Design Sprint to Re-imagine TA in Nigeria

Co-creation Team 1: Re-imagining interactions to build local ownership for greater sustainability.
Agenda

**Day 1:** Unpacking the Current State

**9:00**
- Introductions
- Project & design sprint overview
- Defining the opportunity area
- System actors & roles

**13:00 - Lunch**
- Unpacking current state
- Exploring ownership & accountability

**16:30**

**Day 2:** Designing the Future State

**9:00**
- Future state: What are the desired shifts?
- Brainstorming activity

**13:00 - Lunch**
- Concept development & refinement
- Developing concept pitches

**16:30**

**Day 3:** Validating Our Ideas

**9:00 (Additional visitors join 9:00-14:00)**
- Visitor introductions & orientation
- Concept pitches & feedback
- Discussion: Additional opportunities & the future of TA in Nigeria

**13:00 - Lunch**
- Concept refinement & planning
- Considering a systems change
- Next Steps

**16:30**
Re-Imagining Process
Tips for our time together

Be present
Defer judgement
Embrace the pace

Trust the process
Use the tools
Be optimistic
### Emerging Principles: Good TA should...

<table>
<thead>
<tr>
<th>Create conditions for collaboration</th>
<th>Resist the quick fix</th>
<th>Design for resilience</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Align on common purpose and success</strong></td>
<td><strong>Shift from buying solutions to owning problems</strong></td>
<td><strong>Slow down</strong></td>
</tr>
<tr>
<td>How might we better understand the drivers and outcomes for all parties to align criteria for purpose and success?</td>
<td>What does it mean to shift from a fragmented solution focus, to an aligned problem focus?</td>
<td>How might we shift priorities and goals from trading away the certainty of short term efficiency to the possibility of improving the system in the long run?</td>
</tr>
<tr>
<td><strong>Leverage local wisdom</strong></td>
<td><strong>Strengthen feedback loops</strong></td>
<td><strong>Consider the system as a whole</strong></td>
</tr>
<tr>
<td>How might we amplify the voice of local wisdom to ensure better understanding of local context and needs?</td>
<td>How might we ensure knowledge and data is distributed in a way that is more accessible to empower individuals to make requests and decisions?</td>
<td>TA is a constellation of interconnected systems, each with its own set of unique properties. How do we consider the whole system and its interdependencies?</td>
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<tr>
<td><strong>Build mechanisms of accountability</strong></td>
<td><strong>Scale trust</strong></td>
<td><strong>Balance individual gain with collective good for mutual benefit</strong></td>
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<td>How might better accountability build trust and create strong feedback loops across the system?</td>
<td>How might we better understand the mechanisms of trust to ensure that time for building trust is an intrinsic component of a TA process?</td>
<td>How might we change incentive structures to ensure that individual gain contributes to collective benefit?</td>
</tr>
<tr>
<td><strong>Distribute ownership</strong></td>
<td><strong>Reduce dependencies that perpetuate short-termism</strong></td>
<td><strong>Standardize the core, tinker around the edge</strong></td>
</tr>
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<td>Needs identification, design, and implementation of TA currently sit primarily with donors and governments. How might these processes become more inclusive to include state governments, health providers and community?</td>
<td>How might we build a self-sustaining system, where the system self-regulates from internal resources to maintain its equilibrium based on what is available?</td>
<td>How do we streamline core TA functions while preserving diversity at the edges?</td>
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Opportunity Areas

Re-imagining interactions to build **local ownership** for greater sustainability

How can actors at all levels of the system be empowered to take the lead as well as be held accountable for their actions?

Re-imagining knowledge **flow** to support strategic decision-making

How can data use and knowledge flow improve decision making and a shared understanding of what is working, what is needed, and what matters most?

Re-imagining incentives to build greater **workforce capacity** & maximize impact

How might TA empower the workforce at all levels through strategic use of resources that align with real needs and leverage the dynamics of local context?
Our Focus Area

Re-imagining **interactions** to build **local ownership** for greater sustainability

Local ownership of TA initiatives is key to achieving sustainable impact. Yet, despite best intentions, initiatives continue to be mostly top down, largely driven by donor agendas.

