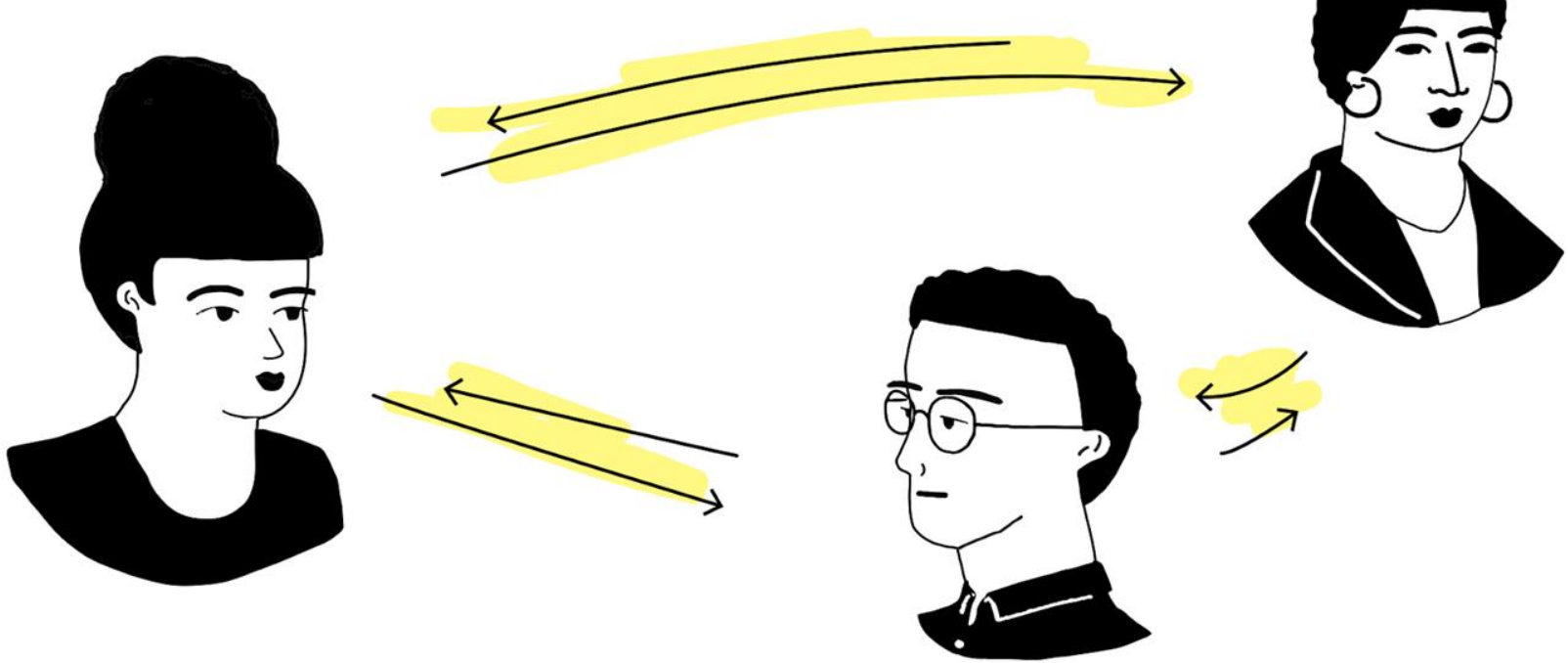


Design Sprint to Re-imagine TA in Nigeria

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)*

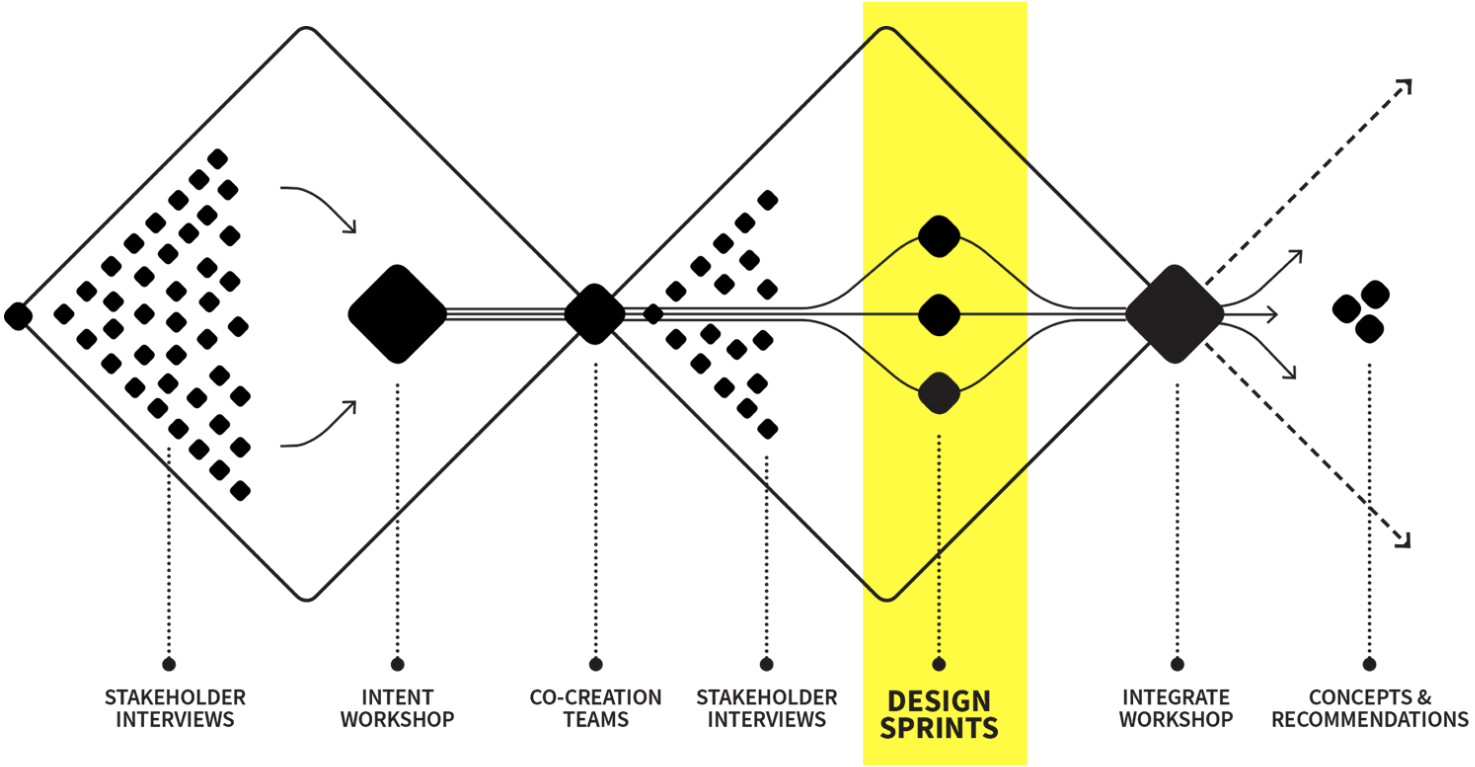
Visitor introductions & orientation
Concept pitches & feedback
Discussion: Additional opportunities & the future of TA in Nigeria

13:00 - Lunch

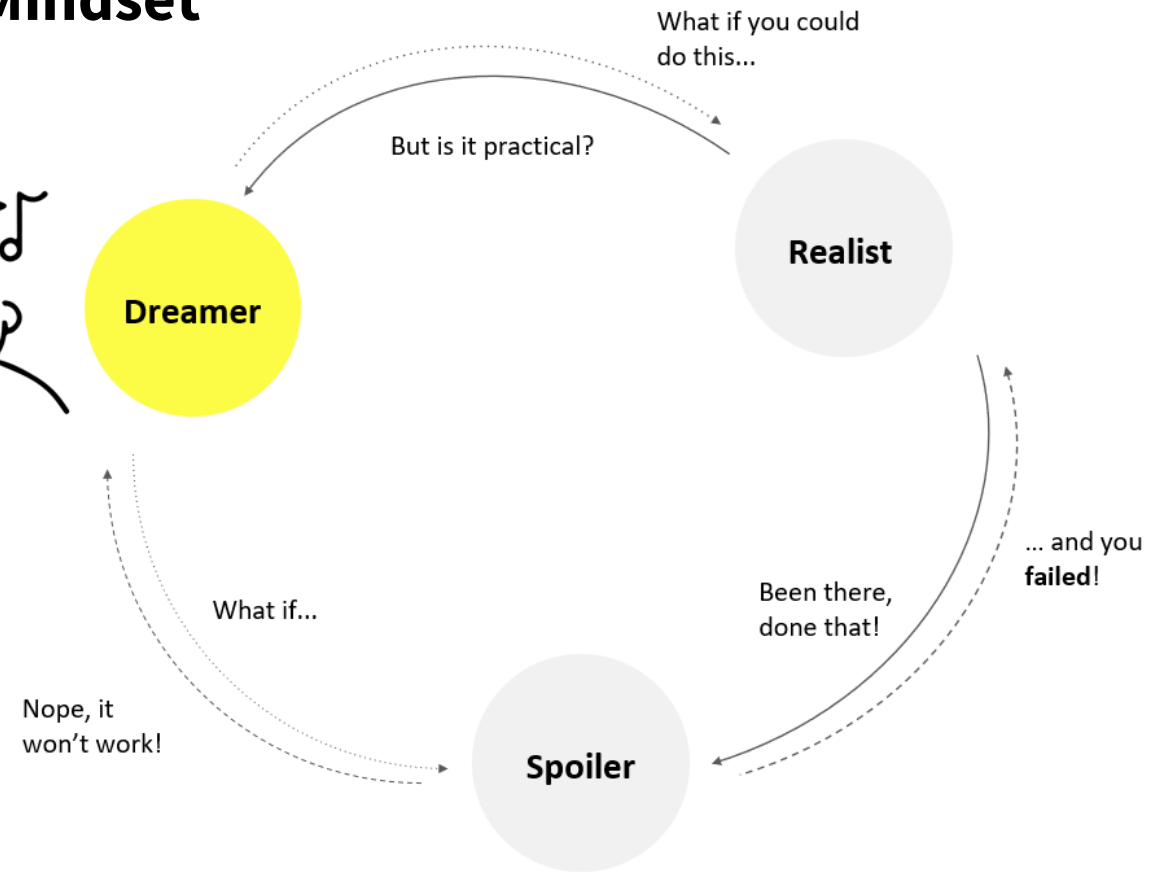
Concept refinement & planning
Considering a systems change
Next Steps

16:30

Re-Imagining Process



Designer Mindset

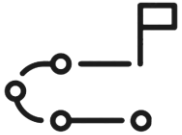


Tips for our time together

Be present

Defer judgement

Embrace the pace



Trust the process

Use the tools

Be optimistic

Emerging Principles: Good TA should...

Create conditions for collaboration

Align on common purpose and success

How might we better understand the drivers and outcomes for all parties to align criteria for purpose and success?

Leverage local wisdom

How might we amplify the voice of local wisdom to ensure better understanding of local context and needs?

Build mechanisms of accountability

How might better accountability build trust and create strong feedback loops across the system?

Shift from buying solutions to owning problems

What does it mean to shift from a fragmented solution focus, to an aligned problem focus ?

Strengthen feedback loops

How might we ensures knowledge and data is distributed in a way that is more accessible to empower individuals to make requests and decisions?

Scale trust

How might we better understand the mechanisms of trust to ensure that time for building trust is an intrinsic component of a TA process?

Resist the quick fix

Slow down

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?

Consider the system as a whole

TA is a constellation of interconnected systems, each with its own set of unique properties. How do consider the whole system and its interdependencies?

Balance individual gain with collective good for mutual benefit

How might we change incentive structures to ensure that individual gain contributes to collective benefit?

Design for resilience

Distribute ownership

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?

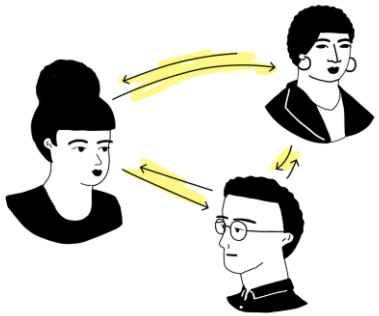
Reduce dependencies that perpetuate short-termism

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?

Standardize the core, tinker around the edge

How do we streamline core TA functions while preserving diversity at the edges?

