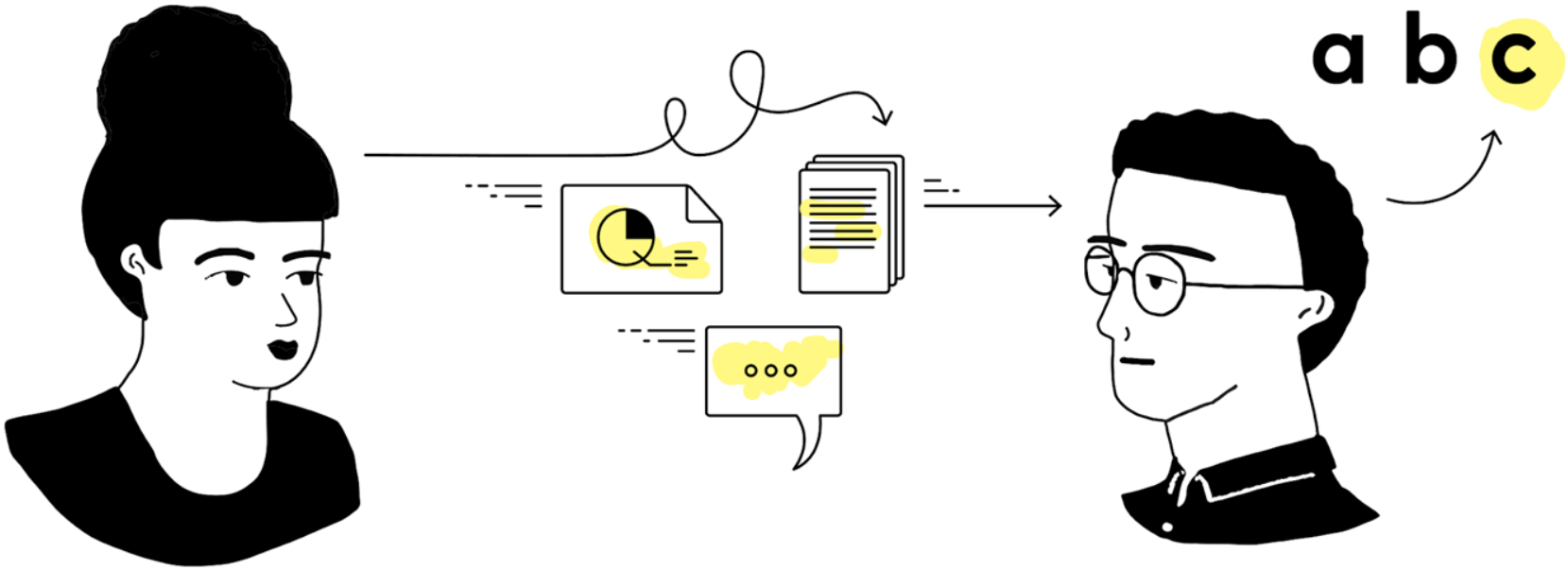


Design Sprint to Re-imagine TA in Nigeria

Co-creation Team 2: Re-imagining knowledge flow to support strategic decision-making.

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)*

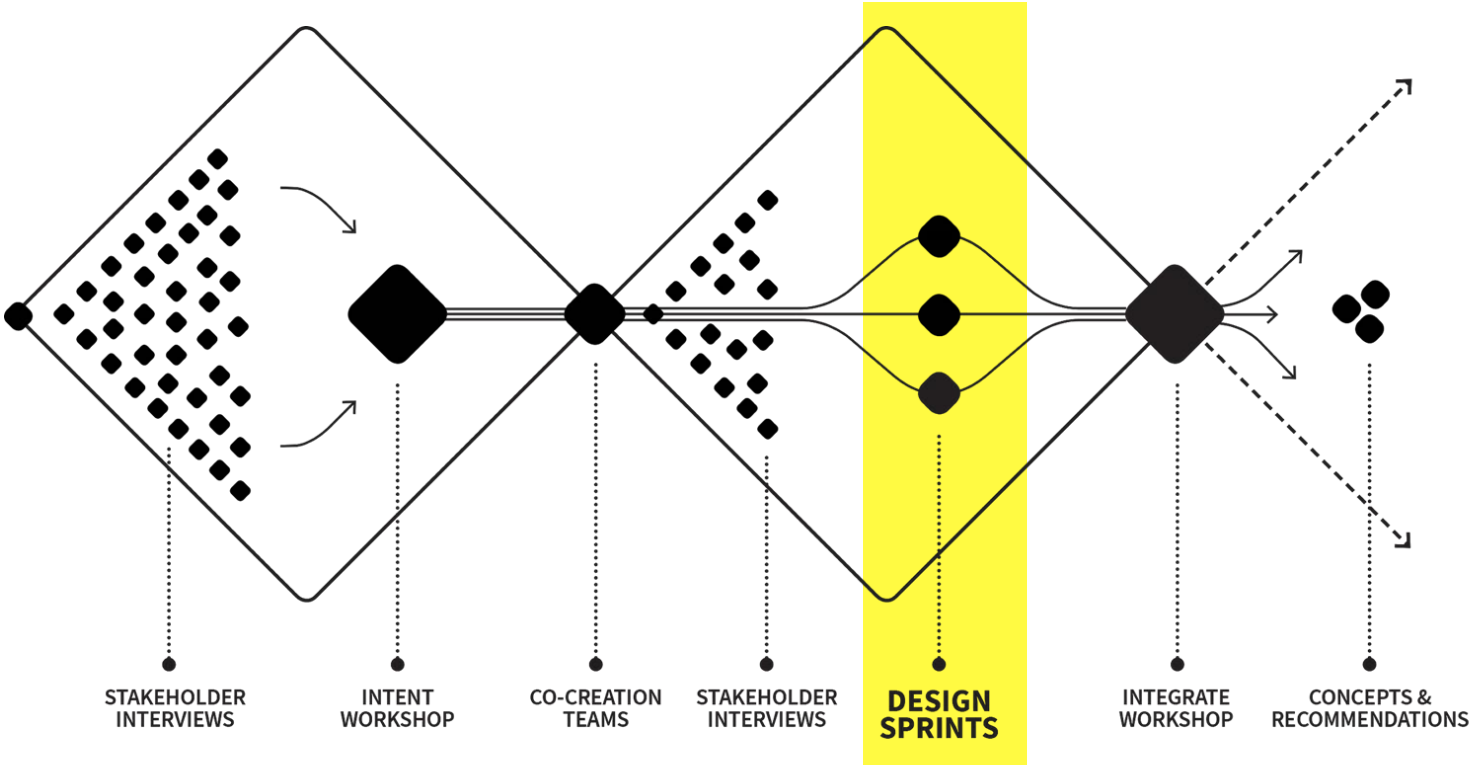
Visitor introductions & orientation
Concept pitches & feedback
Discussion: Additional opportunities & the future of TA in Nigeria