*How can actors at all levels of the system be empowered to take the lead as well as be held accountable for their actions?*

**RELATED CHALLENGES:**
- Ownership at all levels and transfer of ownership
- Poorly defined TA roles between stakeholders
- Poor communication from policy makers to partners
- Poor health care finance adherence
- Designing pilots with scale in mind
- From project ownership to problem ownership
Interactions

When I go out to the field as a staff of NPHCDA, I will be given 25% of attention by the states or the local government authorities. But when UNICEF or WHO comes with their white Jeep, that is the end of all of the attention they are giving to me. TSU

One reason we don’t have much outcome is that implementing partners are not collaborating, partners come in with donors distinct mandates that are not flexible. Every implementation partner want to do what the funding has mandated.

FMOH

Some flexibility can be built into government structures - government should try to provide the opportunity for delegation of authority, this gives us opportunity to act faster.

Dept HPRS, FMOH

We are moving to a donor, government partnership - partners are a supportive, critical friend. If something is not going to work we have the duty to tell the donor, this is not going to work and walk away. You can speak the truth, say tough words when they need to be said -

TA Hub

We must review our project design strategies, project design is poor and projects are not integrated - it is not just the fault of the partners but we have so many people doing similar things, we are repeating ourselves and there is a lot of waste, activities are currently fragmented across different departments.

FMOH

TA culture in Nigeria has been a combination of arrogance and lack of interest. Donors don’t know what they are doing but must do everything while recipients passively accept assistance and play the role of idiot.

TA Hub
Decisions, influence and power

We do not get data inputs from donors, they are not transparent, they are spending the money, they have records but they do not share.
FMOH Child Health Division

There is a disconnect between what we are trying to solve and the process we have to follow, the process has become an end in itself.
MSH

The truth is the needs are very many but we should have priorities and we should be going with priorities but, in any case we will work with the donors agenda.
FMOH Child Health Division

There is a gap between what we are wanting to achieve and easy to measure outputs. To understand TA effectiveness we need softer qualitative feedback as well as the numbers.
DFID

The problem with Nigeria is not just the documents, when the reports come out what do we do with them? How do we get decisions to respond to data? We need more advocacy, the data may not be aligned to the political agenda.
Dept HPRS, FMOH

Nigerians are very hopeful people, We set targets that we can’t possibly reach and neglect strategy for what is possible.
TA Hub

There is a disconnect between the human problem we are trying to solve and the process we have to follow, the process has become an end in itself.
MSH
I am not getting the TA I want and need

From my view what I get should be what I want, I should not have to dance around the assistance you want to give me.

I work in the system, I understand the dynamics and I can say in the next 2 years these will be my needs. I want the leverage to think for myself and by myself.

The entry point the National Planning Commission NPC they go there before they come to the ministry and the pact/contract is signed with the NPC with no input from the ministry of health - we can’t influence we should have a say about the type of assistance we are getting.

For a long time we were not implementing the strategic plan, what is delivered depends on doing the donor mandate not necessarily what we want.

I just wake-up and someone is there and they say this is it. At some point I had an experience where someone was just imported and I was told I had to work with them, I said no. When they drop such an individual on you you can not guarantee the capacity at the end of the day you end up doing double work.

The entry point for partners is the NCP - they don’t bother to come to the ministry anymore they just go straight to the states.
Ownership

The promise you give is to the donor, they are the piper who plays the tune.

Ownership means you can’t start the project with your mandate without government approval and participation.

Ownership of projects sits with the donor - the community should own but sometimes for someone to own something they need to see why they need it - how it benefits.

Sometimes the recipient of aid does not understand it, the beneficiary has no idea what they want from supply - Taking over and doing it means there will always be a donor project.

We are funded by multiple partners to provide similar programs and they are each accountable to their funders, they are tied to tight time frames and rather than taking time to assess the situation, to understand need, coordination and collaboration they are just focused on implementation, but are they implementing the right things?

