** – requiring significant planning and deployment of resources to fulfill
- **De-prioritized TA needs** – not feasible or misaligned with strategic priorities of NPHCDA



TA resources are deployed

TA resources from within and outside NPHCDA are deployed to the state.

Resources:

- Knowledge resources such as guides, SOPS, manuals, policies, etc. and database
- A pool of resource persons within and outside NPHCDA
- Comprehensive map showing resource persons within and outside SPHCBs and their core competencies

TA delivered to the states through:

- Sending knowledge product
- TA providers to deliver on-site support
- Peer to peer learning among states

Leadership Development Academy

The Leadership Development Academy was set up to expand pool of staff proficient in planning and coordination to support TA delivery to states. The focus is on mid level staff from technical departments.

Monitoring & Evaluation

1
TSU and TA provider set expectations for each TA to be delivered and agree on data required and collection approach

2
TSU analyses the quality of TA delivery, competency gains and effect of TA delivered on SPHCB functioning

3
TSU facilitates development of TA performance report

4
In-house or external personnel engaged by NPHCDA will evaluate the overall program

10 Strengthening Local Partners (r4d)

Building capacity in local organizations to provide TA to the government.

CHARACTERISTICS:

- Building capacity on the local level
- Longer-term engagement

ADVANTAGES:

- Leveraging local expertise.
- Building local capacity without relying on the government.
- Reducing the cost of providing TA to

DISADVANTAGES:

- There are still challenges with working with local organizations (issues with scaling up).
- Building a parallel system, government still dependent on external TA.

10 Strengthening Local Partners (r4d) *cont.*

Donor

- Need assurance that the project will be delivered successfully.
- Want to ensure global expertise is applied & adjusted for local context.

International Partner

- Difficult for them to establish permanent local team. More often, team flies in for 6 months.
- Do not have local cultural context and expertise.
- Expensive.

Local Partner

- On the ground, available for long term work.
- Have deep local context.
- Lack the type of global expertise that is needed for reforms.
- Provide services at much lower cost.

State government/ SMOH

- Needs long-term engagement.
- Will need to eventually cover the cost, so the solution needs to be low cost.

11 TA Hub (BMGF)

A temporary agency model. States with funding for a particular TA initiative are connected with best suited partners. The hub also manages the project.

CHARACTERISTICS:

- De-fragmenting the system / improving coordination
- State-led
- Building capacity / system strengthening
- Outsourcing management capacity
- Stronger monitoring / transparency / data-collection
- Shifting power dynamics by re-routing funds through the state government

ADVANTAGES:

- Solves fragmentation/coordination issues at the state level by tracking all projects and making sure all requests go through the state gov.
- Supports data-driven decision making.
- By encouraging state-funded work, it transfers ownership and accountability over to gov.

DISADVANTAGES:

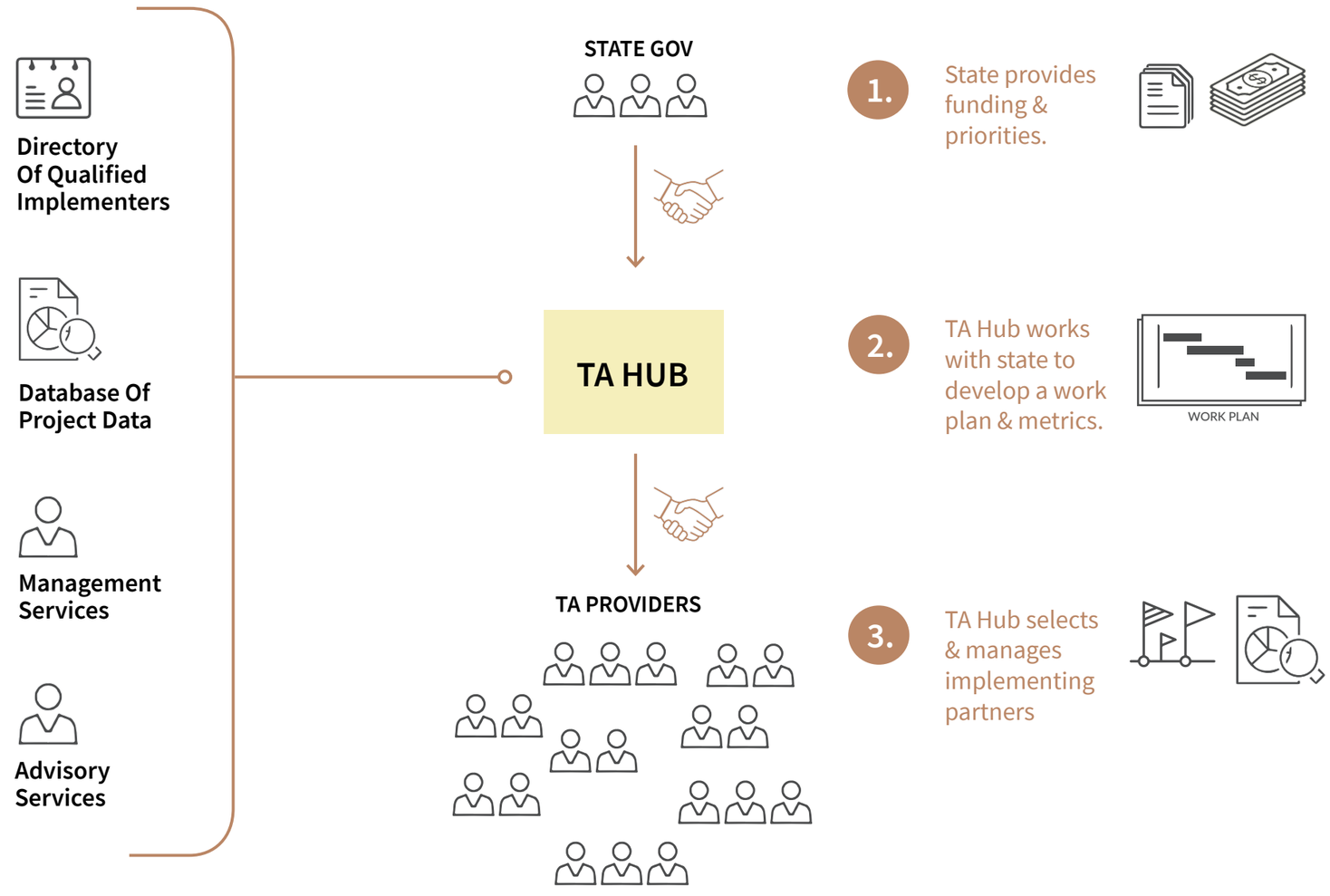
- Ignores the issue of where the funding is coming from. Currently only feasible for states that can manage to secure their own funds for projects.
- Creates a parallel system rather than internal capacity to manage TA at the state government.
- Does not work well with more advocacy oriented implementing partners who secure their own funding & then look for states to implement in.

11 TA Hub (BMGF) *cont.*

The TA Hub operates similarly to a temp agency model. States with funds for specific projects can outsource the work of identifying and managing implementers.

KEY FEATURES:

- Operating as a consortium of several implementing partners, currently only in Kaduna state.
- The hub is an independent entity. Currently financed by BMGF. The hope is more donors will join. Eventually, the organization will function as a social enterprise, charging states for the services.
- The hub maintains a database of qualified TA providers in the state who subscribe to be part of the platform.
- The hub collects data and expertise to advise states on how to best reach their goals.
- Over time, they aim to have all the funding flow through the states to the hub. The hub will then pay the partners.



11 TA Hub (BMGF) *cont.*

IDEAL FUTURE STATE PROCESS

State funds a TA request/ project

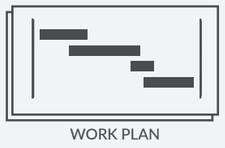
The state is responsible for identifying & funding it's own TA projects, either through the state budget or a donor.

State signs contract with TA Hub

The TA Hub is brought in to manage a specific TA request.

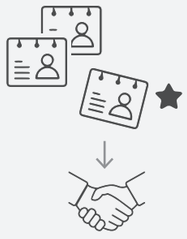
TA Hub creates work plan

TA Hub uses their expertise to advise the state on the most effective, data-driven approach. It also harmonizes with any existing work to avoid duplication of efforts.