13:00 - Lunch

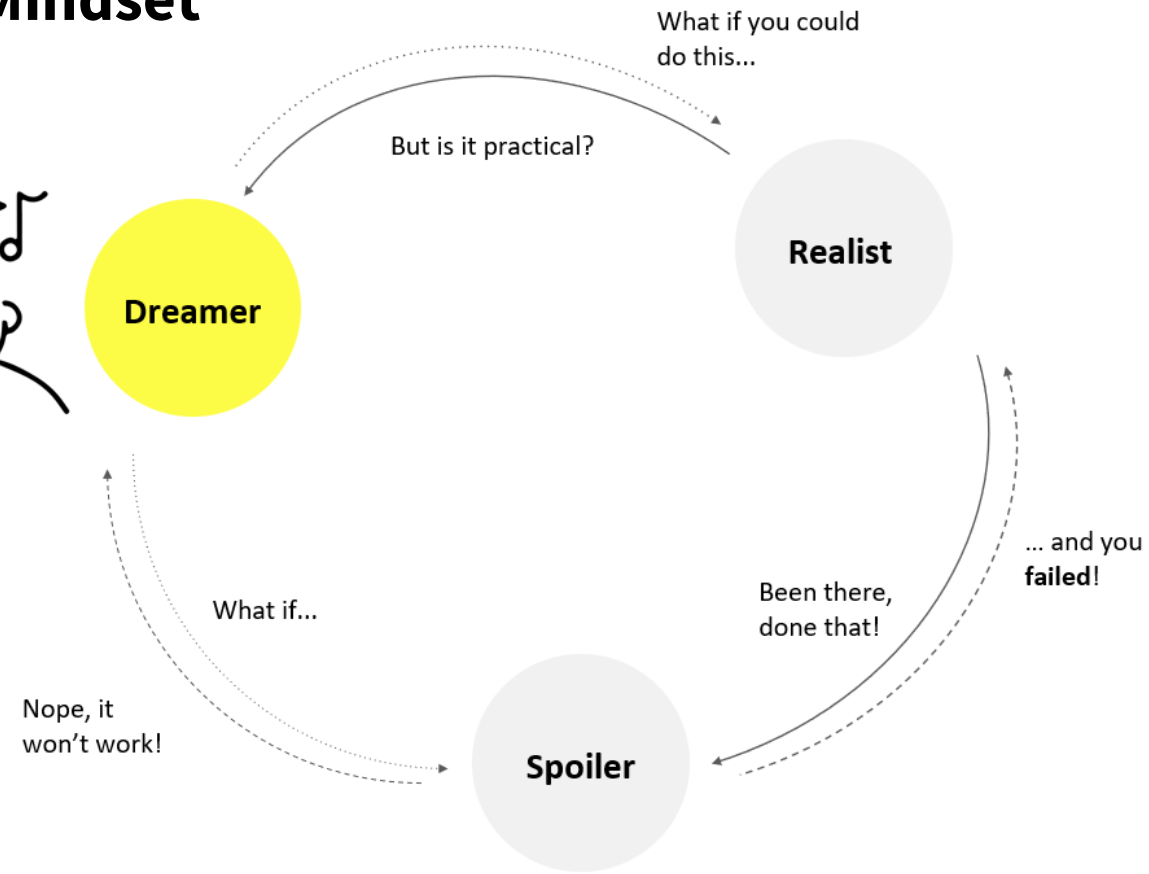
Concept refinement & planning
Considering a systems change
Next Steps

16:30

Re-Imagining Process



Designer Mindset

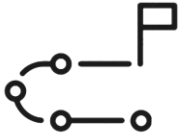


Tips for our time together

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?

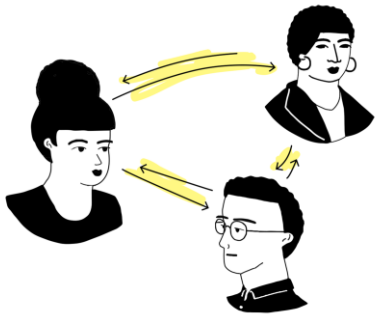
Reduce dependencies that perpetuate short-termism

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?

Quotes from interviews

Our Focus Area

Re-imagining knowledge flow to support strategic decision-making

There is a lack of clarity around who is making decisions about TA priorities, what is informing those decisions, and how they are communicated to the broader network of stakeholders.

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?

RELATED CHALLENGES:

- Inadequate TA for successful advocacy
- A human centred approach to data use: How data hinders and empowers? How it is useful at different levels of the system?

Decisions, influence and power

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

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

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

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

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

We need better proposals

The donors and funders, they don't come directly to the agency. They go through the National Planning Commission. And that is where we always mess up things. Because at that time, the input of the beneficiary agents is needed. It's like you are shaving my head behind me. All those things that are supposed to the in the MOU. Because he who wear the shoes know where we need change most will not be there. And our donors, when they have signed that MOU, they are intoxicated somehow, saying that this is how I'm going to do it because I have signed with government and the face of gov is the National Planning Commission, not the agency. TSU

Most of the time. there is always some booby traps in the MOU because you are not part of the crafting and you don't know. You will just be using your gov regulations to do some implementations and after maybe one year they say that you have embezzled some money because you don't actually follow to the letter what they have put in there TSU

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

The TA hub: defines needs, infuses knowledge from implementation research, brings in learnings from other places, is able to guide the donor through debate - we hope that through this process the quality of the proposal and TOR should improve. It is no longer the onetrack approach of donors - who come in with we know what is needed and we know how to get it done. DAI TA Hub

Problem Framing discussion

- Lots of data is available, but how do we summarize to make it accessible to decision-makers? **We need to move away from 700 page reports & instead package data to be simple and politically attractive.**
- **How do we make sure data is accurate and can be used by anybody?**
- How can we protect the “whistleblower” trying to make sure data is reported correctly even if it’s not convenient for leadership? What is the reward system for doing the right thing?
- Community level is where you can still find true data. Things get distorted based on interests as they go up the chain.
- “Good data” depends on your reference point
- **Currently, data has only one direction -- going up. Feedback doesn’t go back down.**
- How do we shift mindset -- going beyond just performance.
- Those generating data, do they know how it is being used?
- Issue with trust/confidence
- Data purity: timeliness, completeness, accuracy + data purity
- In most of the work we do we have a baseline but, it is not used for decision making, there is a mountain of data from facilities and hospitals but the tools to collate it and disseminate it are not there - the data is fraught with gaps
- Facilities lie, don’t even have tools to collect most data
- How do we bridge the gaps between the data we have and the decisions we make?
- Mostly data is about meeting the targets of the donor, and people lie about the data to make it look good
- Data is all about the technical not about decision making, decisions are emotional and political
- How do we stress data is important and should be used?
- Most programs, data is left at tech level, just to meet requirements.
- I thought data is neutral, but it is treated as negative if the targets are not met.
- How can we move away from data being technical (given targets are used to evaluate performance (m&e)
- “Emotional data” -- “our people are suffering” -- these are decisions that don’t use numbers.