When partners comes into the country, they have already decided, they come to inform us.

The ownership of projects sits with the donor.

Sometimes the recipient of aid does not understand it, the beneficiary has no idea what they want from supply - Taking over and doing it means there will always be a donor project.

Ownership means you can’t start the project with your mandate without government approval and participation.

FMOH Child Health Division

Dept HPRS, FMOH

Partner

FMOH Child Health Division

DAI
Relationships and trust

Donors are our friends they are supposed to collaborate with us. Their activities have a place in the strategic plan but we have an issue that the government does not have a say in who does what and how
HPRS FMOH

An open discussion where I can specify our needs and TORs will help to ensure ownership and ensure that the TA brings out results and the results are aligned with our needs and sustained..
FMOH Child Health Division

The procedures for each donor differs- we are not changing those procedures . FMOH

Even the role of the federal agencies is not clearly defined. What is the role of the federal level? It is not to travel to the states you are supposed to adopt global best practice, create policy that cascades to the states to implement.
Partner

It is all about putting the beneficiary in the center, in the driver’s seat - if you put the recipient of aid at the centre the government will not argue
DAI

They are coming with funding. They have monetized everything. When we go there, what we preach is do your routine job effectively. When UNICEF and partners come, they come with carrots. Those things that you are supposed to do routinely, we have some stipend for you to do it. But we, we just come with Bennie Hill approach, just to preach. TSU
Accountability

The accountability piece is about if government has committed to receiving a particular type of assistance, they have to commit to creating the environment for it to be delivered and that commitment needs to be at the highest level of government.

MSH

A lot of the risk of donor investment is transferred to us as an organization, we need to make sure that this thing is delivered appropriately and if not we will be held to account. We are risk managers, it is accountability, we defer risks to ensure funds are delivered appropriately MSH

We do not get data inputs from donors, they are not transparent, they are spending the money, they have records but they do not share.

FMOH Child Health Division

It needs to be a tripartite agreement, if it's going to work. So that they hear from the beneficiary agency or ministry what you actually need that money for. Agencies need to be involved in the development of the work plan so we can see up front what that money is going to be spent on. What are the dos and don'ts on that level. It would then be very easy for implementation to take place, because you are part of the agreement and you know what is there. TSU

We do not have a strong accountability for implementing partners because their MOU is with the donors. Without a tripartite agreement we can't hold to account.

Dept HPRS, FMOH

When things come to you free you don't intervene you just accept

Dept HPRS, FMOH
**Defining key terms**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>country owned</td>
<td>Representation from all levels across country – all sit down and design and implement. Civil society orgs involved as well – entire cabinet from top executives. Should go beyond health only. Good example of ownership - Ebola. Everyone was afraid and very engaged. We did not sit back to say how did we do that? Other countries came to study us. Private sector also got involved. Right now the private sector is not participating in health at all.</td>
</tr>
<tr>
<td>government owned</td>
<td>Pronouncements and force citizens. For example state health insurance agencies. Country owned is an end result. Co-creation can lead to a country owned strategy. This might be more leadership versus ownership. Can be a law or mandate.</td>
</tr>
<tr>
<td>locally owned</td>
<td>Cohesive group bound together. Not looking for external parties to solve problems.</td>
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<tr>
<td>donor owned</td>
<td>Whoever plays the tune – they have the $ so we don’t have the power so we did not take leadership.</td>
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<tr>
<td>co-created</td>
<td>Can have external stakeholders. Co-creation is the beginning.</td>
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</table>
### Imperatives/Mandatory - IDEAL

- Donors have to be accountable and transparent for their own tax payers and to the governments they are supporting. BMGF is accountable to Board.
- Log frame for country
- Lots of restrictions around how $ get spent
- Project duration locked in
- Security and safety (risk management)
- Maintain brand and reputation