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

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

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

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 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 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

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

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

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.
FMOH

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.
FMOH

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.
FMOH

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. FMOH

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.
FMOH

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
FMOH

Ownership

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?
Dept HPRS, FMOH

Ownership means you can't start the project with your mandate without government approval and participation.
FMOH Child Health Division

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

The 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. Partner

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

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 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

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

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

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

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

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 transfered 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 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*

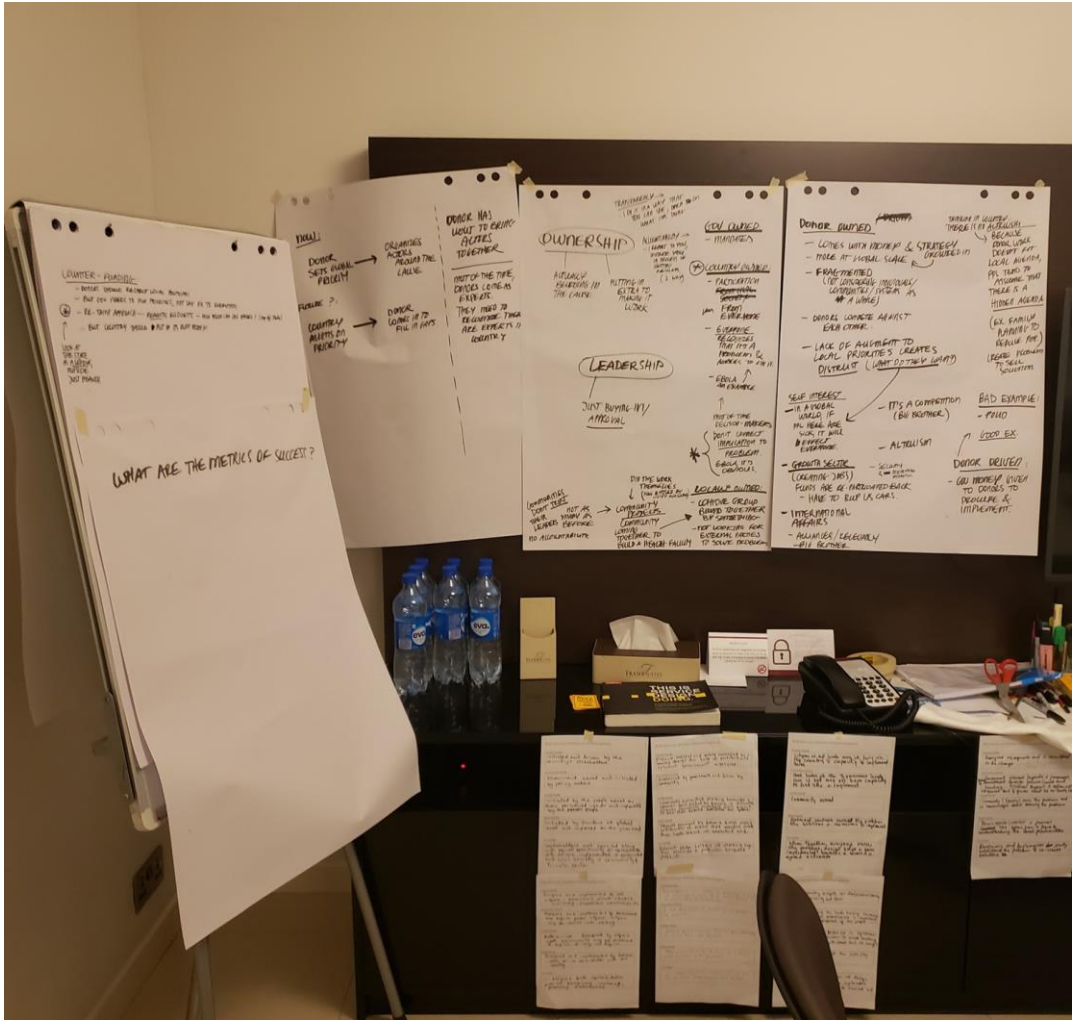
We do not have a strong accountability for implementing partners because their MOU is with the donors. Without a tripartite agreement we can't hold to account.

Dept HPRS, FMOH

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

Dept HPRS, FMOH


AGREEMENTS ARE MADE.
NEEDS ARE IDENTIFIED
- WHAT ACTIVITIES
- WHICH STATES
HOME COUNTRY
INITIATIVE IS DESIGNED
IMPLEMENTATION STARTS
M & E
PROJECT ENDS
DISSEMINATION
DONOR
DATA
CONTRACT
GLOBAL AGENDA
ANALYSIS & INSIGHTS
RFP/ RFC/ RFA
PROPOSAL
SUSTAINABILITY PLAN
COOPERATION AGREEMENT
MOU
STATE GOVERNOR
IMPLEMENTER
(LOCAL) IMPLEMENTER
PERFORMANCE REVIEW
SUB-GRANT AGREEMENT
PERFORMANCE FRAMEWORK & PLAN
FED & MOH
LGA GOV
SUPPLIES
TRAINING MANUAL
END OF PROJECT EVAL.
REPORT
SUSTAINABILITY PLAN
ANALYSIS & INSIGHTS
DATA
TRAINING MANUAL
DRIVE DEMAND
CIVIL SOCIETY ORGS
PROFESSIONAL ASSOC.
HEALTH FACILITIES
HEALTH SERVICES
CASH TRANSFERS
COMMUNITY LEADERS
STAKEHOLDERS
PEOPLE
ACCOUNTABILITY FRAMEWORK
LETTER OF SUPPORT
STRATEGIC PLAN
WORK-SHOP
SMOH
FMOH
BASKET FUND
PLANNING OFFICER DPRS
COSTED WORK PLAN
STRATEGIC PLAN
REPORT



Defining key terms

country owned	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.
government owned	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.
locally owned	Cohesive group bound together. Not looking for external parties to solve problems.
donor owned	Whoever plays the tune – they have the $ so we don't have the power so we did not take leadership.
co-created	Can have external stakeholders. Co-creation is the beginning.

DONOR

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

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

Imperatives/Mandatory - IDEAL Identify and solve problems Provide enabling environment Proper funds appropriation Provide strategic plan to guide implementation Feedback loop	**Roles - IDEAL** Change attitudes of community through empowerment (information) Own projects to achieve and solve problems of the community
Behavior - IDEAL Misplaced priorities Not owning project and not coordinating Not transparent	**Enabling environment - IDEAL** Ownership Understanding the needs of the population and appropriately address them as well as prioritize
Success changing the lives of people reporting valid data seen physical improvements align with partners to achieve a common goal	**Undesirable (things that compromise their functions)** Lack of funding Insecurity Lack of ownership Poor M&E Poor accountability

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

IMPLEMENTER

Imperatives/Mandatory - IDEAL Donor funding Rules and regulations of donor Alignment with org priorities Accountable to donors collaboration with government and community counterparts Security	**Roles - IDEAL** Strengthen capacity Technical support Implement donor strategies
Behavior - IDEAL Alignment with local priorities and policies Work with established systems Us local resources Human capacity development Good understanding of local context Coordination with other IPs Strengthening existing system Demonstrate tested practices Joint planning, implementation, monitoring with stakeholders	**Enabling environment - IDEAL** Donor funds Enabling environments (policy and government commitments) Donor responsiveness
Success Achieve results Demonstrate attribute Demo viability Good working relationship with government stakeholders	**Undesirable (things that compromise their functions)** Lack of donor flexibility Lack of adequate information Governments not being open to new ideas and change

interactions with the rest of the system:

- 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

Imperatives/Mandatory - IDEAL	**Roles - IDEAL**
Need to follow protocol Set regulations Approve programs and project implementation Top down approaches	To provide guidance for implementation - Policies and training guidelines Accountability - Monitoring and supervision - Data collation to follow programs - Feedback to state governments Ensure donors align with national priorities Leadership and ownership - Program design and evaluation - Coordination Laws and regulation
Behavior - IDEAL Current Too slow Bureaucratic Rigid in budget planning FUTURE Open to change Own problems Be accountable to the people	**Enabling environment - IDEAL** Ensure enough resources available to ensure phc is functioning Funding allocated released and utilized appropriately Roles clearly defined Allow for innovation Willingness to change Efficiency
Success Achieving SDGs Achieving country targets Effective coordination of partner/donor activities Effectively tracking progress	**Undesirable (things that compromise their functions)** Poor knowledge of donor/IP activities Poor leadership Poor coordination Top down planning Implementing (state level)

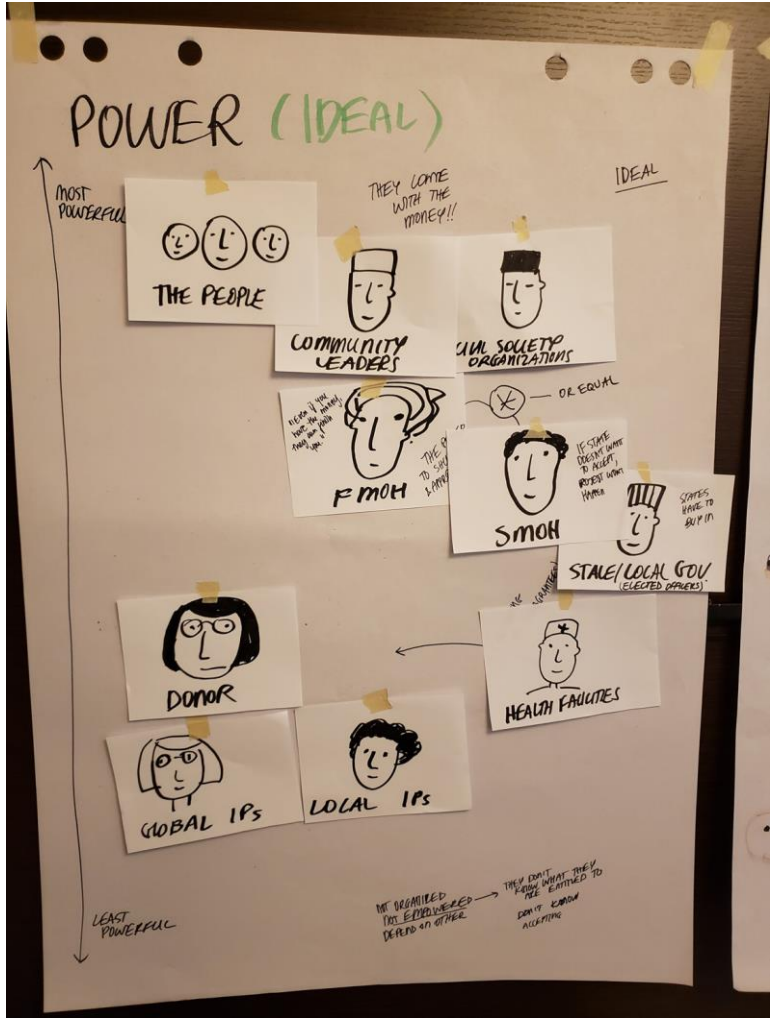
- Development of policies and guidelines/ Policy formulation/technical policy guidance
- Co-creation with implementers
- Resource mobilization (funding and TA requests, counterpart funding where needed)
- Advocacy (to state government, multiple stakeholders)
- Capacity building of states/technical support to states
- Coordinate donors, IPs and stakeholders
- Data and results, monitoring and evaluation, research, evidence generation

HEALTH FACILITIES

Imperatives/Mandatory - IDEAL Differs based on ownership (private, public, faith based, not for profit) Not autonomous (receive direction from government) Provide healthcare	**Roles - IDEAL** Provide healthcare services Respond to outbreaks and other health needs of the local community Report health statistics (data)
Behavior - IDEAL Should follow protocols and guidelines Should be patient centered Should be accountable	**Enabling environment - IDEAL** Good infrastructure and equipment Funding (operating expenses) Adequate and skilled staff Adequate remuneration and working conditions Trainings and regular update through CPDs
Success Improve health outcomes of the local community Adopt better health seeking behavior Improve waiting time Improved quality of care	**Undesirable (things that compromise their functions)** Poor funding by government Inability to follow protocols and guidelines by healthcare workers Government prioritizing income yielding sectors Multiple projects reporting requirements

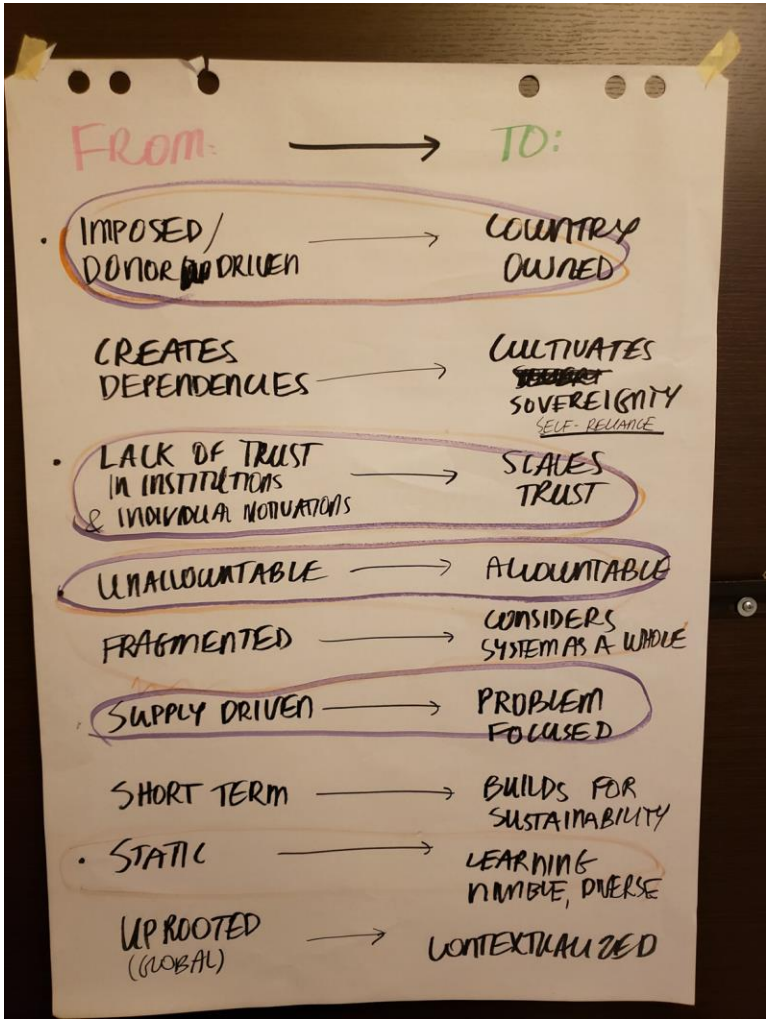
- Outreach – health education
- Direct implementation of TA support
- Logistics
- Procure commodities
- Request TA from IPs
- Providing HR for training
- Providing data for monitoring and decision making; compile and submit data
- Receive supervision
- Receive instructions around guidelines and protocols