- “Political” -- improving quality of life, it’s a political issue. Keen that numbers make sense so that we get the same funding the following year. There is a hesitancy to collect negative data (ex. Malnourished kids not being recorded) OR showing too much improvement (no more malnourished kids means no funding)
- Decision makers are not in the field, very hard to know what is actually going on. You might know your data is wrong, but you have no choice but to use it.
- How do we shift decision making closer to the community?
- The data is not showing all our effort at the community level so there is something wrong, we need to do something different
- **How do we motivate and reward the ability to uncover the problem?**
- Wrong data might mean more resources -- “demonstrating results”
- Capacity to measure/collect the right info is lacking on the frontlines
- **Upward & downward impact accountability should be more balanced**
- The person in the field is responding to conflicting demands (capture accurate data or adjust numbers to meet targets). **There are always pre-defined expectations of what the data should be.**
- Most of our logframes and indicators are in numbers
- There is no accountability to report the right numbers. But there is accountability for not delivering the right results.
- **We need to rethink the whole feedback loop, from what results we are expecting to who we are accountable to** -- should be the common man.
- There are power dynamics at play. Why set the targets?
- For donors, this is a business investment -- what is realistic is always in tension with what is desired.

Profiles

Community leader

The power I hold

Influence over community participation, Community entry, Community mobilization

The decisions I make *Identify community health needs* *Community activities to drive implementation* *Available community resources*	 *How best to use my available resources* *Who I will work with* *Location and scale of programs*
What influences those decisions *Leadership influence and abilities* *Ho to deliver my mandate to constituents* *Time/ duration with the office*	*Knowledge and understanding of the health area* *Funding and resources* *What will demonstrate the greatest impact* *Available resources from community, government and donor*
The data I have *Health facility data* *CHEWS data and CHIPS* *Population data/ community* *Land use data*	*Community volunteers workers data* *Scoping and mapping data on communities* *Data from community disease surveillance* *Data on KAPB per community* *Community resources available*

Donor

The power I hold

The money, Convening power, Set the Global agenda

The decisions I make *Funding* *Investment size* *Location* *Health area priority*	 *Scale* *Project duration* *Program priority* *Implementation strategy*
What influences those decisions *Quick wins* *Knowledge and information* *Global health agendas* *Business interests*	*Personal interest* *Political situation* *Need for support* *Investment* *Relationships*
The data I have *Global health indices* *Global declarations* *Program data*	*Commissioned research* *Political economic analysis* *National surveys* *Baseline data*

National Planning Commission

The power I hold

Convening power, Select implementation sites, Access to territory nationally, Accountability for results.

The decisions I make *Reaching agreements with the donor* *Partner eligibility* *Government agencies to involve*	*State selection*
What influences those decisions *Donors business interest* *Existence of legal frameworks for collaboration* *Health indices*	
The data I have *Bilateral agreements and contracts* *National and international conventions, declarations and treaties*	*DAD policies* *Gov priorities/ sector* *NAtional surveys and routine data*

FMOH

The power I hold

Convening power, Priorities and policy instruments, strategic oversight, IP recommendations

The decisions I make *Strategic oversight* *Policy* *Domestic funding allocation* *Partner coordination*	*Implementation framework design* *How TA is provided to subnational level* *Metrics for how to measure progress* *Resource leveraging*
What influences those decisions *Presence of other stakeholders* *Funding availability - donor/ domestic* *Donor priorities*	*Available health indices* *SMOH readiness and capacity to implement*
The data I have *NDHS national survey* *National and international conventions, declarations and treaties* *Partner mapping*	*HMIS routine data* *HR profile management Information system* *Policy Instruments: Strategies, SOP's , Frameworks, action plans* *Appropriation Acts*

Implementing partner

The power I hold

Policy setting - influence, Evidence generation, Advocacy

The decisions I make *Implementation strategy* *How to allocate available funds* *Program design*	*What grants to chase* *Who to partner with* *Where to implement*
What influences those decisions *Existing relationships* *Technical expertise and experience* *Sustainability issues*	*Familiarity with setting* *Political environment* *Value for money*
The data I have *Routine M+E data* *Program data* *Funding data and cost effectiveness*	*Surveys* *Human interest stories* *Implementation stats*

SMOH

The power I hold

Convening power, Economic power, Political power, mobilization power

The decisions I make *What is our health strategy* *Funding allocation and release* *What policies to adopt/ adapt*	*Siting locations for programs* *How to coordinate partners* *Priority data and information*
What influences those decisions *Funding availability* *Quick wins* *State priorities*	*Political realities* *Fiscal space* *State priorities* *Baseline indices* *Capacity within civil services*
The data I have *Baseline data* *ISS data* *HMIS data*	*DQA* *Financial data*

NURSE

The power I hold

The decisions I make *Economic decisions - how to earn more* *Procurement decisions* *How to meet targets for the facility*	*How to access more women* *Performance management* *How to build health capacity*
What influences those decisions *Program areas funding* *Training and capacity strengthening* *Security and safety*	*Availability of tools and commodities* *Feedback on quality of work* *Government funding for health* *Logistics, transport access to the community*
The data I have *Outpatient data* *Primary data - number of women - number of children* *Health facility data*	*Disease surveillance data* *Outreach data - catchment population* *Household and community maps* *Product information and source of supply*

Principles

Design principles

Scales trust	Is co-ordinated	Is Country owned	Strengthens the health system
Strengthen evidence	Co-ordinate partner activities	Create a good user experience	Reduce dependencies
Strengthen feedback loops	State lead	Participatory, inclusive and respectful of local knowledge	Increase sustainability and longer term thinking
Joint accountability / results driven	Take an integrated/ whole system approach	Shift from buying solutions to owning problems	Meet basic needs: wages, functioning facilities
Improve program guidance and oversight	Standardise the core and tinker around the edges	Slow down	