### Roles - IDEAL

- **Facilitate** - (bring various actors together towards a specific cause)
- **Advocacy** - convene govt to commit funding to key causes
- **Funding** - galvanize in country resources
- **Resource mobilization**
- **Bring accountability**
- **Bringing in global country expertise and build country capacity**

### Behavior - IDEAL

- Focus on monetary accountability
- Efficiency
- Respect country policies and regulations and comply
- Support locally grown initiatives
- Plan with government – go at own pace; build on what the country is doing
- Should be willing to be accountable to country government
- Be transparent on spending

### Enabling environment - IDEAL

- Government that is responsive
- Need security within the country for them to thrive
- Require host government to honor commitments
- Need to know capacity of the government levels they are working with – for example it is different between states and national.
- Resources and counterpart funding
- Policies need to be in place to enable implementation

### Success

- Want to attribute success to their activity
- IDEAL – when government is self sufficient
- Donors don’t want to share success
- Making an impact
- Contribute to overall impact
- Celebrate milestones

### Undesirable (things that compromise their functions)

- No policy
- Unhealthy competition between donors – want to be able to attribute successes to their projects
- Lack of alignment
- Lack of security

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**interactions with the rest of the system:**

- Legal agreements
- Scoping visits
- High level needs assessments
- Orientation or sensitization meetings
- Advocacy for policy change
- Sensitization
# STATE GOVERNMENT

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<tr>
<th>Imperatives/Mandatory - IDEAL</th>
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<tbody>
<tr>
<td>Identify and solve problems</td>
<td>Change attitudes of community through empowerment (information)</td>
</tr>
<tr>
<td>Provide enabling environment</td>
<td>Own projects to achieve and solve problems of the community</td>
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<tr>
<td>Proper funds appropriation</td>
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<tr>
<td>Provide strategic plan to guide implementation</td>
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<tr>
<td>Feedback loop</td>
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</table>

<table>
<thead>
<tr>
<th>Behavior - IDEAL</th>
<th>Enabling environment - IDEAL</th>
<th>Undesirable (things that compromise their functions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Misplaced priorities</td>
<td>Ownership</td>
<td>Lack of funding</td>
</tr>
<tr>
<td>Not owning project and not coordinating</td>
<td>Understanding the needs of the population and appropriately address them as well as prioritize</td>
<td>Insecurity</td>
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<tr>
<td>Not transparent</td>
<td></td>
<td>Lack of ownership</td>
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<td></td>
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<td>Poor M&amp;E</td>
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<td></td>
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<td>Poor accountability</td>
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Success:
- changing the lives of people
- reporting valid data
- seen physical improvements
- align with partners to achieve a common goal

interactions with the rest of the system:
- Scaling up best practices
- Policy implementation
- HRM
- Service design
- Coordinate service delivery
- All previously listed FMOH and service delivery
- Policy domestication
- Stakeholder involvement
- Request TA from FMOH
### IMPLEMENETER

<table>
<thead>
<tr>
<th>Imperatives/Mandatory - IDEAL</th>
<th>Roles - IDEAL</th>
<th>Interactions with the rest of the system:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Donor funding</td>
<td>Strengthen capacity</td>
<td>- Scoping meetings</td>
</tr>
<tr>
<td>Rules and regulations of donor</td>
<td>Technical support</td>
<td>- Resource mobilization – write proposals</td>
</tr>
<tr>
<td>Alignment with org priorities</td>
<td>Implement donor strategies</td>
<td>- Advocacy</td>
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<tr>
<td>Accountable to donors collaboration with government and community counterparts</td>
<td></td>
<td>- Introductory visits to states and other stakeholders</td>
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<tr>
<td>Security</td>
<td></td>
<td>- Talking to government at multiple levels.</td>
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<th>Un desirable (things that compromise their functions)</th>
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<tr>
<td>Alignment with local priorities and policies</td>
<td>Donor funds</td>
<td>Lack of donor flexibility</td>
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<tr>
<td>Work with established systems</td>
<td>Enabling environments (policy and government commitments)</td>
<td>Lack of adequate information</td>
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<tr>
<td>Us local resources</td>
<td>Donor responsiveness</td>
<td>Governments not being open to new ideas and change</td>
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<td>Human capacity development</td>
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<td>Good understanding of local context</td>
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<td>Coordination with other IPs</td>
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<tr>
<td>Strengthening existing system</td>
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<tr>
<td>Demonstrate tested practices</td>
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<tr>
<td>Joint planning, implementation, monitoring with stakeholders</td>
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- Scoping meetings
- Resource mobilization – write proposals
- Advocacy
- Introductory visits to states and other stakeholders
- Talking to government at multiple levels.
- Engage with community leaders who they will be working with as well as civil society
- Research and M&E
- Capacity building/development
- Technical assistance
- Infrastructure upgrades
- Co-creation
- Planning
### FMOH