POWER
MOST POWERFUL
IDEAL
THEY COME WITH THE MONEY!!
DONOR
THE POWER TO SHUT YOU & AMBOYE
FMOH
STATES HAVE TO BUY IN
STATE/LOCAL GOV. (ELECTED OFFICERS)
IF STATE DOESN'T WANT TO ACCEPT, PROJECT WON'T HAPPEN
SMOH
GLOBAL IPs
LOCAL IPs
ARE GLOBAL IPs (USAID/PEPFAR)
CIVIL SOCIETY ORGANIZATIONS
HEALTH FACILITIES
COMMUNITY LEADERS
LEAST POWERFUL
THE PEOPLE
NOT ORGANIZED FOR EMPOWERED DEPEND ON OTHER
THEY DON'T KNOW WHAT THEY ARE ENTITLED TO DON'T DEMAND ACCEPTING


POWER (IDEAL)
MOST POWERFUL
IDEAL
THEY COME WITH THE MONEY!!
THE PEOPLE
COMMUNITY LEADERS
CIVIL SOCIETY ORGANIZATIONS
OR EQUAL
FMOH
SMOH
STATE/LOCAL GOV. (ELECTED OFFICERS)
DONOR
HEALTH FACILITIES
GLOBAL IPs
LOCAL IPs
LEAST POWERFUL
NOT ORGANIZED FOR EMPOWERED DEPEND ON OTHER
THEY DON'T KNOW WHAT THEY ARE ENTITLED TO DON'T DEMAND ACCEPTING


BUILD MECHANISMS OF ACCOUNTABILITY
How might ● better Accountability build trust & create strong feedback loops across the system?
SCALE TRUST
How might we better understand the mechanisms of trust to ensure that it is an intrinsic component of the TA process?
ALIGN ON Common Purpose & Success
How might we better understand the drivers & outcomes for all parties to align criteria for purpose & success?
DISTRIBUTE OWNERSHIP
How might these processes become more inclusive to include state (DH), health providers & communities?
CONSIDER THE SYSTEM AS A WHOLE
How might we shift away from fragmented/siloed projects to more comprehensive system-wide initiatives?
SLOW DOWN
How might we shift priorities and goals from treating always the certainty of short term efficiency to the possibility of implementing the system in the long run?
STANDARDIZE THE CORE, TINKER AROUND THE EDGE
How do we streamline TA functions while preserving diversity at the edges?
STRENGTHEN FEEDBACK LOOPS
How might we ensure knowledge & data is distributed in a way that is more accessible to empower individuals to make requests & decisions?
REDUCE DEPENDENCIES THAT PERPETUATE SHORT-TERMISM
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?
LEVERAGE LOCAL WISDOM
How might we amplify the voice of local wisdom to ensure better understanding of local context & needs?
SHIFT FROM BUYING SOLUTIONS TO OWNING PROBLEMS
How might we use a more bottom-up approach based on local community priorities rather than coming in with siloed cookie cutter solutions?
BALANCE INDIVIDUAL GAIN WITH COLLECTIVE GOOD FOR MUTUAL BENEFIT
How might we change incentive structures to ensure that individual gain contributes to collective benefit?
SCALED TRUST

Concept Brainstorm (critical shifts)


FROM: → TO:
IMPOSED / DONOR DRIVEN → COUNTRY OWNED
CREATES DEPENDENCIES → CULTIVATES SOVEREIGNTY
SELF-RELIANCE
LACK OF TRUST IN INSTITUTIONS & INDIVIDUAL MOTIVATIONS → SCALES TRUST
UNACCOUNTABLE → ACCOUNTABLE
FRAGMENTED → CONSIDERS SYSTEMS AS A WHOLE
SUPPLY DRIVEN → PROBLEM FOCUSED
SHORT TERM → BUILDS FOR SUSTAINABILITY
STATIC → LEARNING NIMBLE, DIVERSE
UPROOTED (GLOBAL) → 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 collab 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
- FMH 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

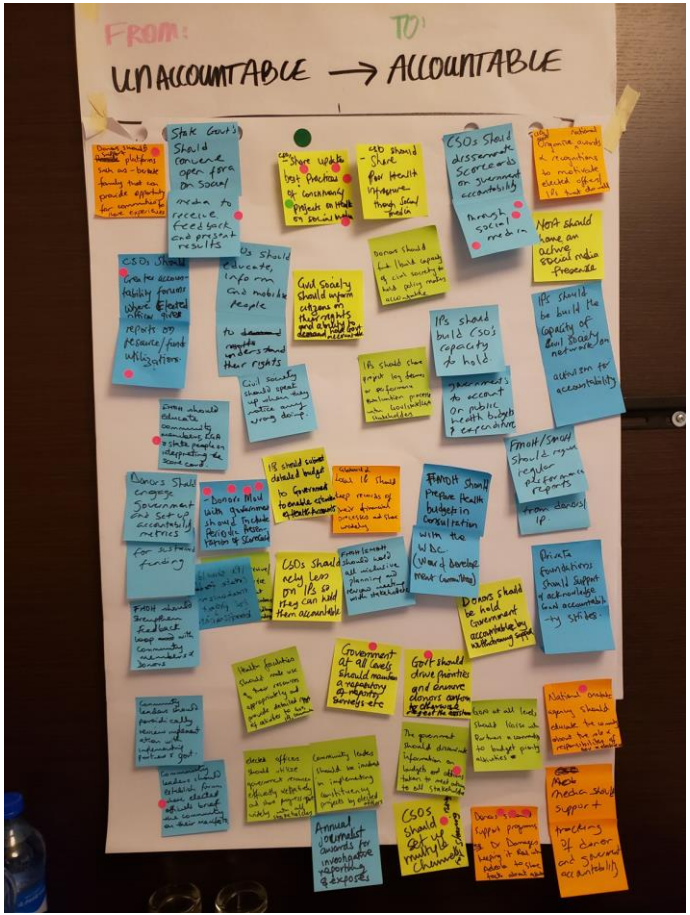
- Community leaders should accept only those interventions they think will work in their context
- Citizens should demand quality care
- CSOs sensitize people to ask for their rights **

From lack of trust in institutions and individual motivations to scaled trust

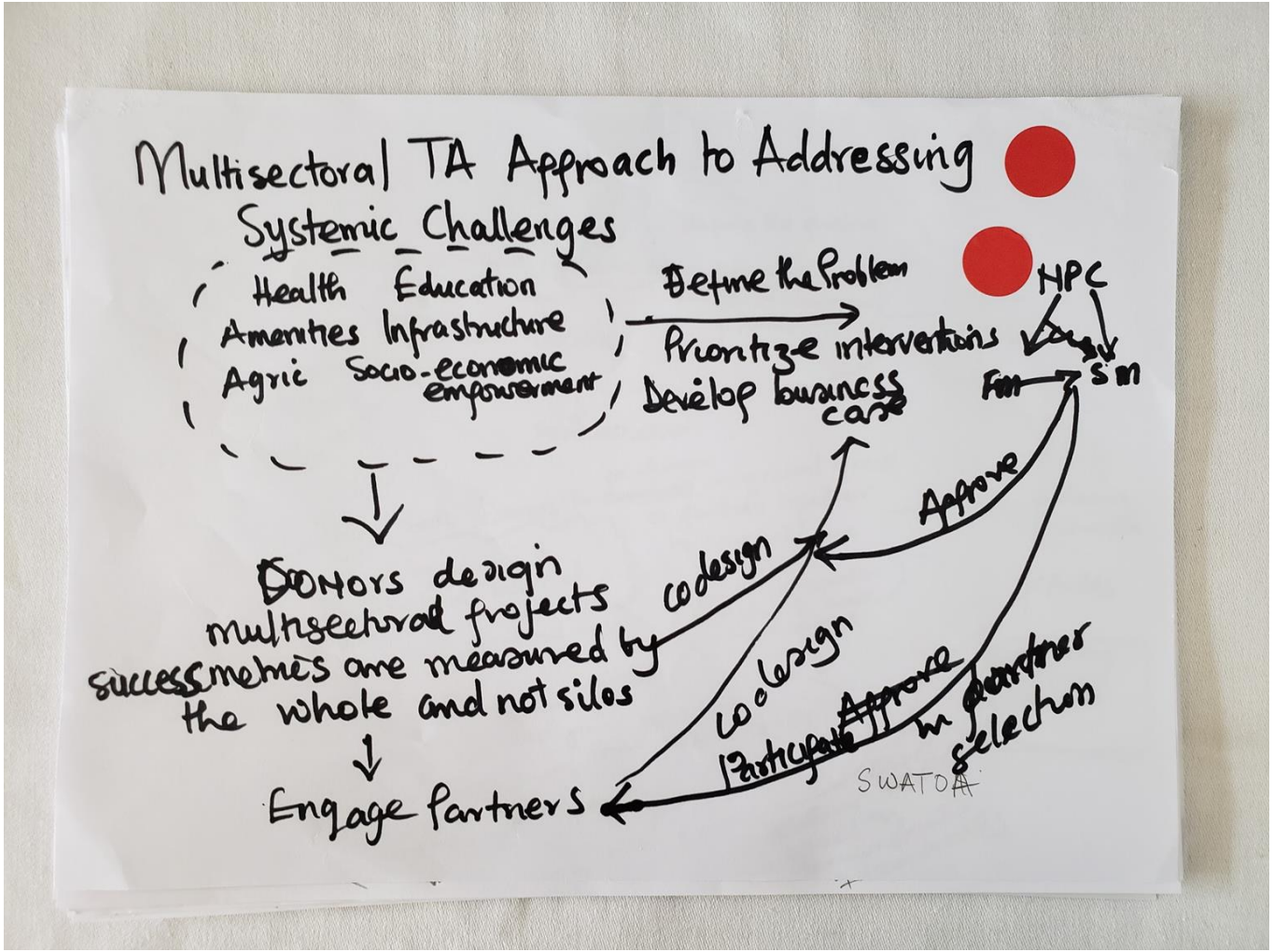
- Donors should break down cost to let FMOH/SMOH know how much is spent on actual health system or service delivery activities
- Donors should share a detailed breakdown of budget **
- Coordination and collaboration of all stakeholders should be done at all times to strengthen the system *
- Donors/IPs 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



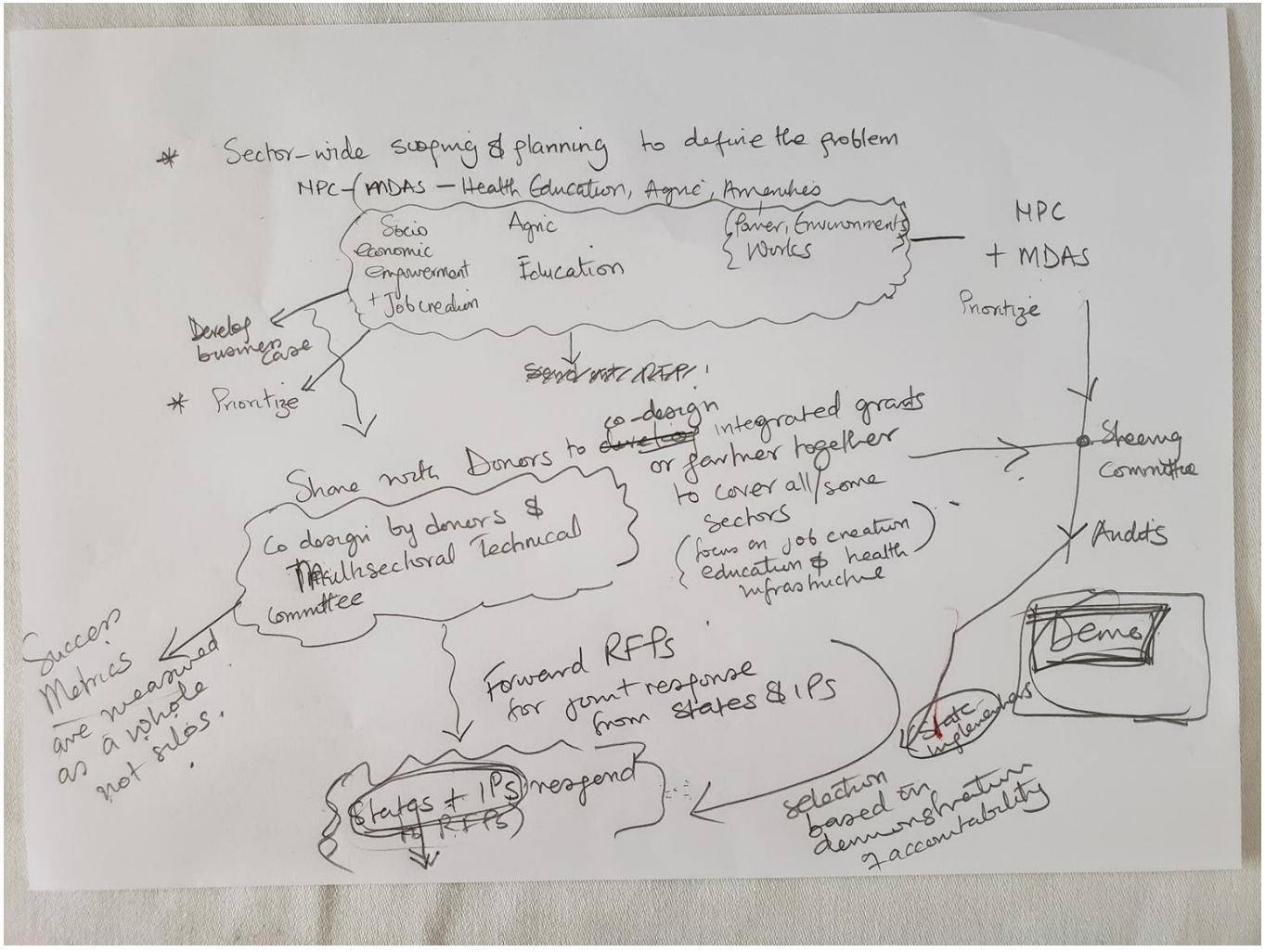
Multisectoral TA Approach to Addressing Systemic Challenges