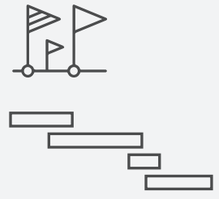
TA Hub selects vendors

TA Hub selects best qualified TA providers from the database it maintains.



TA Hub manages the work

TA Hub actively manages the work throughout the duration of the project.

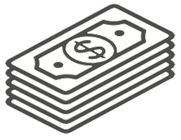


Payment is made

Money is paid out directly from the state to the Hub. The Hub manages the project plan and pays the providers.

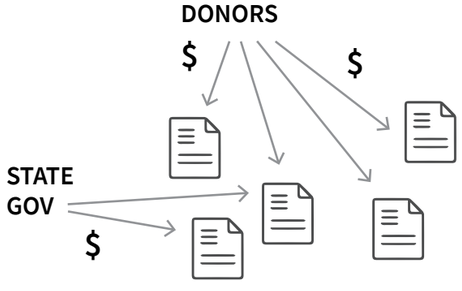
TA Hub performs M&E

The Hub collects data from all of it's projects in a database. It's used to evaluate current work and informs how to best execute future projects.



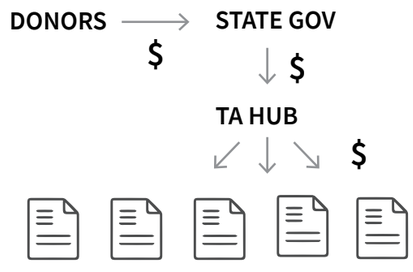
The Hub wants to shift how TA work gets funded

Currently, most of the TA work is donor-funded. The money is paid out directly to the implementing partners. The implementers are reporting to the donors, not the state government, making it impossible for the government to set strategy and coordinate.



Shifting to a government funded model

TA Hub aims to disrupt the current funding structure. By assisting with vendor selection, project management and M&E, the Hub will make it easier for donors to send money to the states, rather than the implementing partners.



12 Integrated MOU (Kaduna State)

Multiple donors sign a single MOU with the state to ensure better coordination, clear roles & responsibilities, and more efficient use of funding.

CHARACTERISTICS:

- De-fragmenting the system / improving coordination
- State-led
- Greater accountability

ADVANTAGES:

- Multiple organizations are brought together under one contract, making it easier to coordinate efforts.
- Setting roles and responsibilities for each organization helps to improve accountability.

DISADVANTAGES:

- New approach, it will take time to understand how best to operationalize it.
- Impossible to include all organizations in a given state.

12

Integrated MOU (Kaduna State) *cont.*

Jan 2016

Improving Routine Immunization (RI) MOU

3 year MOU between Kaduna state, Dangote Foundation, and BMGF.

BILL & MELINDA GATES foundation

DANGOTE FOUNDATION

September 2016

Improving Primary Health Care (PHC) Systems MOU

4 year MOU between Kaduna state, BMGF, and DFID.

BILL & MELINDA GATES foundation

DFID Department for International Development

Early 2017

Supporting Resilient & Sustainable Health Systems Partnership

Partnership between Kaduna state and the Global Fund.

The Global Fund

unicef

November 2018

Integrated MOU

The signatories of the RI MOU and PHC MOU, along with the UNICEF came together to develop a new integrated MOU for strengthening Primary Healthcare in entirety. The integrated MOU, while maintaining elements of the existing MOU agreements, will reflect a new common vision for coordination, alignment, and high-level oversight of MOU objectives, inclusive of activities, timelines and partner contributions, in support of a long-term goal to improve and save the lives of women, children, and the most marginalized communities in Kaduna State.

"Key to the Kaduna MOU success was that it came in as a request from the government. They requested for the 5 donors to come together and sign a single MOU. It would have been really hard to accomplish anything without this. Even now, we have it on paper now. We have to actually make it work."

13 Training the Trainers (IMCI, WHO)

Training the trainers (one in each state) at the national level. Then it's up to the state to organize the "step-down" training.