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<tr>
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<tbody>
<tr>
<td>Need to follow protocol</td>
<td>To provide guidance for implementation</td>
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<tr>
<td>Set regulations</td>
<td>- Policies and training guidelines</td>
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<tr>
<td>Approve programs and project implementation</td>
<td>- Accountability</td>
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<tr>
<td>Top down approaches</td>
<td>- Monitoring and supervision</td>
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<td>- Data collation to follow programs</td>
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<td>- Feedback to state governments</td>
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<td>Ensure donors align with national priorities</td>
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<td></td>
<td>Leadership and ownership</td>
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<td></td>
<td>- Program design and evaluation</td>
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<td>- Coordination</td>
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<td></td>
<td>Laws and regulation</td>
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<th>Roles</th>
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<tr>
<td></td>
<td>Ensure enough resources available to ensure phc is functioning</td>
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<td>Funding allocated released and utilized appropriately</td>
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<td>Roles clearly defined</td>
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<td>Allow for innovation</td>
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<td></td>
<td>Willingness to change</td>
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<td>Efficiency</td>
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<tbody>
<tr>
<td>Current</td>
<td></td>
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<tr>
<td></td>
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<tr>
<td>Too slow</td>
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<td>Bureaucratic</td>
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<td>Rigid in budget planning</td>
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<tr>
<td>FUTURE</td>
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<tr>
<td>Open to change</td>
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<tr>
<td>Own problems</td>
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<td>Be accountable to the people</td>
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<table>
<thead>
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<table>
<thead>
<tr>
<th>Success</th>
<th>Undesirable (things that compromise their functions)</th>
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<tbody>
<tr>
<td>Achieving SDGs</td>
<td>Poor knowledge of donor/IP activities</td>
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<tr>
<td>Achieving country targets</td>
<td>Poor leadership</td>
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<td>Effective coordination of partner/donor activities</td>
<td>Poor coordination</td>
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<tr>
<td>Effectively tracking progress</td>
<td>Top down planning</td>
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<td></td>
<td>Implementing (state level)</td>
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- Development of policies and guidelines/ Policy formulation/technical policy guidance
- Co-creation with implementers
- Resource mobilization (funding and TA requests, counterpart funding where needed)
- Advocacy (to state government, multiple stakeholders)
- Capacity building of states/technical support to states
- Coordinate donors, IPs and stakeholders
- Data and results, monitoring and evaluation, research, evidence generation
<table>
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<tr>
<td>Differs based on ownership (private, public, faith based, not for profit)</td>
<td>Provide healthcare services</td>
</tr>
<tr>
<td>Not autonomous (receive direction from government)</td>
<td>Respond to outbreaks and other health needs of the local community</td>
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<td>Provide healthcare</td>
<td>Report health statistics (data)</td>
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<tr>
<td>Should follow protocols and guidelines</td>
<td>Good infrastructure and equipment</td>
</tr>
<tr>
<td>Should be patient centered</td>
<td>Funding (operating expenses)</td>
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<td>Should be accountable</td>
<td>Adequate and skilled staff</td>
</tr>
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<td></td>
<td>Adequate remuneration and working conditions</td>
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<td>Trainings and regular update through CPDs</td>
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<table>
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<th>Success</th>
<th>Undesirable (things that compromise their functions)</th>
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<tr>
<td>Improve health outcomes of the local community</td>
<td>Poor funding by government</td>
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<tr>
<td>Adopt better health seeking behavior</td>
<td>Inability to follow protocols and guidelines by healthcare workers</td>
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<tr>
<td>Improve waiting time</td>
<td>Government prioritizing income yielding sectors</td>
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<tr>
<td>Improved quality of care</td>
<td>Multiple projects reporting requirements</td>
</tr>
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</table>