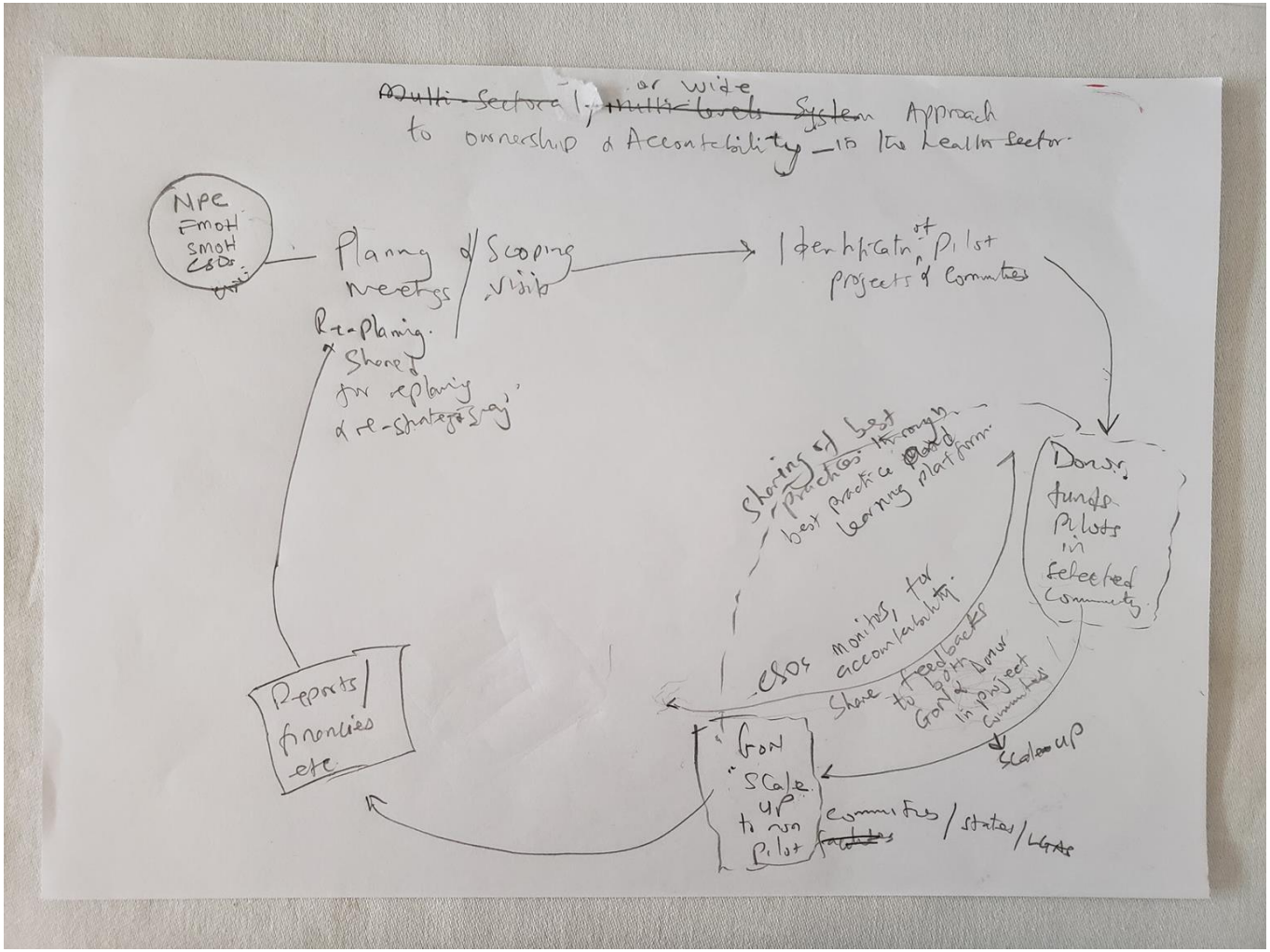
Viewing health issues as systemic challenges (health, education, amenities, infrastructure, agric, socio-economic empowerment)

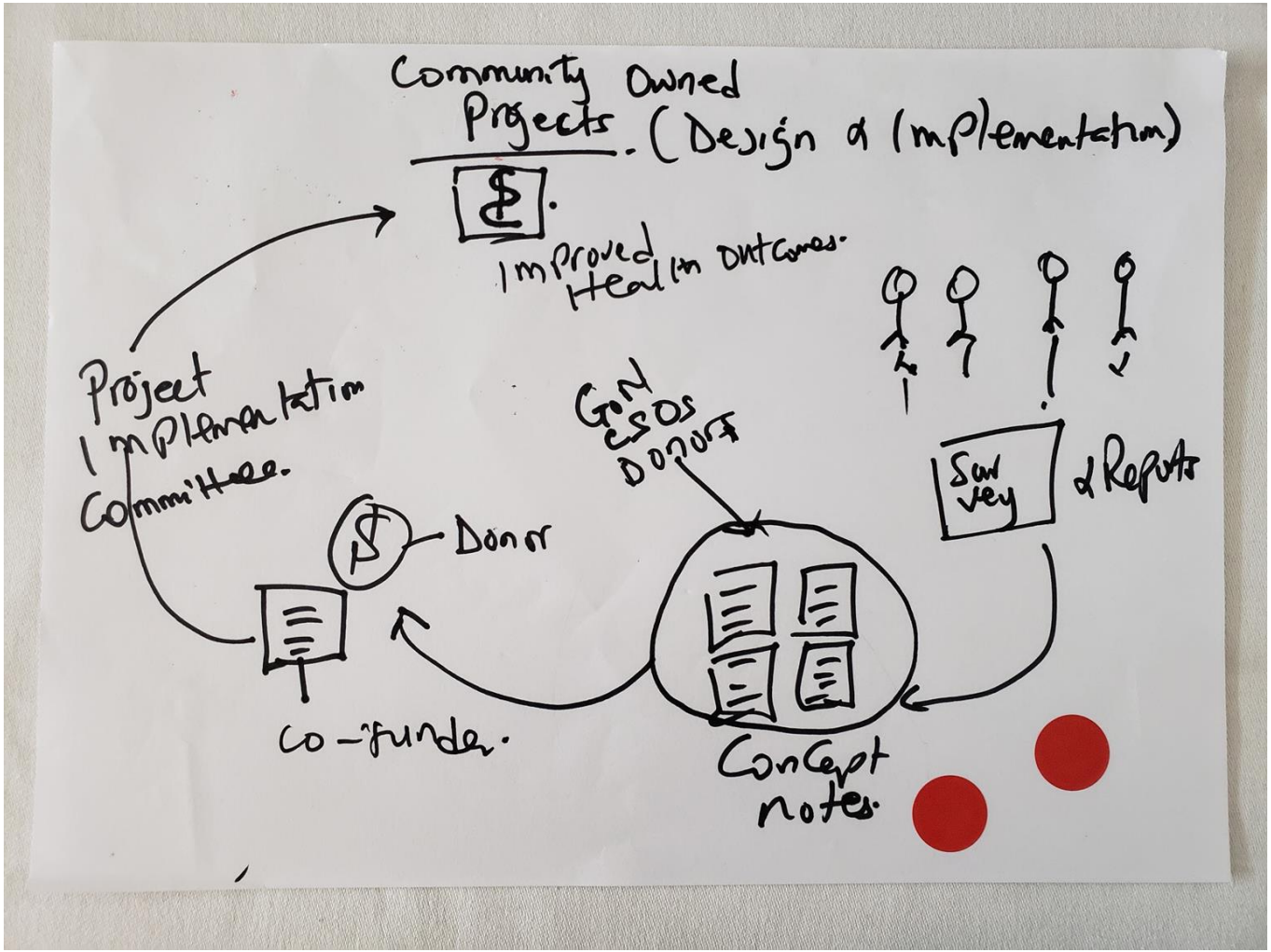
- Define the problem
- Prioritize interventions
- Develop business case
- Share with donors & make sure they design multi sectoral projects.
- Success metrics are measured by the whole, not in siloes.
- Government participates in the partner selection.

CONCEPTS:

- Priorities are set by government
- Taking a multi-sectoral approach
- Government is involved in the partner selection


* Sector-wide scoping & planning to define the problem
NPC – MDAs – Health Education, Agric, Amenities
Socio Economic Empowerment + Job creation
Agric
Education
Power, Environment, Works
NPC + MDAs
Develop business case
* Prioritize
Prioritize
Share with Donors to co-design integrated grants or partner together to cover all/some sectors
(focus on job creation education & health infrastructure)
Steering committee
Audits
Co design by donors & MDAs/sectoral Technical committee
Success Metrics are measured as a whole not silos.
Forward RFPs for joint response from States & IPs
Demo
State implementation
States + IPs respond to RFPs
selection based on demonstration + accountability


Multi-Sectoral / Multi-levels System or Wide Approach
to ownership & Accountability in the Health Sector.
NPC
FMoH
SMoH
CSOs
Planning / Scoping meetings / visits
Identification of Pilot Projects & Communities
Re-Planning. Share for replanning & re-strategising
Sharing of best practices through best practice learning platform.
Donors funds Pilots in selected Communities
CSOs monitors for accountability
Share feedbacks to both Donor & GoN & Project in project Communities
Reports / finances etc
GoN "Scale up to non Pilot" communities / States / LGAs
Scale up

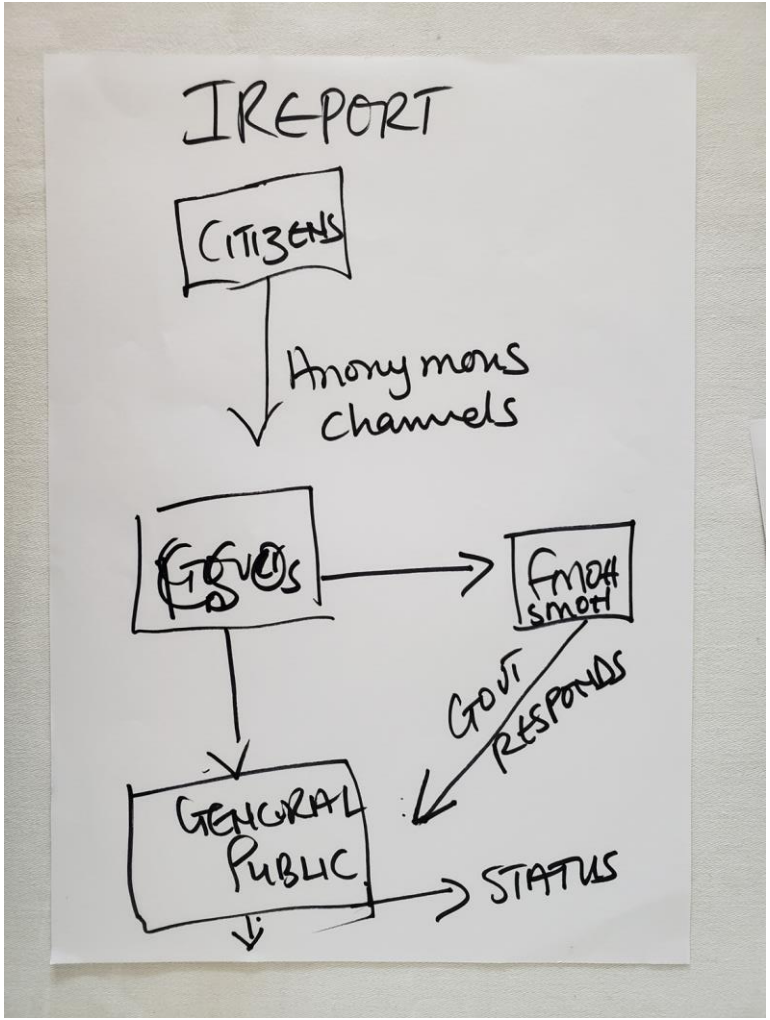


Country Owned Projects (Design and Implementation)

- 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.