Builds transparency, accountability and trust

Strengthen evidence	Strengthen feedback loops	Joint accountability / results driven	Scales trust	Improve program guidance and oversight
Simplify measurement standards and improve quality Improve the documentation and contextual analysis of programs Suggest evidence based strategic shifts for programs Improve knowledge management for partners and the government Strengthen and improve existing data systems- the same yard stick for all *Shift from project/ program monitoring to evidence generation and knowledge sharing*	*There is a gap between what we want to achieve and easy to measure outputs. To understand TA effectiveness we need softer qualitative feedback* *Data does not find its way to some decision makers* *Dooner data - leaves the system does not feedback to government or community* Strengthen and improve existing data systems- the same yardstick for all	Increase transparency and and effective resource management *Agreement by key stakeholders- community, government, donor, Cso, IP's on high level deliverables around which to target TA* *Results from different program areas should align with these targets* ***Use simple easy to understand terms to analyse and disseminate results*** *Recognize the different levels of reporting* *Use these results to inform decision making*	There is a lot of trust issues across the various actors that we have in TA for health. Government thinks that Implementing partners has a hidden agenda that promotes their own agenda Communities don't think donors will bring money without wanting something in return Implementing partners can't follow government if they can't see commitment,	Improve systems for overall **visibility and access** for all stakeholders Shift from silos to holistic program oversight **Improve systems for overall visibility** and access for all stakeholders Support the global agenda of the country

Is coordinated

Co-ordinate partner activities	State lead	Take an integrated/ whole system approach	Standardise the core and tinker around the edges
A clear map of what is going on in the state - who is doing what, where, when, how much Support the use of feedback loops for better quality Programs and QI Support efficient planning, inclusion, monitoring and better accountability Priorities should be based on internal resources and health needs to promote ownership VFM shares expertise equally across health priorities	TA should be targeted at the state level where there is more potential for resilience, innovation and organic functionality leading to greater sustainability	ODAF conceptualization should effect the interconnectedness of other sectors of health NPC should consult widely and listen actively while designing the ODAF *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	**Simplify measurement standards and improve quality** *Use simple easy to understand terms to analyse and disseminate results*

Is country owned

Create a good user experience	Participatory, inclusive and respectful of local knowledge	Slow down	Shift from buying solutions to owning problems
Make interventions easy to transition to stakeholders Adaptability, advocacy and learnability Co-create sustainability plans with stakeholders for ownership and adoption	Involve community input and engagement and elicits continuous feedback from all levels Recognises local nuances and structures with a view to strengthening them	*The biggest challenge is **TIME.** It is a major challenge, the government is slow and can not move at the pace of the private sector, we take our time and the time for the funds lapses. The partners is not patient with government because funding will laps.* *FMOH* *The elasticity should be higher, the government system is designed to take its time. The ideal state is that the partners slow down a bit to work hand in hand with governme*nt. Special Assistant on Dept HPRS, FMOH	Understands the importance of assessment analysis before commencing the program, project TA is aimed at changing or improving the status quo Allows ownership at all level *x*

Strengthens the health system

Meet basic needs: wages, functioning facilities	Reduce dependencies	Increase sustainability and longer term thinking
Strengthens / equips existing facilities rather than building new infrastructure	TA should be targeted at strengthening health systems- not on doing the work directly TA should be disruptive and change the usual way of doing things Shift from starting with a solution and hoping to transfer to government to designing with government Transfer competency If there is no capacity transfer, the donor is just meeting their own agenda, when the TA goes away their knowledge goes with them that means you never set out to help me you just wanted to fill your own agenda FMOH child health division	*Government is involved in the design of sustainability plans* *Sustainability plans are built into Government strategic planning* *Timeframes are extended to show adoption and results*

Pledge to the transformation of TA in Nigeria

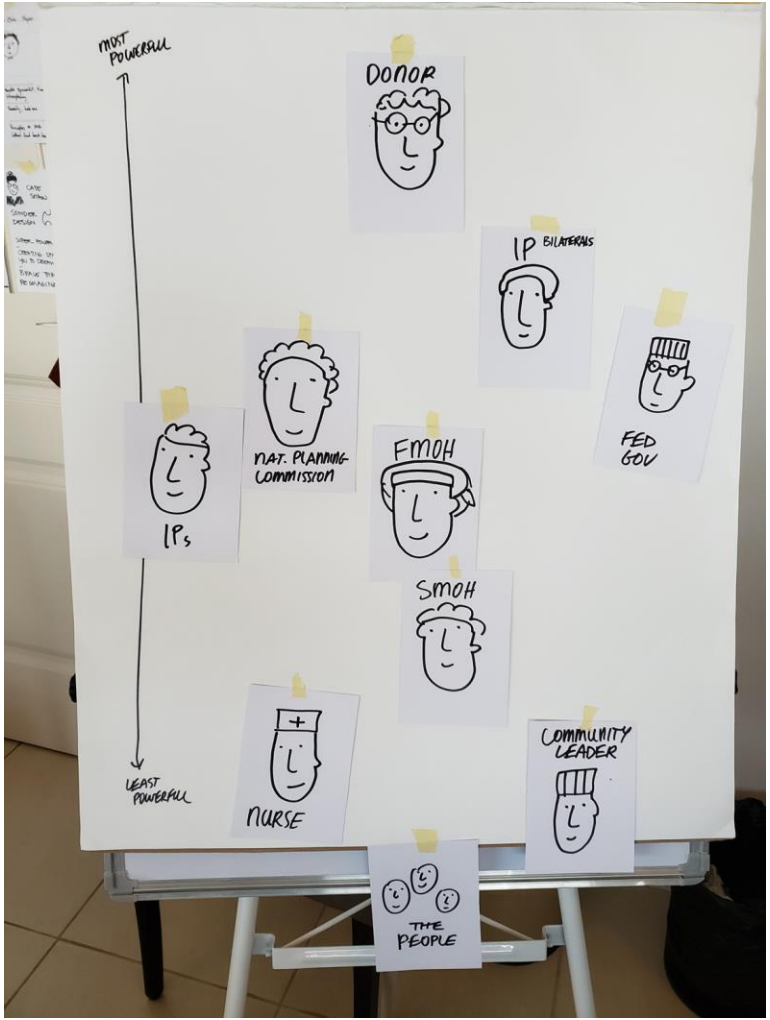
Our pledge to the transformation of TA in Nigeria