- Outreach – health education
- Direct implementation of TA support
- Logistics
- Procure commodities
- Request TA from IPs
- Providing HR for training
- Providing data for monitoring and decision making; compile and submit data
- Receive supervision
- Receive instructions around guidelines and protocols
POWER

IDEAL

MOST POWERFUL

THE PEOPLE

COMMUNITY LEADERS

GLOBAL IFS

LOCAL IFS

HEALTH FACILITIES

COMMUNITY LEADERS

DONOR

STAKE/LOCAL GOV (ESSENTIAL SOURCES)

SMOH

IDEAL

THE PEOPLE

COMMUNITY LEADERS

GLOBAL IFS

LOCAL IFS

HEALTH FACILITIES

STAKE/LOCAL GOV (ESSENTIAL SOURCES)

DONOR

SMOH
Concept Brainstorm (critical shifts)
FROM:

- Imposed/Donor driven
- Creates dependences
- Lack of trust in institutions/individual motivations
- Unaccountable
- Fragmented
- Supply driven
- Short term
- Static
- Uprooted (global)

TO:

- Country owned
- Cultivates sovereignty/self-reliance
- Scales trust
- Accountable
- Considers system as a whole
- Problem focused
- Builds for sustainability
- Learning, nimble, diverse
- Contextualized
From donor driven to country owned

**DONORS**
- Donors should listen and align with priorities of the government, FMOH, SMOH
- Donors should engage with all stakeholder before developing an agenda
- Donors should be accountable to the government
- Donors should build the capacity of the government to sustain or take over activities from IPs**
- Donor funding should address FMOH resource gaps.
- Donors should explore partnerships for an integrated approach to problem solving the multidimensional problems of education, economic empowerment, health, security and infrastructure *****
- Donors should push for multi-sectoral collaboration to address developmental challenges*
- Donors should share financial/TA report with countries and policy makers
- Donors should recognize the problem of the people and design projects to address them.**

**FMOH/government**
- FMOH should negotiate with donors on SOW and decline projects if donors refuse
- FMOH should own and lead projects that aligns with its plan; if not reject the project***
- FMOH should create good relationships with donors to achieve a common goal
- FMOH/SMOH should hold performance review meetings with donors **
- FMOH should insist on tripartite agreement between donors, NPC, and FMOH/SMOH.
- NPC should consult FMOH before signing donor agreement ***
- Government should provide quality information/context for donors/IPS to use in making decisions
- FMOH should develop an evidence based plan that identifies resource gaps in collaboration with development partners*
- State government should engage with donors based on the people’s needs
- Govt should honor agreements made with donors**
- SMOH should reflect citizens voice in its strategic planning
- Governments should coordinate with elected officials and policy makers so they have one voice
- FMOH should orient the legislators on health issues for better understating and funding *
- Countries and governments should give honest feedback to donors
- State governments should hold health budget performance reviews with the people
- FMOH should have an annual health report that is widely disseminated to guide the investment.***
- Governments and countries should put in place mechanisms to manage their resources better or communicate with donors *

**IPs**
- IPs should be able to give honest feedback about what is and is not working
- IPs should push country first agenda
- IPs should conduct scoping and co-create intervention with state governments to inform their RFP and proposal development.
- IPs should be accountable to beneficiaries *
- IPS should properly manage projects for better outcomes *