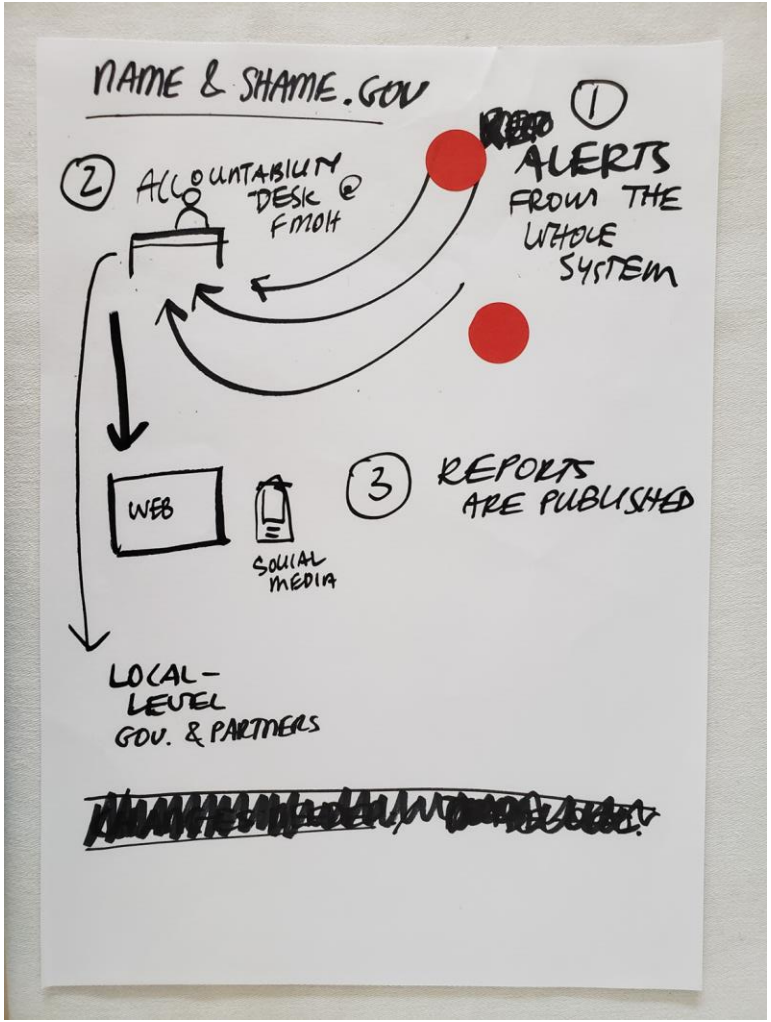
I-Report

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



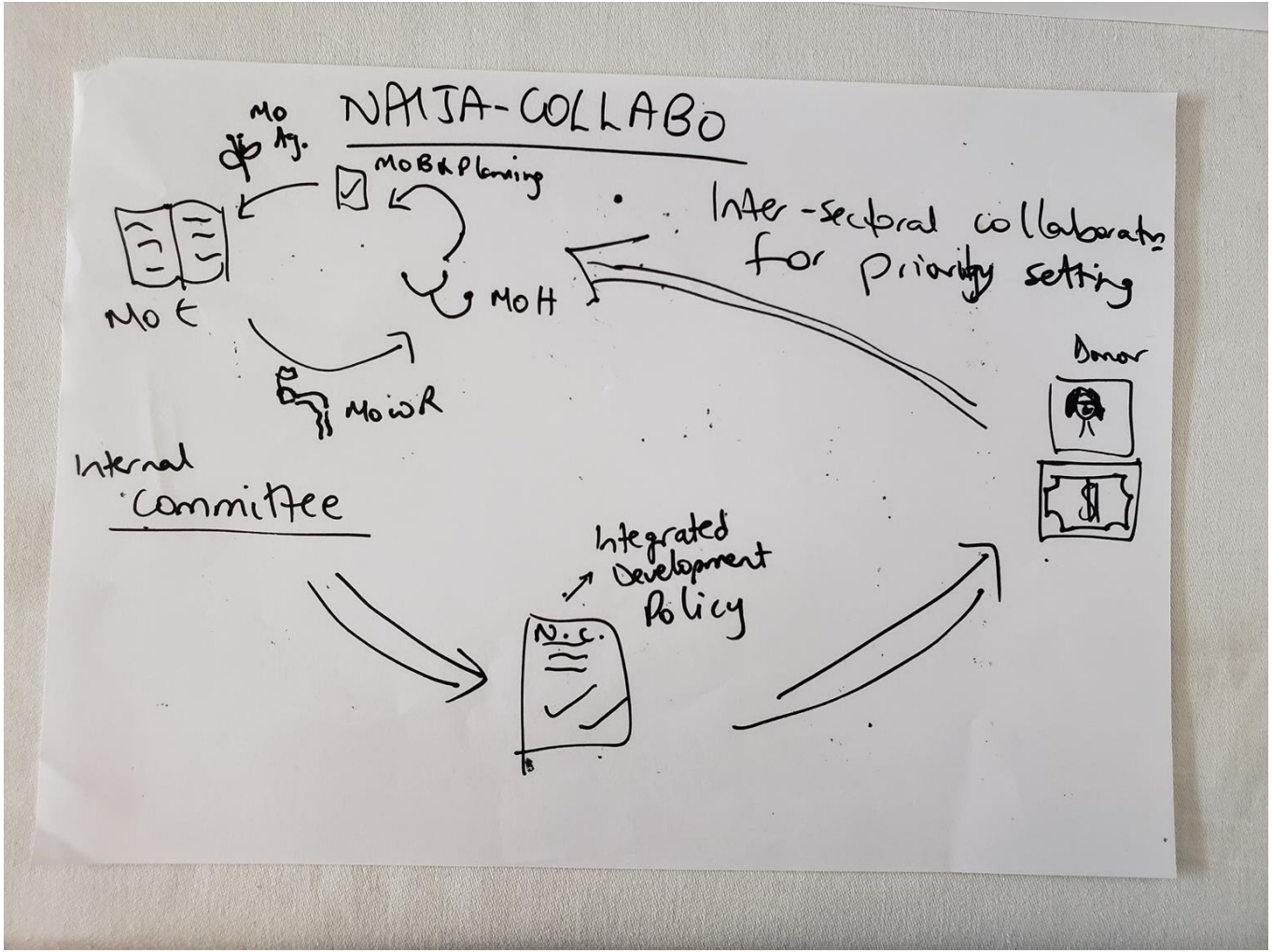
Name&Shame.gov

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



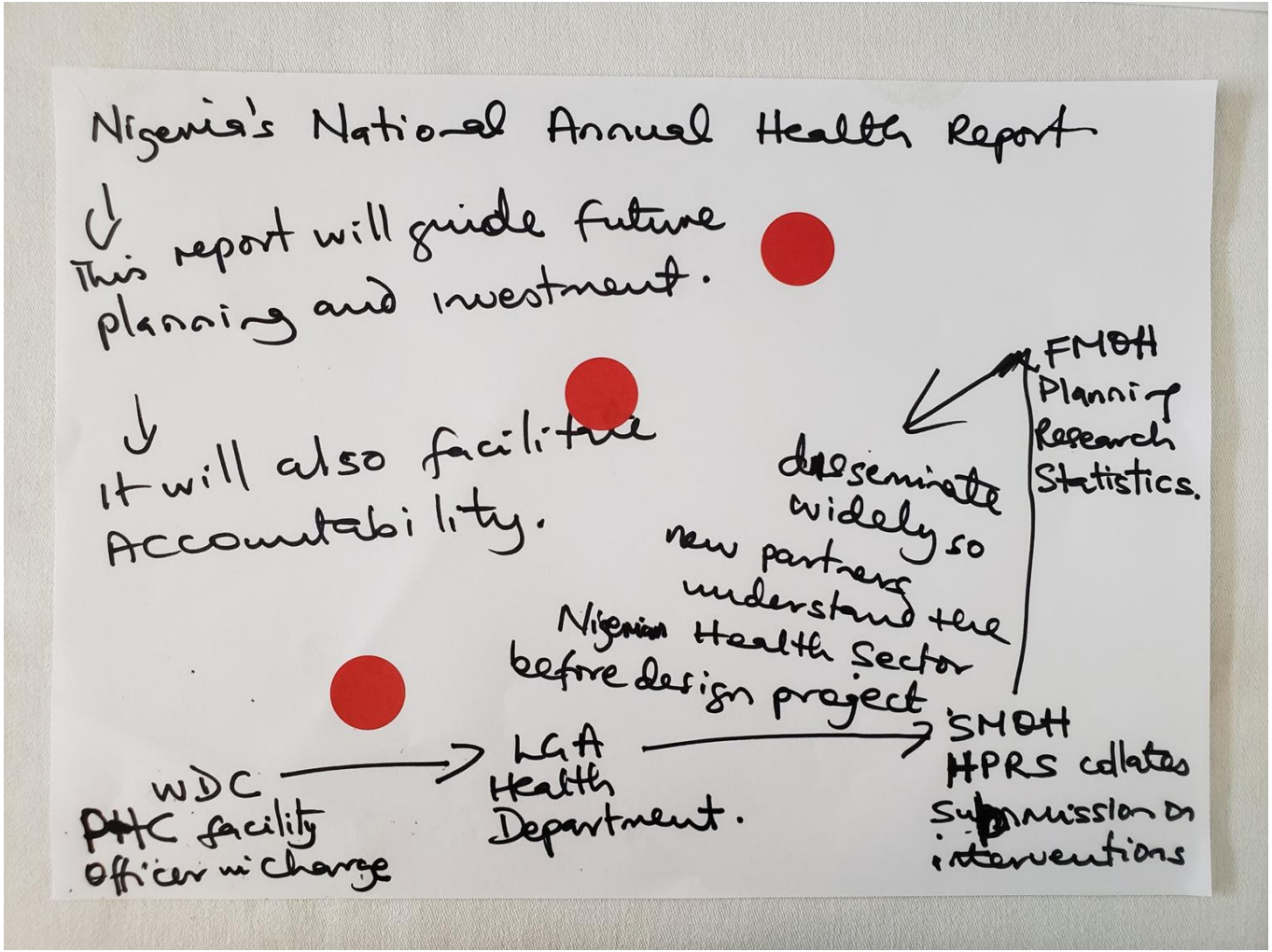
Naija Collabo

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



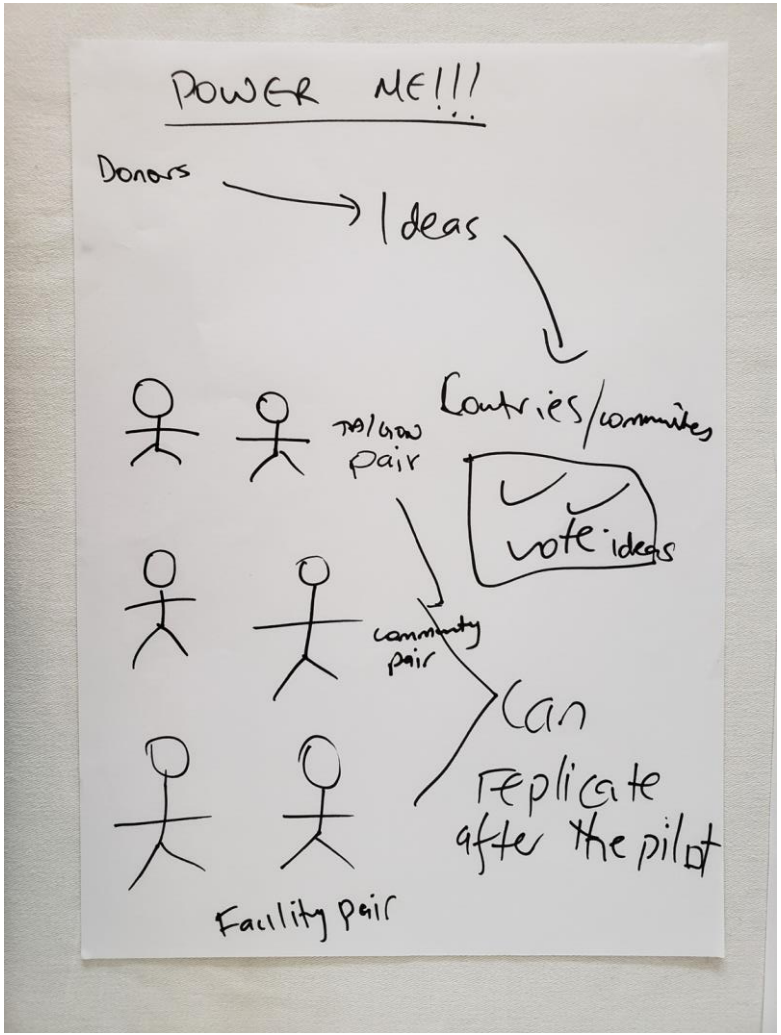
Nigeria's National Annual Health Report

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



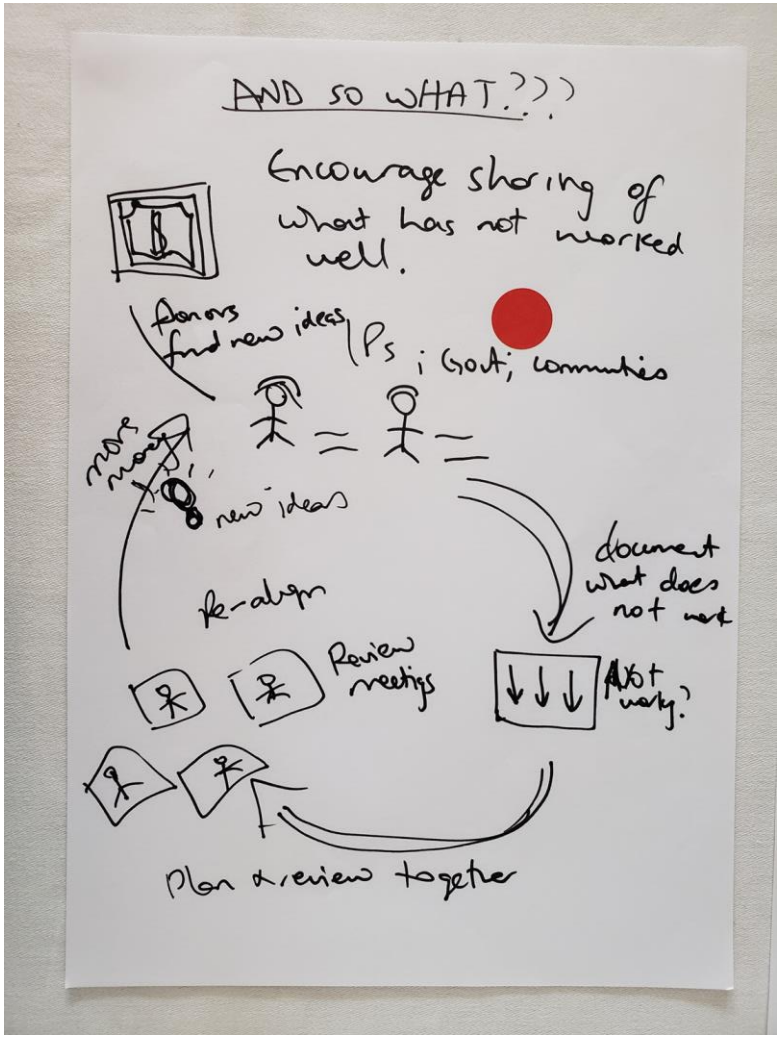
Power Me

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?