CHARACTERISTICS:

- Federal-level
- Top-down
- Building capacity

ADVANTAGES:

- Training of the trainers on the federal level works relatively well.
- Trainers on the federal level are experts in their field and are able to provide accurate, up-to-date information.
- Top down approach ensures a single, unified strategy and minimal duplication.

DISADVANTAGES:

- Training is not reaching the community level. States are completely dependent on donors when it comes to training initiatives. No state currently spends their own money on these efforts.
- Orphan States: some states don't get any donor funding at all.
- Even when funding is awarded to a state, programming is not reaching all parts of the state, just focused on several LGAs.
- The people chosen to be trained aren't always the right ones. An adim/supervisor might be invited to the training instead of the provider. Some might get trained twice while others not at all.

13 Training the Trainers (IMCI, WHO) *cont.*

GLOBAL

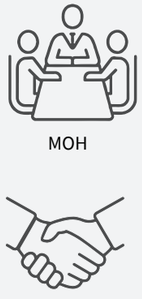
Global program launched

WHO & UNICEF introduces the Integrated Management of Childhood Illness (IMCI) Program globally.

FEDERAL

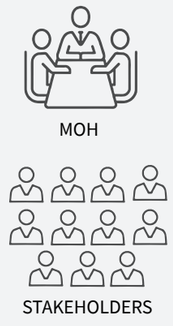
FMOH is engaged

Country Project Team engages with the Ministry of Health officials.



Stakeholder workshop is organized

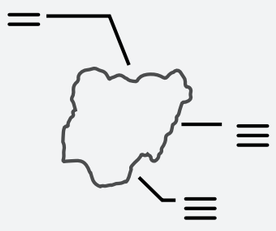
Project Team organizes a workshop with MOH representatives from each state to introduce the program.



STATE

Training needs are determined

Project team determines IMCI prevalence and training needs across the 6 geopolitical zones.



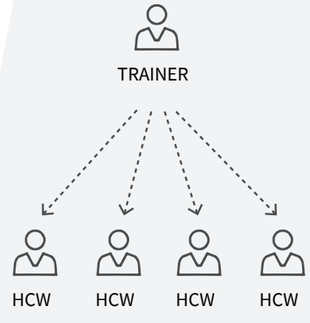
State-level trainers are trained

Technical experts work with states to develop capability to train their own trainers.

LOCAL

Step-down training conducted

Beyond the program, states need to contribute their own money to do the step down training. (Many states do not ever commit funds to do this.)



Emerging Questions

1. What are the costs and benefits of a fractured system?

2. How does bottom up meet top down?

3. What inhibits the reach, scalability and sustainability of TA?

4. How is TA measured?

5. What are the shared accountabilities for TA investment and impact?

Emerging Questions

As we are still in the process of discovery, we want to stay away from framing insights too early. However, there are some guiding questions emerging from our conversations with stakeholders.

These questions will inspire the design team to dig deeper in new directions.

In this section we have captured some of these questions. It can be that these questions will be discarded as we narrow down on the insights, but at this point in the process, we like to explore the richness of information that comes to us and how it could direct our inquiry.

The following five questions are intended to be a conversation starter, a design tool to which different stakeholder could react to. Through these questions we can speculate together with stakeholders on some of the underlying issues in more depth.

For example one stakeholder could react to one question: "I think you are asking the wrong question" or "This is a very interesting reflection, I have something to add."

1 What are the costs and benefits of a fractured system?

A fractured system creates gaps and duplicative efforts. Yet many actors learned to cope, even benefit, from these inefficiencies.

The fractured system creates opportunities at different levels. At one level, there is opportunistic advantage to individuals who may attend training sessions for the per-diem without accountability for project outcomes. At another level, implementers find pockets of opportunity where they can operate effectively.

"In a fractured system, government officials might gain more funds and per diems with less transparency and accountability." –Partner

"How grantees engage is not a level playing field. There is an imbalance, it perpetuates really bad behaviors. Government officials decide which workshop to attend based on the benefits they will get." –Partner

"There is no continuity from the government. People leave their posts and the knowledge goes with them. No capacity for coordination. Gaps on planning and policy level." –Donor

"TA experts in government are funded by a project. The second funding for the project runs out, they are out of there. There is no consistency" –Partner

"Governments won't say no to partner funding, even if they do not have the capacity or the interest to convert it into a sustainable health program." –Partner

2 How does bottom up meet top down?

Federal and state governments pay different, equally crucial, roles in the system. Yet coordination is limited because of a bureaucratic barrier dividing them.