**Community leaders and citizens**
- Community leaders should accept only those interventions they think will work in their context
- Citizens should demand quality care
- CSOs sensitize people to ask for their rights **
From lack of trust in institutions and individual motivations to scaled trust

- Donors should break down cost to let FMOH/SMOH know how much is spent on actual health system or service delivery activities
- Donors should share a detailed breakdown of budget **
- Coordination and collaboration of all stakeholders should be done at all times to strengthen the system *
- Donors/IPs should be able to share financial reports with country/governments so that it is clear what they do with it
- IPs should share progress reports with govt and people***
- Donors should involve FMOH/govt in the proposal technical review committee****
- Donors should dialogue with countries before taking off a project
- Donors should engage with government to set priorities – should do joint planning
- FMOH should become digital

- Community leaders should articulate community needs and priorities and document them. Donor funding should be based on prioritized community needs.
- Community leaders should represent the people. **
- Donors should fund locally initiated projects
- Health facilities should utilize their resources judiciously for service delivery and share with IPs
- Global IPs should demo local CB by recruiting and using local resources as much as possible.
- GoN should review HRM practices to align staff motivations with priorities
- People should be bold enough to reject donor support that is not based on their needs*
- Donors consider recommendation from host government as key requirement for IP selection
- Elected officers should provide a detailed plan to report how they spend public money to the people and to donors
- Community leaders should brief community members with all implementing partners quarterly on progress.
- Community leaders should form project advisory committees that have beneficiaries as members **
- Civil society should always monitor progress of any project *
- Civil society should continuously engage with community members to sensitize them to all their right to health *
From lack of trust in institutions and individual motivations to scaled trust
Concept Sheets
Multisectoral TA Approach to Addressing Systemic Challenges

Viewing health issues as systemic challenges (health, education, amenities, infrastructure, agric, socio-economic empowerment)

- Define the problem
- Prioritize interventions
- Develop business case
- Share with donors & make sure they design multi-sectoral projects.
- Success metrics are measured by the whole, not in siloes.
- Government participates in the partner selection.

CONCEPTS:

- Priorities are set by government
- Taking a multi-sectoral approach
- Government is involved in the partner selection
Multi-Sector Multi-Level System Approach to ownership & Accountability in the health sector.
Country Owned Projects
(Design and Implementation)

- Donors bring data to the communities
- Government and CSOs develop concept notes.
- Donors fund projects (counterpart funding provided by gov)
- Project implementation committee oversees implementation.
- Improved health outcomes.

CONCEPTS:
- Donors bring data to community
- Community come up with their own project ideas
- Donors fund community-designed projects.
I-Report

A platform to allow citizens to anonymously report project performance.

- Establish anonymous channels that report to the CSOs.
- CSOs report to the MOH and the general public.
- MOH responds to the feedback.
- General public is kept updated on the progress of the gov responses.

CONCEPTS:
- Collecting project feedback from community
Name&Shame.gov

A platform to allow citizens to report issues with health projects or TA consultants in their community.

- Alerts are collected from the whole system and forwarded to the accountability desk officer at the FMOH.
- Reports are published on website and social media.
- Information is passed down back to the relevant communities and appropriate officials.

CONCEPTS:
- Collecting project feedback from community
Naija Collabo

A platform for Inter-sectoral collaboration for priority setting.

- An internal committee made up of MOE, MOWR, MOH, MOB + planning, and Ministry of Ag. gets together.
- They develop an integrated development policy and share it with the donors.

CONCEPTS:
- Priorities are set by government
- Taking a multi-sectoral approach
Nigeria’s National Annual Health Report

A report which will guide the future planning and investment in the health sector and facilitate accountability of the system actors.

- WDC PHC facility officer in charge sends data to the LGA Health Department.
- SMOH collates data.
- FMOH Planning Research Statistics disseminate the report widely so new partners understand the Nigerian Health Sector before designing project.

CONCEPTS:
- Data is collated for decision-making
- Priorities are set by government
- Priorities are widely shared
Involving the communities in selecting which ideas to implement and scaling up beyond the pilot.