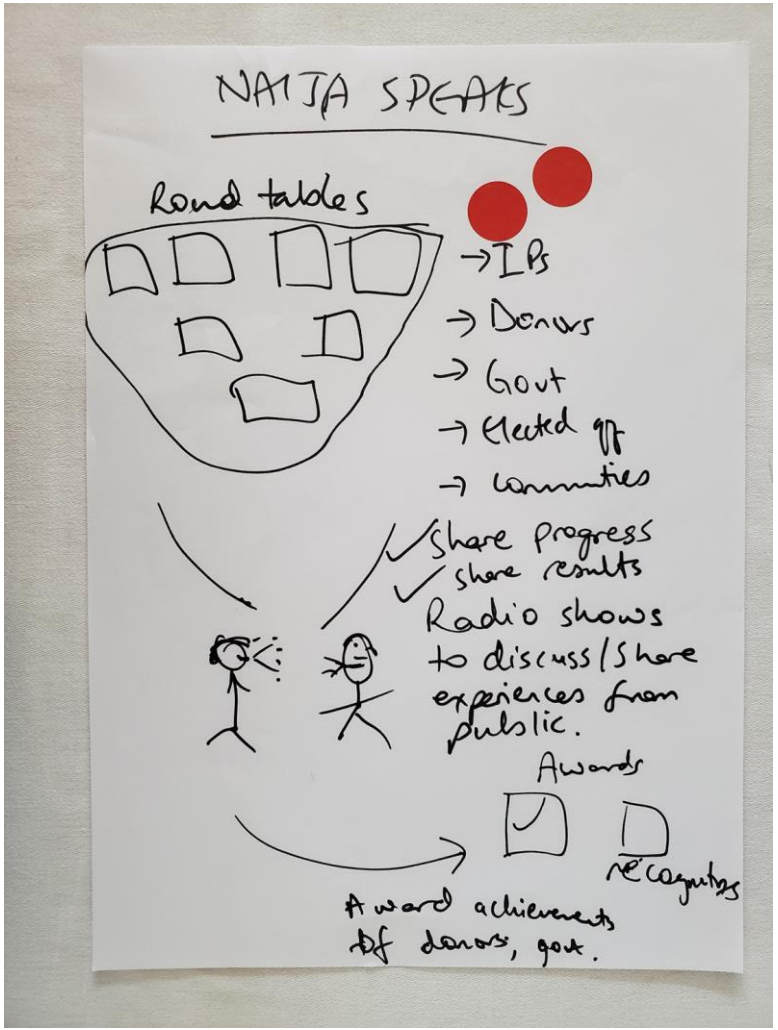
Using the community as sounding board to move projects beyond the pilot stage and come up with new ideas to fund.

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



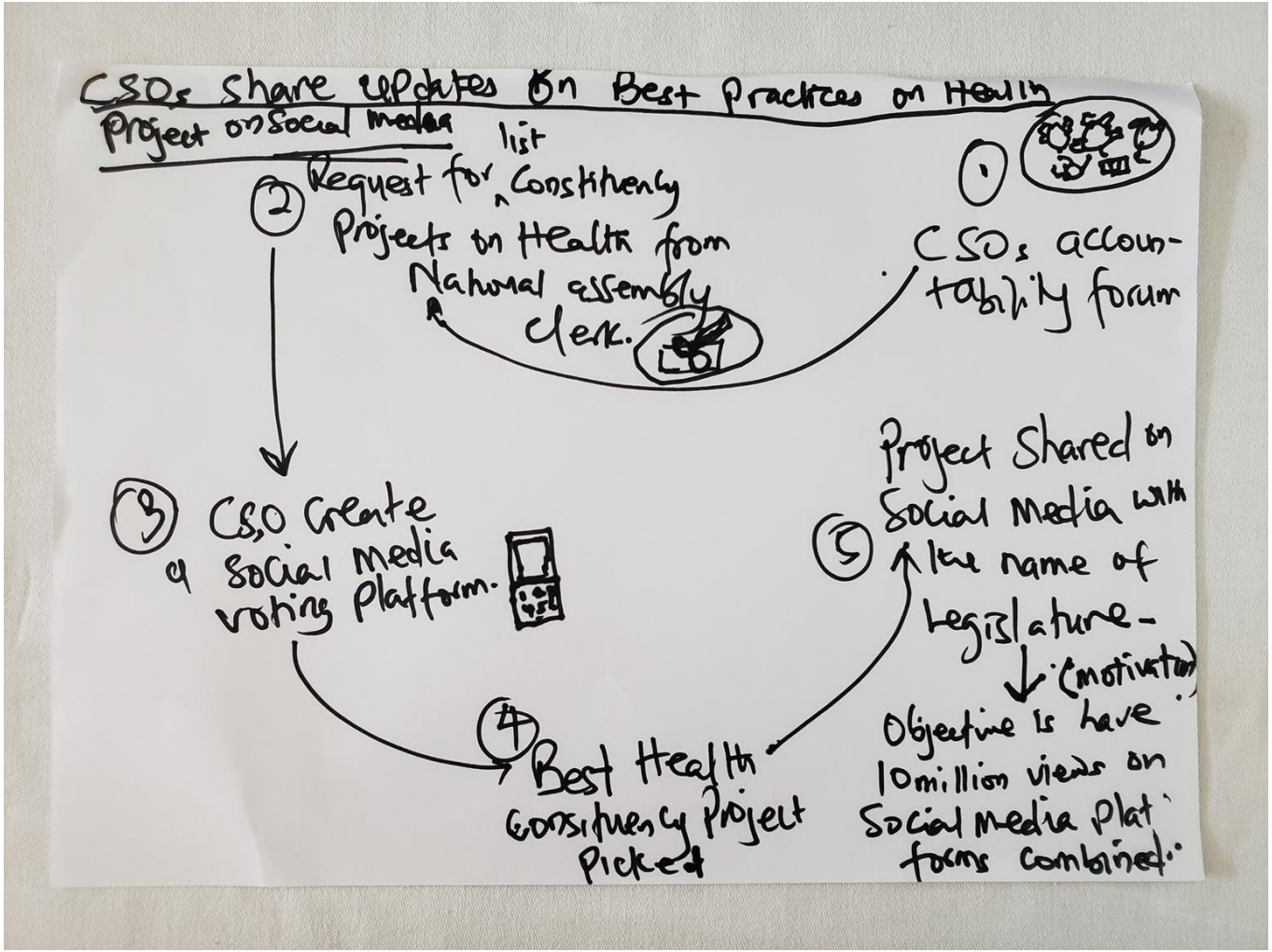
Naija Speaks

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

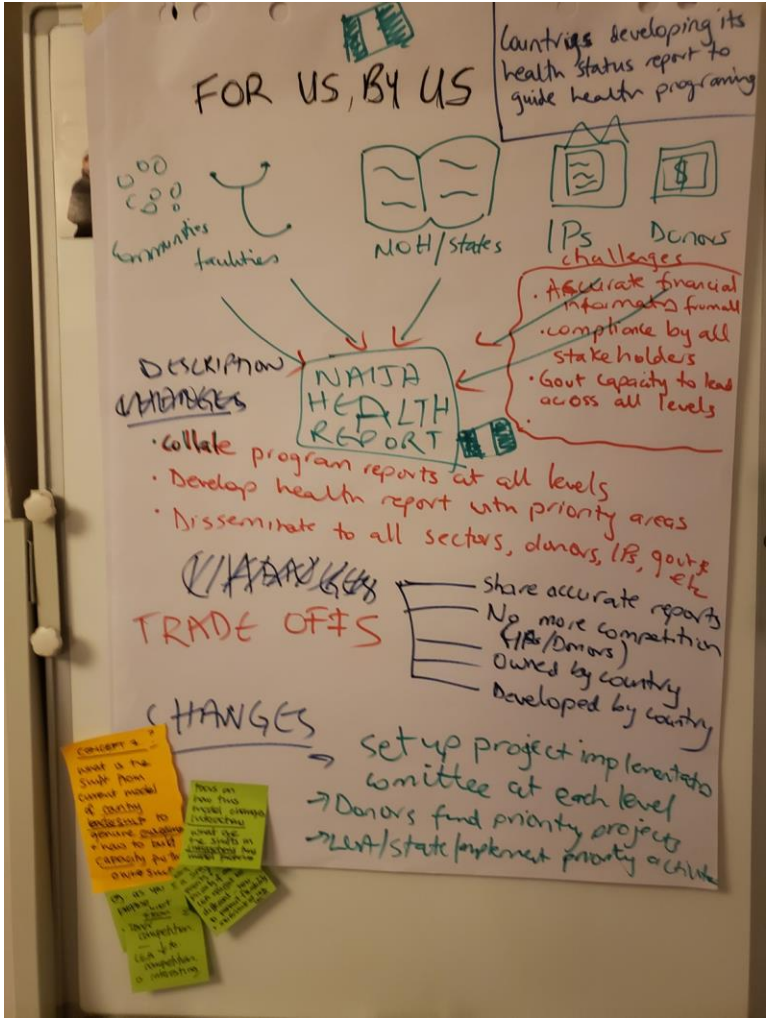
Using social media publicity as a way to motivate local legislators to own successful health initiatives.

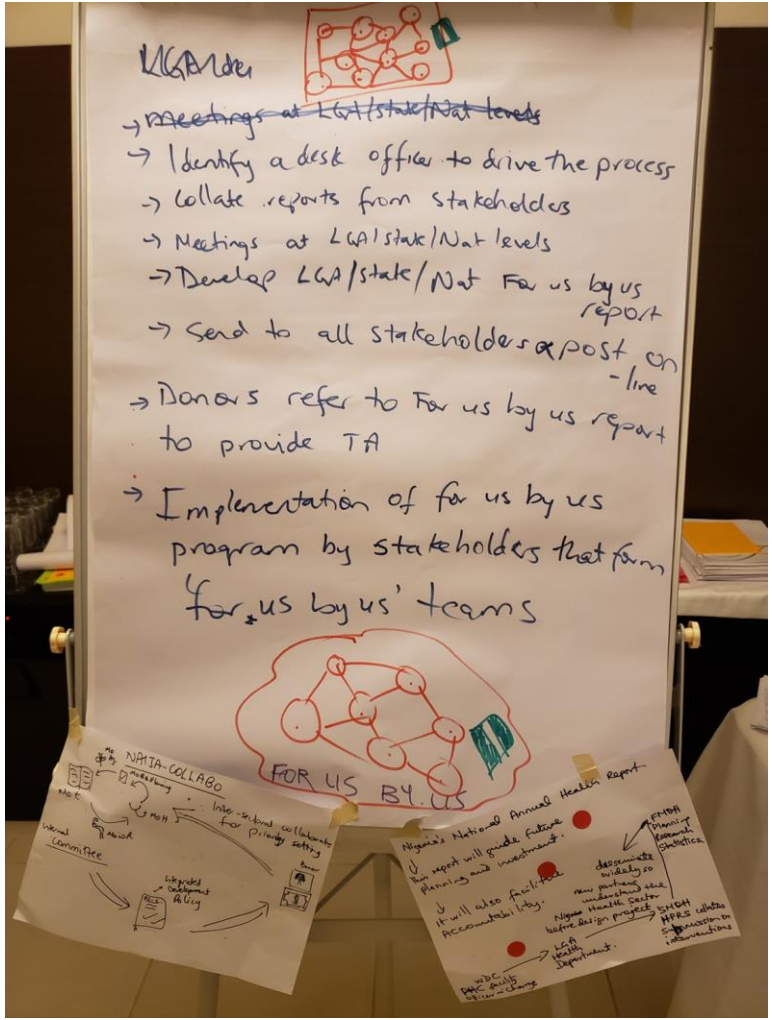
1. CSOs accountability forum
2. Request for a list of constituency projects on health from National Assembly clerk.
3. CSOs create a social media voting platform. The objective is to have 10 million views on social media platforms so that legislators are motivated to be involved.
4. Best health constituency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