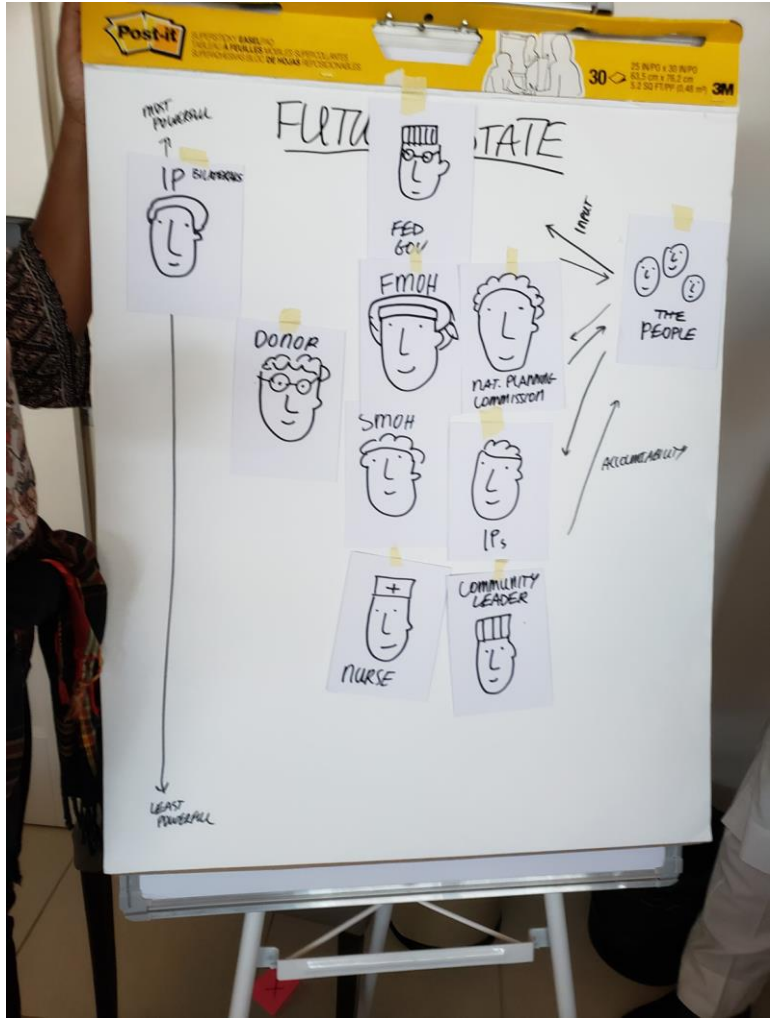
Our commitment as IP's and donors	What we will demand from government
● Align to government priorities based on evidence ● Transfer competencies and expertise to the MOH and civil society ● Support government to develop and implement sustainable programs ● Share cost drivers and health expenditure data with government ● Provide TA tailored to the priorities of government ● Mobilize additional as needed to support program implementation ● Strengthen existing accountability mechanisms HMIS and support redesign as appropriate	● Play are more prominent role in the leadership and ownership for health ● Clearly articulate their needs, gaps and priorities ● Increase budget allocation and improve timely cash backing (release) for health programs ● Lead the partners coordination mechanism and increase frequency and participation ● Provide clear health metrics for all partners with guidance on measurement standards ● Shift the timeframe of the strategic health development plan from 5 years to longer term ● Extend the current HMIS to capture community data

Our pledge to the transformation of TA in Nigeria

Our commitment as Government	What we will demand from IP
● Improve transparency and accountability - fiscal ● Improve internal coordination in program planning and implementation ● Strong political will for stronger HIS	● Openness and fiscal transparency ● Full alignment of all programs with the government vision ● All partners to help government in strengthening the health information system

Power Dynamics


MOST POWERFULL
DONOR
IP BILATERALS
NAT. PLANNING COMMISSION
FED GOV
IPs
FMOH
SMOH
NURSE
COMMUNITY LEADER
LEAST POWERFULL
THE PEOPLE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THE PEOPLE
DONOR
NAT. PLANNING COMMISSION
SMOH
ACCOUNTABILITY
IPs
COMMUNITY LEADER
NURSE
LEAST POWERFULL

Concepts

Digitize

- What if there was a community led digital approach to increase service delivery
- What is robotics and AI are main vehicles for TA?

Solution ideas:

- Big data to capture community needs
- HRH/Capacity building
- Centralized data bank
- Paperless
- Digital supply chains
- Digital appointment
- Dashboard access
- Data security
- Quality assurance and accountability
- Feedback

Donors give us what we ask for

- Donors are more open with they intentions’
- What if donors can only pick from a database of country TA needs?
- Return power and trust to Nigerians

Solution ideas:

- Address real health problems (focus more on neglected disease areas in country)
- Use national data, not global estimates / Country generates accurate and up to date data on health metrics\
- Improve transparency in Health Fund Management and be more accountable for outcomes.
- Setting country strategy and priorities
- Generate citizen-led plans
- Country devotes substantial resources to health
- Push back on donors

What if there are no more donors

Solution ideas:

- Promote locally-driven health initiatives / use local corporate organizations
- Create stronger accountability mechanisms (vertical & horizontal)
- Health facilities should become bacable
- Community health insurance
- Mobilize community resources for health
- Create trust with citizens thru better services
- Build/transfer TA capacity locally
- Create NGO intervention map
- Coordinate INGOs better for greater economies of scale
- Create an all embracing health strategy -- Health priorities are voted for
- Increase budget allocation for health on local and state levels

Simplify process/ reduce bureaucracy

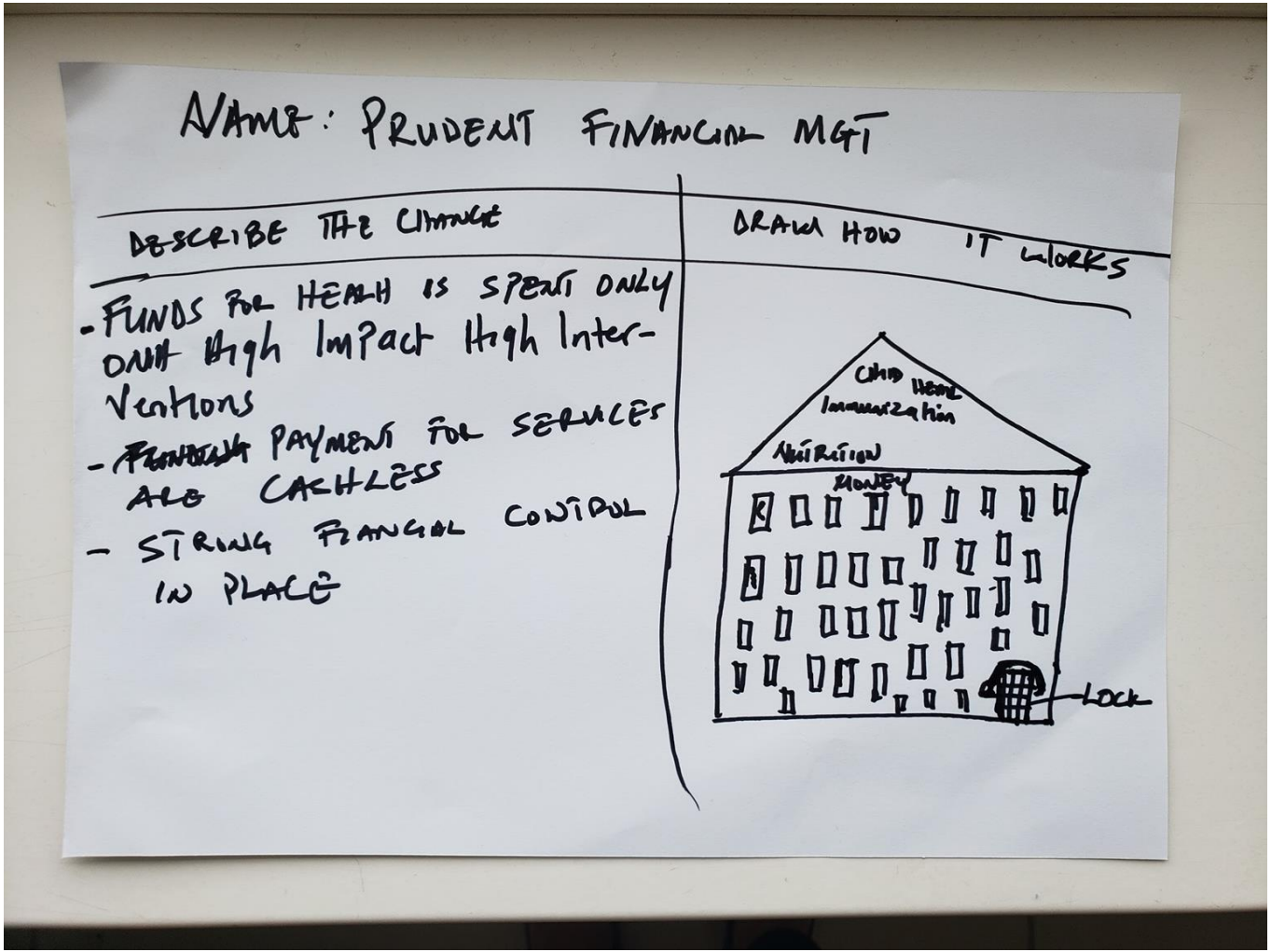
Solution ideas:

- Only 10 indicators for TA in health’
- All IPs report data to the government system
- A single set of indicators, reviewed every 3 years
- Strengthen institutions and individuals / Build better capacity of staff within the ministries and agencies
- Decentralize decision-making
- Improve coordination mechanisms & communication
- Reduce redundancy:
    - Clearer and streamlined roles
    - Go digital
    - Remove duplicate ministries/agencies
    - Limit dul=plication of program management roles
- Create clear guidelines for donors and IPs
- Clarify process and procedures
- Work plan s should be carried out with gov and partners in the same thematic area

TAs are citizen-led / citizens understand the government's health agenda and operation

Solution ideas:

- Citizen forum for more open dialogue and accountability
- SImplified reports of outcomes are shared with citizens
- State health budgets are more evidence-based
- Citizen-let accountability
    - Mandated assessment of program managers by the community
    - No healthcare worker should be promoted without community leader input
- Health consultation in every community
- Building local capacity, especially around data use for decision-making
- TA provided by local organizations
- Votes on TA initiatives via social media
- CItizen-designed programs
- Strengthen community/health faculty committees
- Community leaders ign off on TA before it is provided

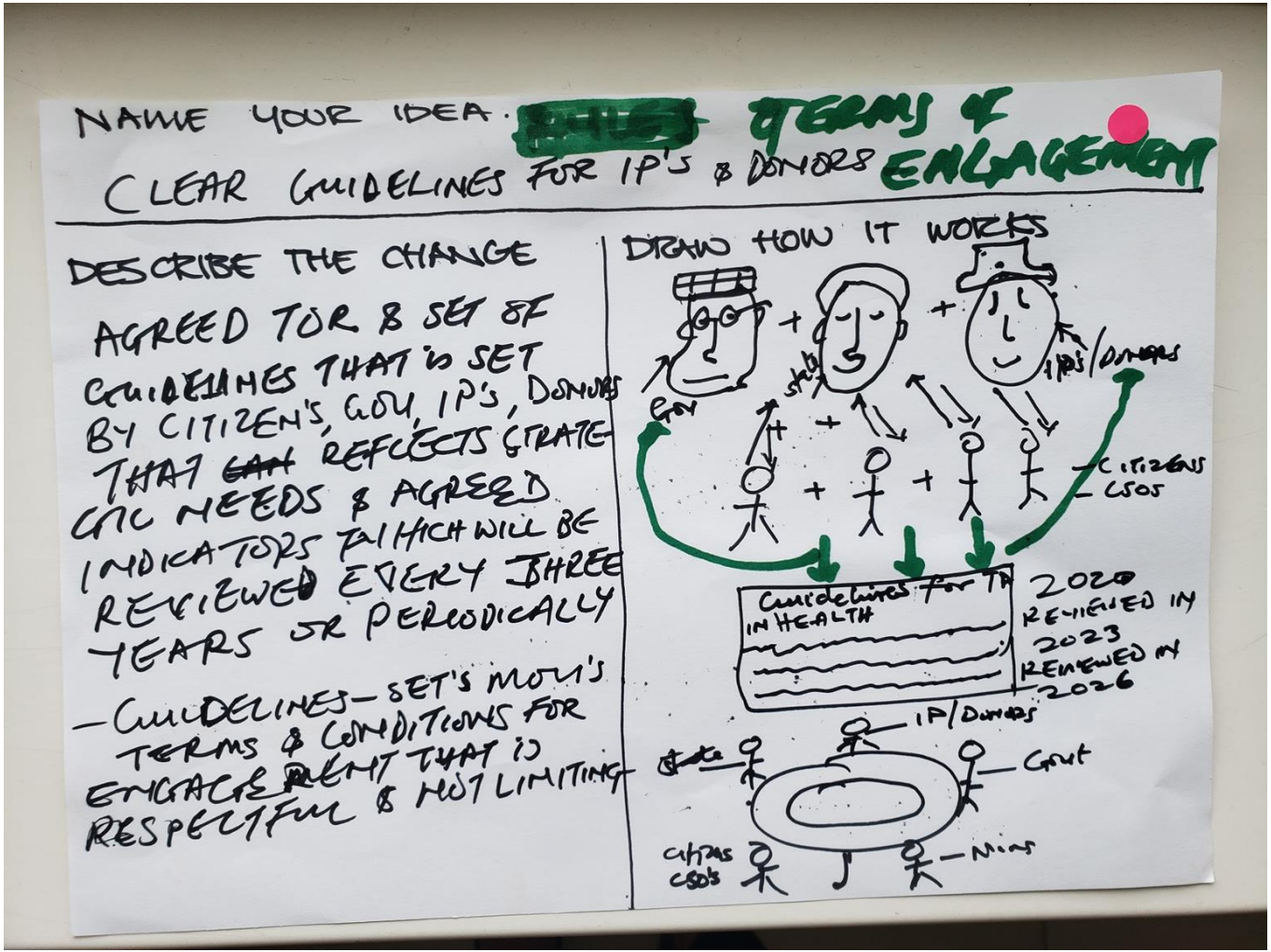


Prudent financial management

Funds for health is spent only oh high impact interventions

PAyment for service is cashless

Strong financial controls are in place



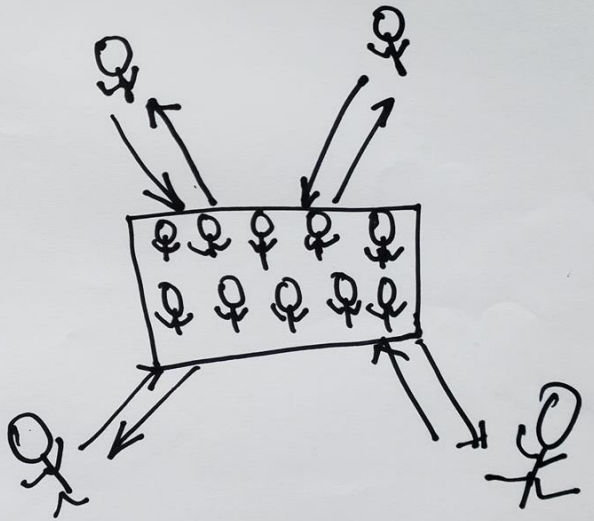
Clear guidelines for IP's and Donors

Agreed TOR and set of guidelines that reflect state needs and agreed indicators

Guidelines sets MOU's terms and conditions for engagement that is respectful and not limiting

NAME YOUR IDEAS:

HUMAN RESOURCE [TA] BANK

DESCRIBE THE CHANGE	DRAW HOW IT WORKS
- MAP SPECIFIC TA EXPERTISE IN THEMATIC AREAS - CERTIFY THEM - UPLOAD IN SEARCHABLE DATABASE - TA PROVIDERS COME ONLY FROM THIS POOL	