The federal government's role is mostly to set policy and guidelines, which don't always trickle down to the state level. Most initiatives are operationalized at the state level. Federal government has little visibility into what is being done in each state. How can these roles be bridged more effectively? What factors contribute to the divisions? What changes need to be put in place? What changes is the government willing to make?

"Policy comes down to states with no capability or funds." –Partner

"Most states don't have a clear agenda, so donors get to set it." –Partner

"There is very good policy at the national level and there is a bureaucratic barrier that prevents its adoption by the states." –Donor

"We need to look at how decisions about TA are made in government. Why do we need to talk to so many different players in the department of health?" –Donor

"Working on the federal level does not bring results. But if we can generate results locally, we can influence the federal policy." –Partner

"We must tailor our technical approach to fit into the structure of governance. The federal is minimal, it is policy and oversight. Where the operations happen and where we think we can ownership and political will is at the subnational level." –Donor

3 What inhibits the reach, scalability and sustainability of TA?

The current TA system is expensive and its impact is limited.

Different contributing factors have been identified including misaligned expectations between donors and governments, and the pathways to get from fast catalytic projects to implementation that is sustainable at scale. What changes can we put in place to tip the scales?

> *"Some states are orphaned. The fact that some states do not receive any donor funding/TA is a know issue that has been raised by the government."* –Donor

> *"The role of the partners is short term– our programs are catalytic they are just programs with time lines to open up a solution not to sustain it."* –Donor

> *"It is difficult to inject innovation into a very strict bureaucratic system or structure."* –Donor

> *"Implementing Partners are pressed from time, so they focus on low hanging fruit instead of looking at what the state actually needs."* –Partner

> *"Donor funding is not enough to scale any efforts at the state level. States have to step up to secure their own money to ensure the programs are brought down to the primary level. Otherwise, the work has very limited impact."* –Partner

4 How is TA measured?

A lot of data is collected, but is the right data reaching decision makers?

Advocacy is a mechanism that partners are using to communicate learning and data to inform decision making at global, national and state levels. Are there other opportunities?

TA rarely gets measured directly. What data can be collected to help evaluate TA more effectively?

> *"TA is not a deliverable for the projects. It doesn't get measured. The M&E is on the project goal, not the effectiveness of the TA."* –Donor

> *"There is no capacity assessment for the institution and facilities we are working with. We provide TA in line with our project work without a plan for TA activities."* –Donor

> *"Advocacy is a big part of the work. We select states where we can collect the right kind of evidence to have impact on the federal. Working on the federal level does not bring results. But if we can generate results locally, we can influence the federal policy."* –Partner

> *"We provide TA in line with our project work. There is no actual plan for TA activities. TA is not a deliverable for the projects. It doesn't get measured."* –Partner

> *"There is poor dissemination of learnings across all states. The way information is shared is not always in a format that can be used by the government and won't be implemented."* –Partner

5 What are the shared accountabilities for TA investment and impact?

How does accountability stack up in a system where every player in the ecosystem only sees their piece?

Motivations can shift from health outcomes to sustaining operations. How is investment in TA accounted for?

"No one is accountable, no one knows where the money is going." –Partner

"The state doesn't give much. They are the system, yet they see the system as something external that gives to them." –Donor

"Even when plans do exist, there is no accountability. If something gets left off, there is no punishment. There is also no linking of the activities to the data. Tracking activities and measuring against the outcomes" –Partner

"The health system is very complex, there are a lot of partners doing the job so that the government doesn't have to." –Donor

"Political pressures cause the money to go to things that get politicians elected rather than towards issues identified through careful analysis." –Partner

"The confusion is created by the donors. We have deliverables/mandates that we are under pressure to deliver. We just want to check the box that something is done, don't care how it effects the government. " –Donor