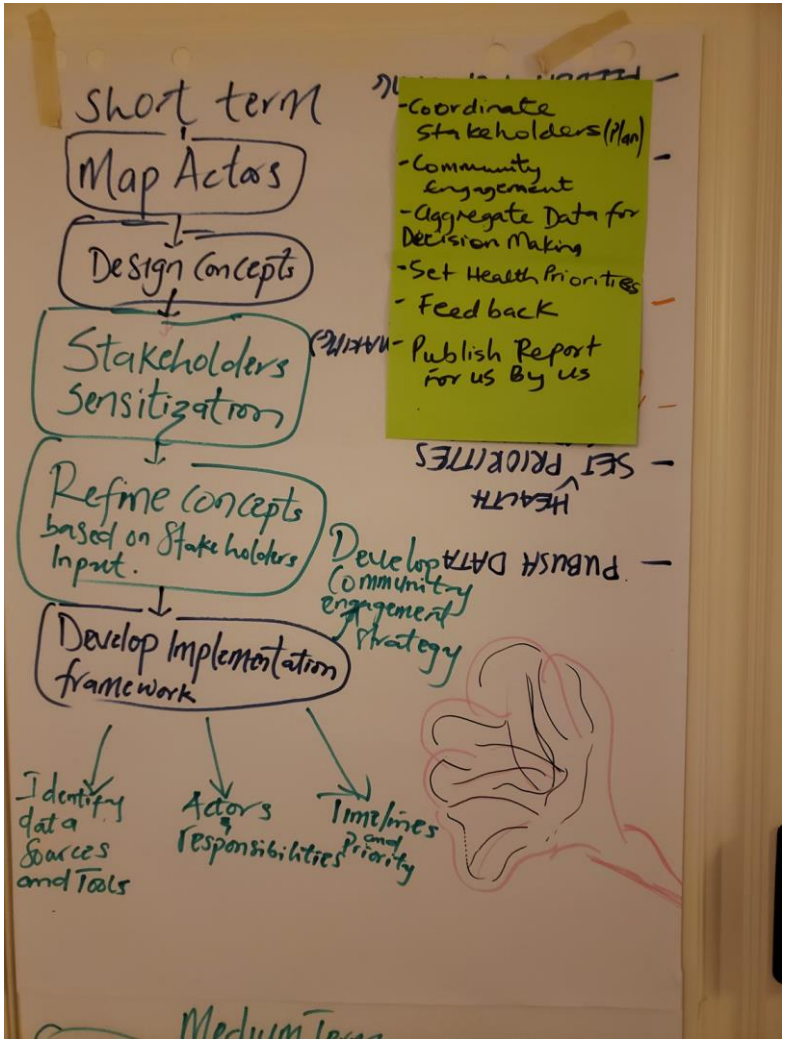
CONCEPTS:

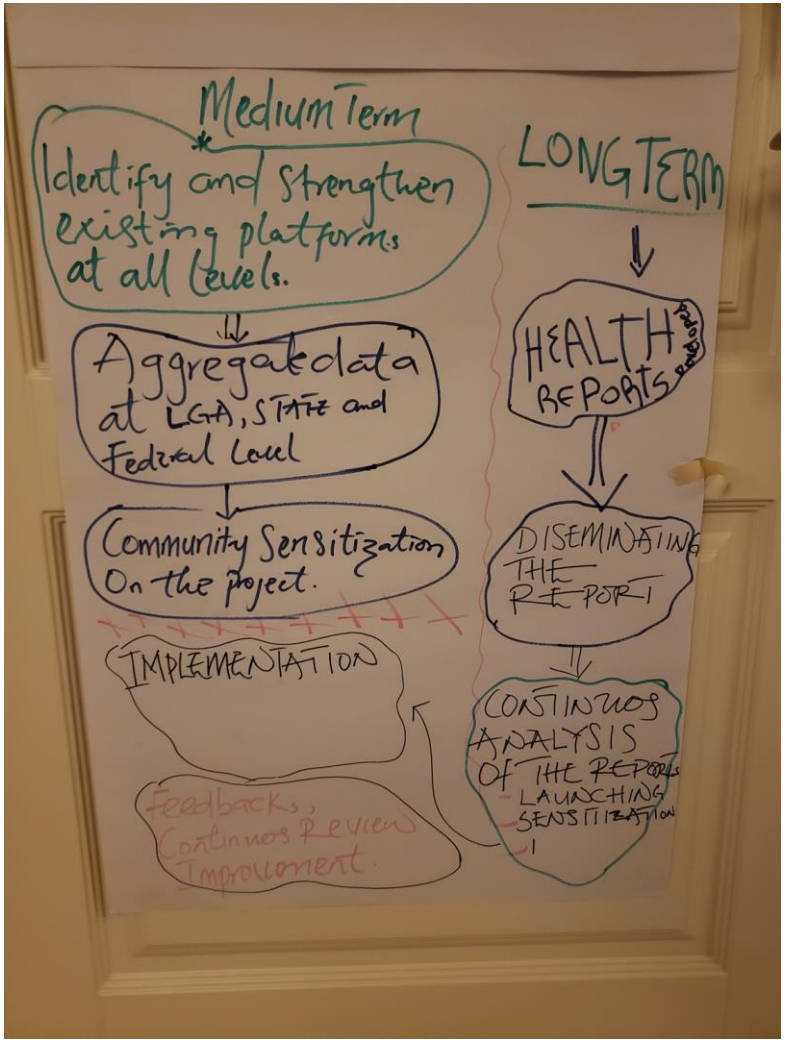
- Sharing project results with community
- Linking legislator name to project
- Recognizing/publicizing successes

Concept: FUBU Report

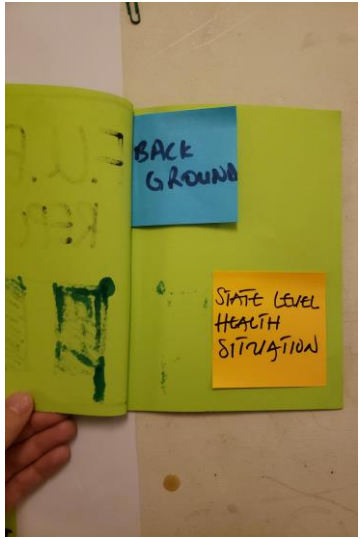

FOR US, BY US
Countries developing its health status report to guide health programing
Communities
facilities
NOH/states
IPs
Donors
challenges
· Accurate financial information from all
· compliance by all stakeholders
· Govt capacity to lead across all levels
DESCRIPTION
NAIJA HEALTH REPORT
· Collate program reports at all levels
· Develop health report with priority areas
· Disseminate to all sectors, donors, IP, govts etc
TRADE OFFS
Share accurate reports
No more competition (IPs/Donors)
Owned by country
Developed by country
CHANGES
set up project implementation committee at each level
→ Donors fund priority projects
→ LGA/state implement priority activities

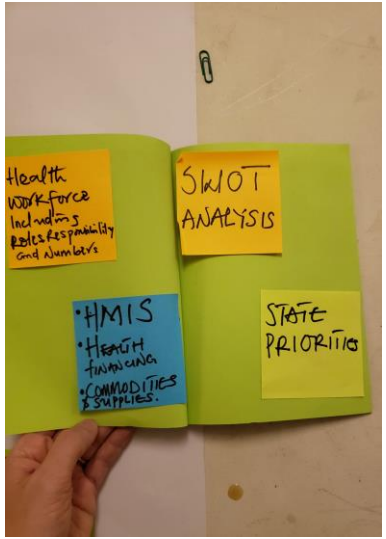

LGA leader
→ Meetings at LGA/State/Nat levels
→ Identify a desk officer to drive the process
→ Collate reports from stakeholders
→ Meetings at LGA/state/Nat levels
→ Develop LGA/state/Nat For us by us report
→ Send to all stakeholders & post on -line
→ Donors refer to For us by us report to provide TA
→ Implementation of for us by us program by stakeholders that form 'for us by us' teams
FOR US BY US
NAIJA-COLLABO
Nigeria's National Annual Health Report

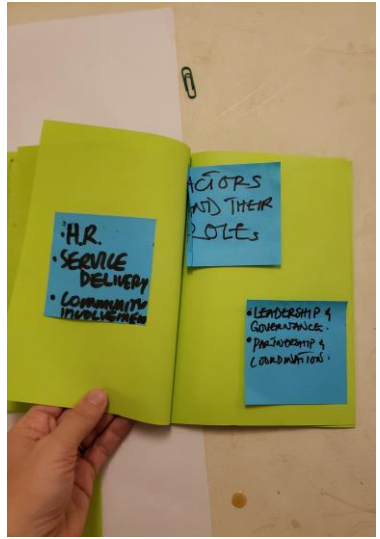

short term
Map Actors
Design Concepts
Stakeholders Sensitization
Refine concepts based on Stakeholders Input.
Develop Implementation framework
Identify data Sources and Tools
Actors & Responsibilities
Timelines and Priority
-Coordinate Stakeholders (Plan)
-Community Engagement
-Aggregate Data for Decision Making
-Set Health Priorities
- Feedback
- Publish Report for us By us
Develop Community engagement strategy


Medium Term
Identify and Strengthen existing platforms at all Levels.
Aggregate data at LGA, STATE and Federal Level
Community Sensitization On the project.
IMPLEMENTATION
Feedbacks, Continous Review Improvement
LONG TERM
HEALTH REPORTS
DISEMINATING THE REPORT
CONTINUOS ANALYSIS OF THE REPORTS
- LAUNCHING
- SENSITIZATION

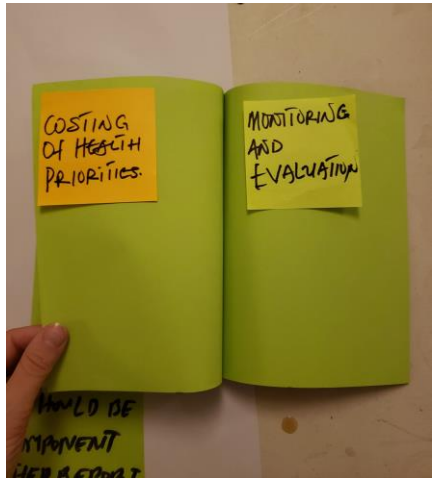

F.U.B.U.
REPORT


BACK GROUND
STATE LEVEL HEALTH SITUATION


Health WORKforce Inclusions Roles Responsibility and Numbers
SWOT ANALYSIS
HMIS
• HEALTH FINANCING
• COMMODITIES & SUPPLIES.
STATE PRIORITIES


ACTORS AND THEIR ROLES
• H.R.
• SERVICE DELIVERY
• LEADERSHIP & GOVERNANCE.
• PARTNERSHIP & COORDINATION.


STATE NARRATIVE
HEALTH SYSTEM BUILDING BLOCKS


COSTING OF HEALTH PRIORITIES.
MONITORING AND EVALUATION


Publish Report.
Set Priorities
FMOH
SMOH
DATA ACCESSED
FEEDBACK
LGAs
HMIS
DATA VERIFICATION BY AN INDEPENDENT AGENT
HEALTH FACILITIES
DATA
ON WASH DAY, TALK TO COMMUNITY ABOUT WASH ASPECTS OF REPORT
STAKEHOLDER SENSITIZATION
COMMUNITY ENGAGEMENT (WDCs)
WDCs
CHURCH
MOSQUE
YOUTHS
BBN
Fed/ Nat.
STATE
LGA
STAKEHOLDER COORDINATION
FMoH
coordinates all health programs
DONORS
CSOs
SMoH
coordinates
states
LGHA
hold stakeholders accountable
IPs
PHCDA
coordinates implementation
FACILITY I/C