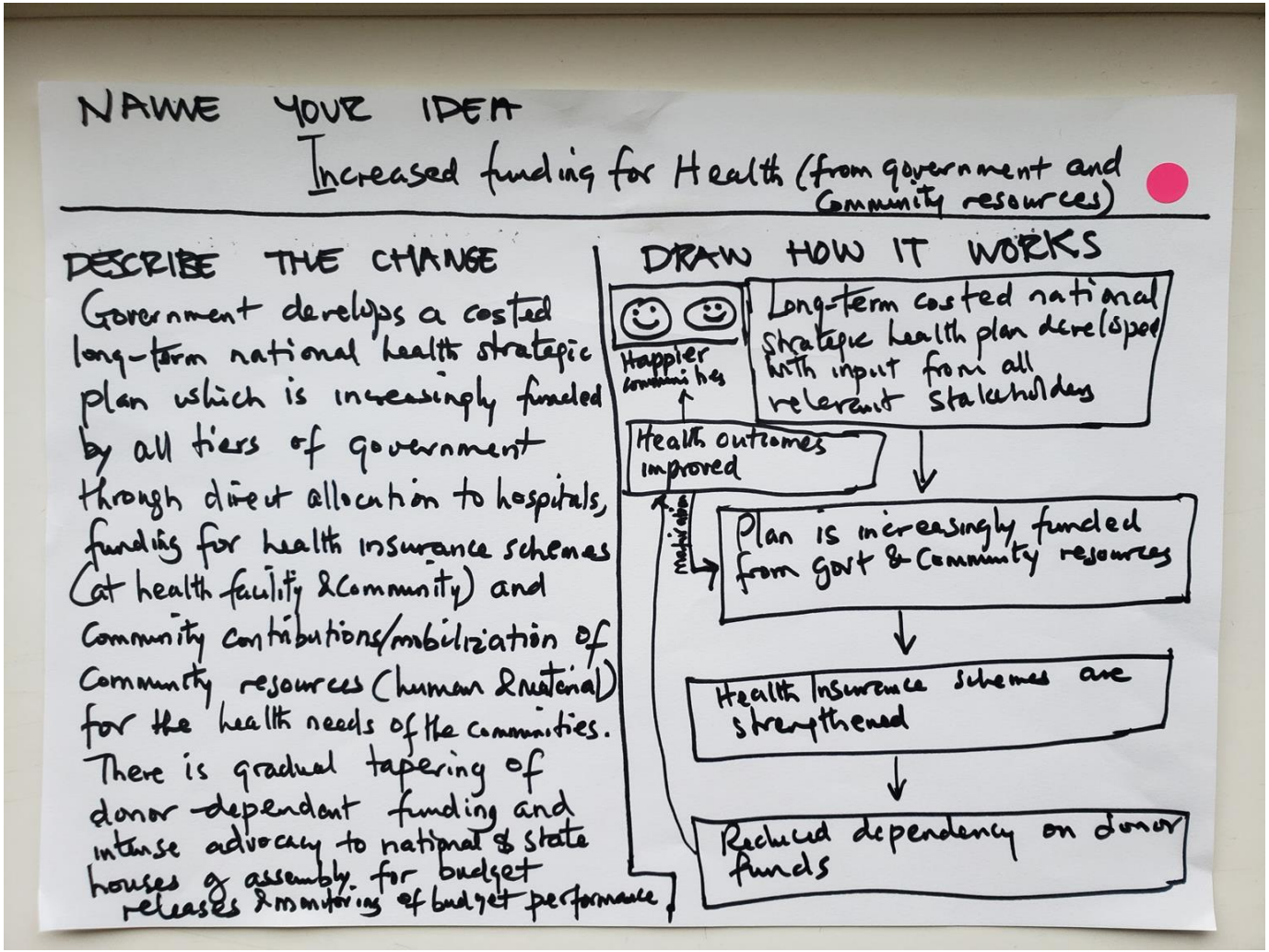
Human resource TA bank

Map specific TA expertise into thematic areas

Certify them

Upload searchable database

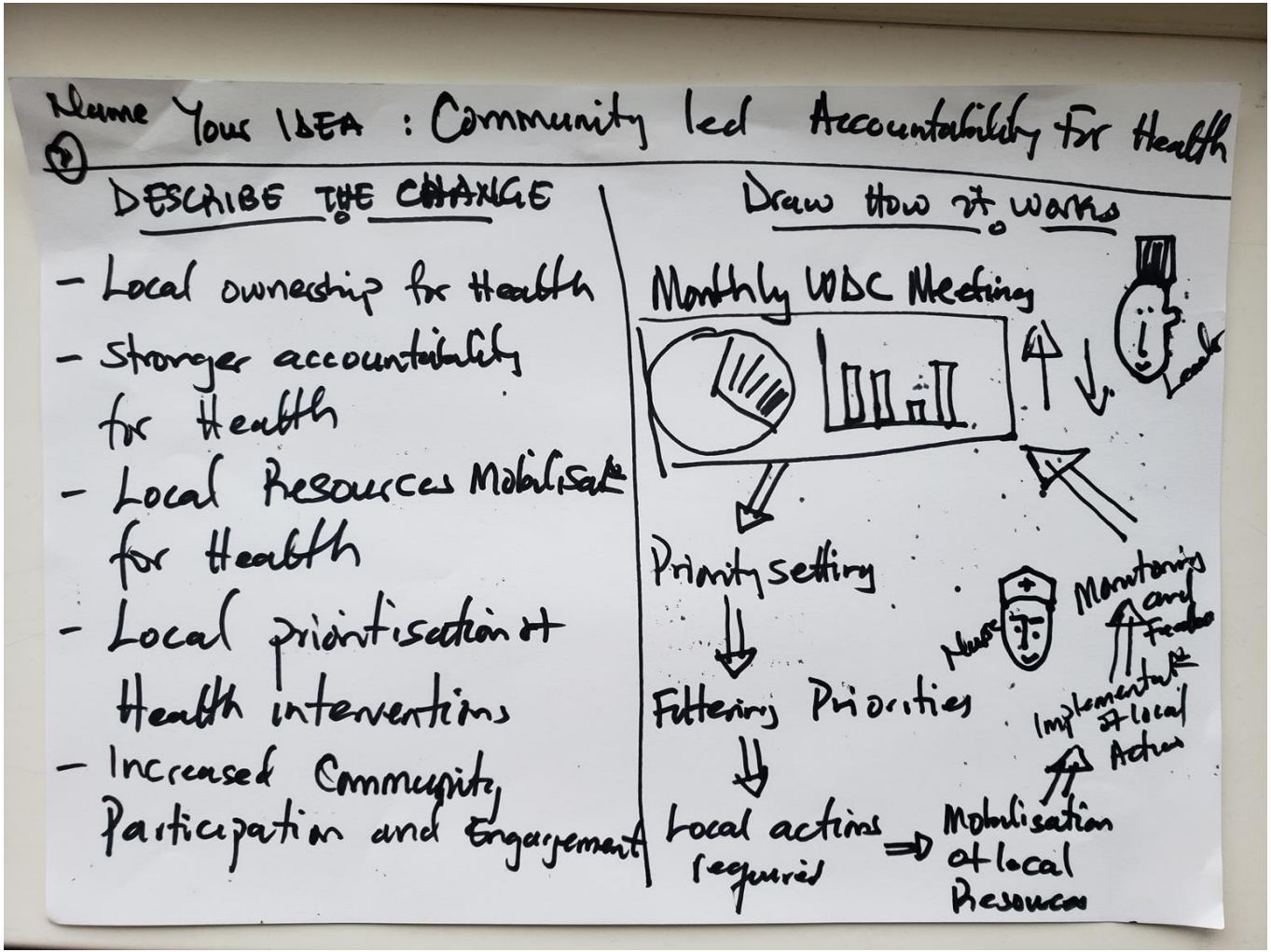
TA providers come only from this pool



Increase funding for health from government and community resources