- Donors bring ideas to communities.
- Representatives from the government, the community, and the facilities vote on which ideas to implement.
- Individuals from a different community are involved in the process so that once the pilot has been completed, they can replicate in their own community.

CONCEPTS:
- Community votes for which projects get implemented
- Local scale-up beyond pilot
And so what?

Using the community as sounding board to move projects beyond the pilot stage and come up with new ideas to fund.

Encourage implementing partners to share what has not worked well and work with community to re-design the approach.

1. Donors fund new ideas
2. IPs implement in a community
3. IPs get together with government and communities to document what is working and not working.
4. Plan and review the work together during review meetings.
5. Re-design and come up with new ideas.
6. Donors fund the new ideas.

CONCEPTS:
- Collecting project feedback from community
- Community-designed projects get funded
- Local scale-up beyond pilot
Naija Speaks
Share progress and project results (including capturing the community voice) and find ways to disseminate back into the communities.

- Round tables including implementing partners, donors, government, elected officers, communities.
- Radio shows to discuss/share experiences from public.
- Awards to recognize the achievements of government and donors.

CONCEPTS:
- Sharing project results with community
- Collecting project feedback from community
- Recognizing/publicizing successes
Civil Society Organizations (CSOs) Share Updates On Best Practices on Health

Using social media publicity as a way to motivate local legislators to own successful health initiatives.

1. CSOs accountability forum
2. Request for a list of constituency projects on health from National Assembly clerk.
3. CSOs create a social media voting platform. The objective is to have 10 million views on social media platforms so that legislators are motivated to be involved.
4. Best health constituency project is picked and shared on social media with the name of the legislature involved (motivation).

CONCEPTS:
- Sharing project results with community
- Linking legislator name to project
- Recognizing/publicizing successes
Concept: FUBU Report
FOR US, BY US

Countries developing its health status report to guide health programming

CHALLENGES
- compilation
- NC/MS
- donors challenges
- data collection
- compliance by all stakeholders
- policy capacity to lead across all levels

DESCRIPTION
- collect program reports at all levels
- develop health report with priority areas
- disseminate to all sectors, donors, etc.

TRADE OFFS
- accurate reporting
- no more competition (HAI/donors)
- ownership, developed by country

EXAMPLES
- setup project implementation committee at each level
- donors find priority project
- NC/MS/stakeholder priority output

Uganda
- meetings at local/stakeholder levels
- identify a desk officer to drive the process
- collect reports from stakeholders
- NC/MS at LA/NAP/Net levels
- develop LA/NAP/Net report
- send to all stakeholders
- refer to report
- for us by us
- implementation of for us by us program by stakeholders that form for us by us teams
Short term
- Map Actors
  - Design Concepts
  - Stakeholders Sensitization
  - Refine concepts based on Stakeholders Input
  - Develop Implementation framework

Medium term
- Identify and Strengthen existing platforms at all levels.
  - Publish data collected
    - Aggregated at LGA, State and Federal level
    - Community Sensitization on the project
    - Implementation
      - Feedbacks
      - Continuous Review Improvement

Long term
- Disseminating the report
- Continuous analysis of the report
  - Launching Sensitization
For Us, By Us

Challenges we are trying to address:

- **Trust**: Is a major problem in TA. Communities don’t think donors will bring money without wanting something in return. Even IP that come to work, what is the need for them? The gov themselves are not trustworthy. There is a lot of trust issues across the various actors that we have in TA for health.
- **Coordination**: We have so many programs working in health in the same areas but they don’t even know about each other, they don’t know each other.
- **Competition**: There is so much competition because every partner, esp the IPs that are being funded, they want to claim that they have achieved x y z so they get more money from donors
- **Power dynamics**: What is currently happening, donors have a lot of power because they bring in the money. What we want to do is shift the dynamics to make sure that the country (the community actors, states, fed gov) should own the project. Own the power.

Objective:

- For Nigeria to develop its own health priorities, it's own health issues that everyone, including donors would focus on.
Concept: Transform Naija