For Us, By Us

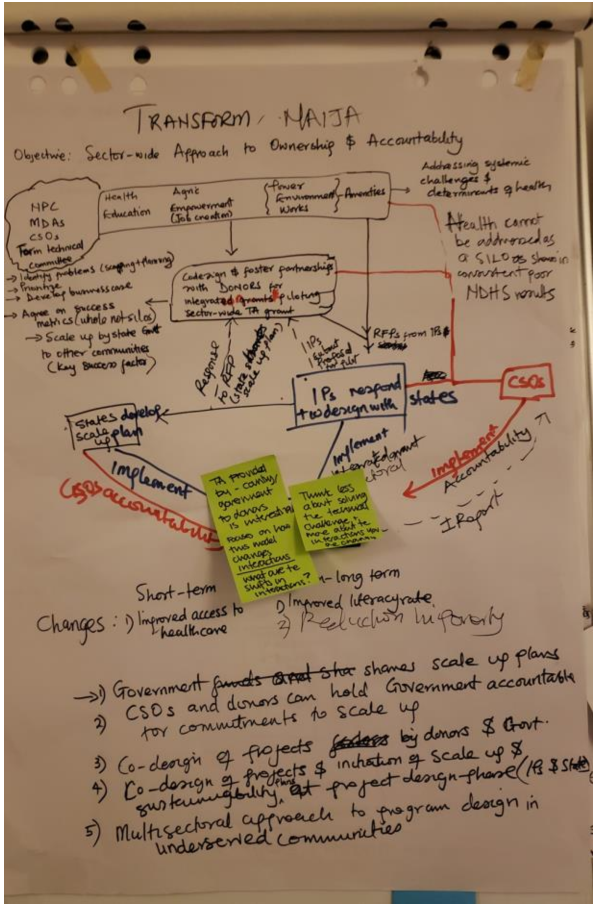
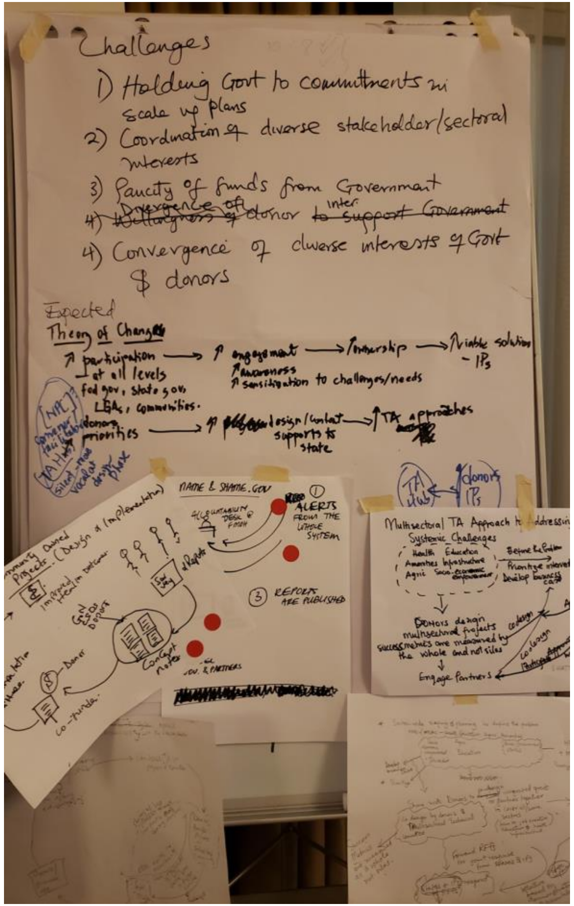
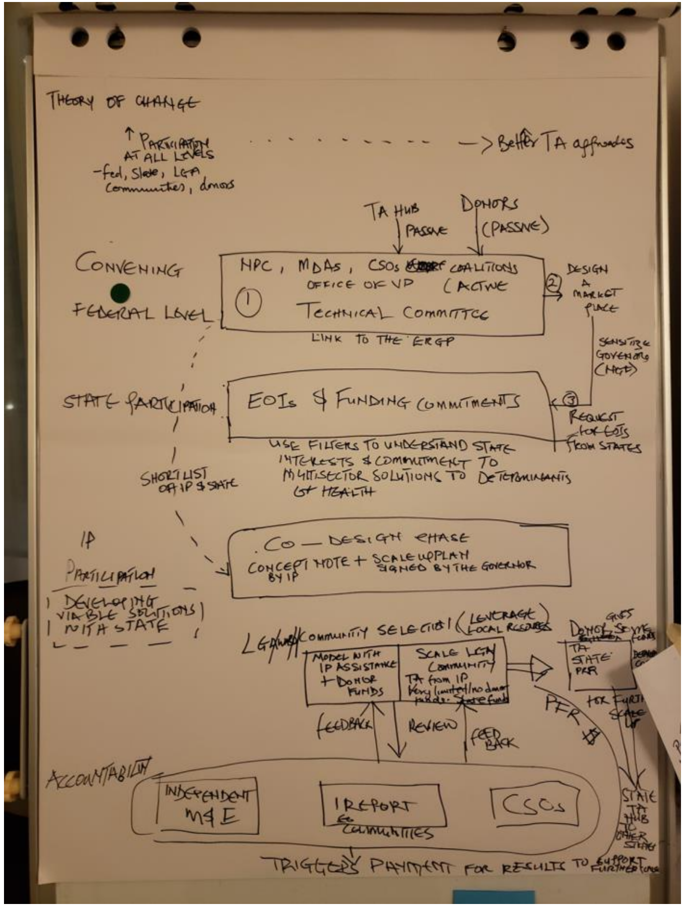
Challenges we are trying to address:

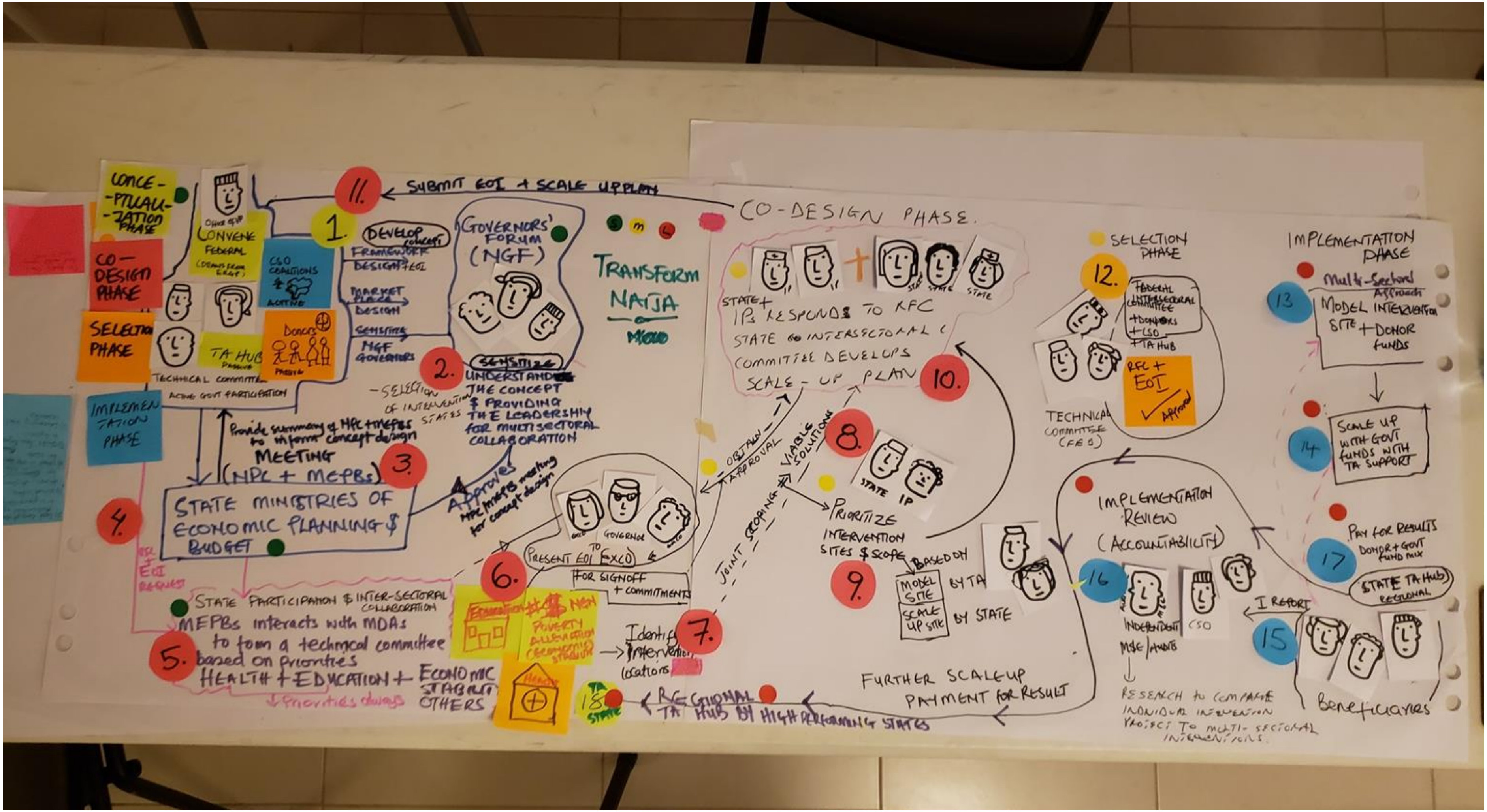
- Trust is a major problem in TA. Communities don't think donors will bring money without wanting something in return. Even IP that come to work, what is the need for them? The gov themselves are not trustworthy. There is a lot of trust issues across the various actors that we have in TA for health.
- 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.
- 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


TRANSFORM NAIJA
Objective: Sector-wide Approach to Ownership & Accountability
NPC
MDAs
CSOs
Form technical committee
Health
Education
Agric
Empowerment (Job creation)
Power
Environment
Works
Amenities
Addressing systemic challenges & determinants of health
Health cannot be addressed as a SILO as shown in consistent poor NDHS results
→ Identify problems
→ Prioritize
→ Develop business case
→ Agree on success metrics (whole not silos)
→ Scale up by state Govt to other communities (key success factor)
Codesign & foster partnerships with DONORS for integrated grants piloting sector-wide TA grant
RFPs from IPs
IPs respond to design with states
CSOs
States develop scale up plan
Implement
CSOs accountability
Implement
Accountability
IReport
TA provided by - country government to donors is interesting
Focus on how this model changes interactions
Think less about solving the technical challenge, the more about the interactions
Short-term
Changes: 1) Improved access to healthcare
Long term
1) Improved literacy rate
2) Reduction in poverty
→1) Government shares scale up plans
2) CSOs and donors can hold Government accountable for commitments to scale up
3) Co-design of projects by donors & Govt.
3) Co-design of projects & initiation of scale up & sustainability at project design phase (IPs & State)
5) Multisectoral approach to program design in underserved communities

Challenges
1) Holding Govt to commitments in scale up plans
2) Coordination of diverse stakeholder/sectoral interests
3) Paucity of funds from Government
4) Convergence of diverse interests of Govt & donors
Expected Theory of Change
↑ participation at all levels
fed gov, state gov, LGAs, communities.
↑ engagement
↑ awareness
↑ sensitization to challenges/needs
→ ownership
→ Viable solution - IPs
donors priorities
↑ codesign/contact supports to state
↑ TA approaches
NAME & SHAME.GOV
ALERTS FROM THE IREPORT SYSTEM
REPORTS ARE PUBLISHED
Multisectoral TA Approach to Addressing Systemic Challenges
Donors design multisectoral projects
success metrics are measured by the whole and not siloes
Engage Partners
co-design
co-funding

THEORY OF CHANGE
↑ PARTICIPATION AT ALL LEVELS
- fed, State, LGA
Communities, donors
→ Better TA approaches
TA HUB
PASSIVE
DONORS
(PASSIVE)
CONVENING
FEDERAL LEVEL
NPC, MDAs, CSOs COALITIONS
OFFICE OF VP
(ACTIVE
1 TECHNICAL COMMITTEE
LINK TO THE ERGP
2 DESIGN A MARKET PLACE
SENSITIZE GOVERNORS (NGF)
STATE PARTICIPATION
EOIs & FUNDING COMMITMENTS
3 REQUEST FOR EOIs FROM STATES
USE FILTERS TO UNDERSTAND STATE INTERESTS & COMMITMENT TO MULTISECTOR SOLUTIONS TO DETERMINANTS OF HEALTH
SHORTLIST OF IP & STATE
IP PARTICIPATION
DEVELOPING VIABLE SOLUTIONS WITH STATE
CO — DESIGN PHASE
CONCEPT NOTE + SCALE UP PLAN BY IP SIGNED BY THE GOVERNOR
COMMUNITY SELECTION (LEVERAGE LOCAL RESOURCES)
MODEL WITH IP ASSISTANCE + DONOR FUNDS
SCALE LGA COMMUNITY TA from IP
FEEDBACK
REVIEW
FEEDBACK
PFR
ACCOUNTABILITY
INDEPENDENT M&E
IREPORT COMMUNITIES
CSOs
STATE TA HUB TO OTHER STATES
TRIGGERS PAYMENT FOR RESULTS TO SUPPORT FURTHER



CONCEPTUALIZATION PHASE
CO-DESIGN PHASE
SELECTION PHASE
IMPLEMENTATION PHASE
CONVENE FEDERAL
CSO COALITIONS ACTIVE
DONORS
TA HUB PASSIVE
TECHNICAL COMMITTEE
ACTIVE GOVT PARTICIPATION
SUBMIT EOI + SCALE UP PLAN
DEVELOP CONCEPT
FRAMEWORK DESIGN & EOI
MARKET PLACE DESIGN
SENSITIZE NGF GOVERNORS
GOVERNORS' FORUM (NGF)
TRANSFORM NAIJA
SENSITIZE UNDERSTAND THE CONCEPT & PROVIDING THE LEADERSHIP FOR MULTISECTORAL COLLABORATION
- SELECTION OF INTERVENTION STATES
Provide summary of NPC + MEPBs to inform concept design
MEETING (NPC + MEPBs)
STATE MINISTRIES OF ECONOMIC PLANNING & BUDGET
Approves NPC/MEPBs meeting for concept design
PRESENT EOI TO EXCO
FOR SIGNOFF + COMMITMENTS
STATE PARTICIPATION & INTER-SECTORAL COLLABORATION
MEPBs interacts with MDAs to form a technical committee based on priorities
HEALTH + EDUCATION + ECONOMIC STABILITY OTHERS
Priorities always
Identify intervention locations
REGIONAL TA HUB BY HIGH PERFORMING STATES
CO-DESIGN PHASE.
STATE + IPs RESPONDS TO RFC
STATE INTERSECTORAL COMMITTEE DEVELOPS SCALE-UP PLAN
OBTAIN APPROVAL
VIABLE SOLUTIONS
JOINT SCOPING
PRIORITIZE INTERVENTION SITES & SCOPE
BASED ON
MODEL SITE BY TA
SCALE UP SITE BY STATE
FURTHER SCALEUP PAYMENT FOR RESULT
SELECTION PHASE
FEDERAL INTERSECTORAL COMMITTEE + DONORS + CSO + TA HUB
RFC + EOI APPROVED
TECHNICAL COMMITTEE (FED)
IMPLEMENTATION PHASE
Multi-Sectoral Approach
MODEL INTERVENTION SITE + DONOR FUNDS
SCALE UP WITH GOVT FUNDS WITH TA SUPPORT
PAY FOR RESULTS DONOR + GOVT FUND MIX
STATE TA HUB REGIONAL
IMPLEMENTATION REVIEW (ACCOUNTABILITY)
INDEPENDENT M&E / AUDITS
CSO
I REPORT
Beneficiaries
RESEARCH to COMPARE INDIVIDUAL INTERVENTION PROJECT TO MULTI-SECTORAL INTERVENTIONS.