Government develops a long term national health strategic plan which is increasingly funded by all tiers of government

There is a gradual tapering of donor dependant funding and advocacy to national and state houses of assembly

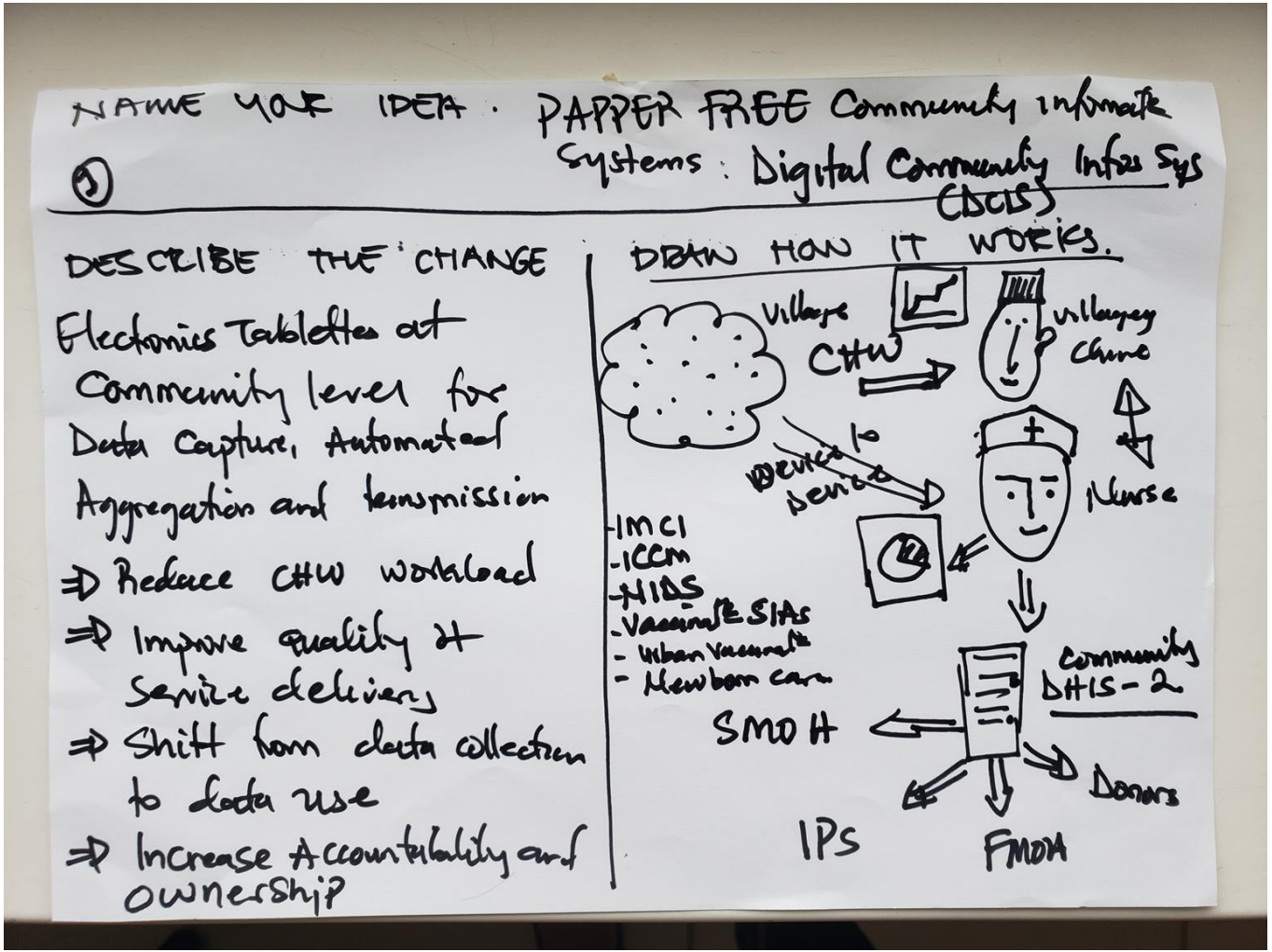


Community led accountability for health

Local ownership for health

Stronger accountability for health

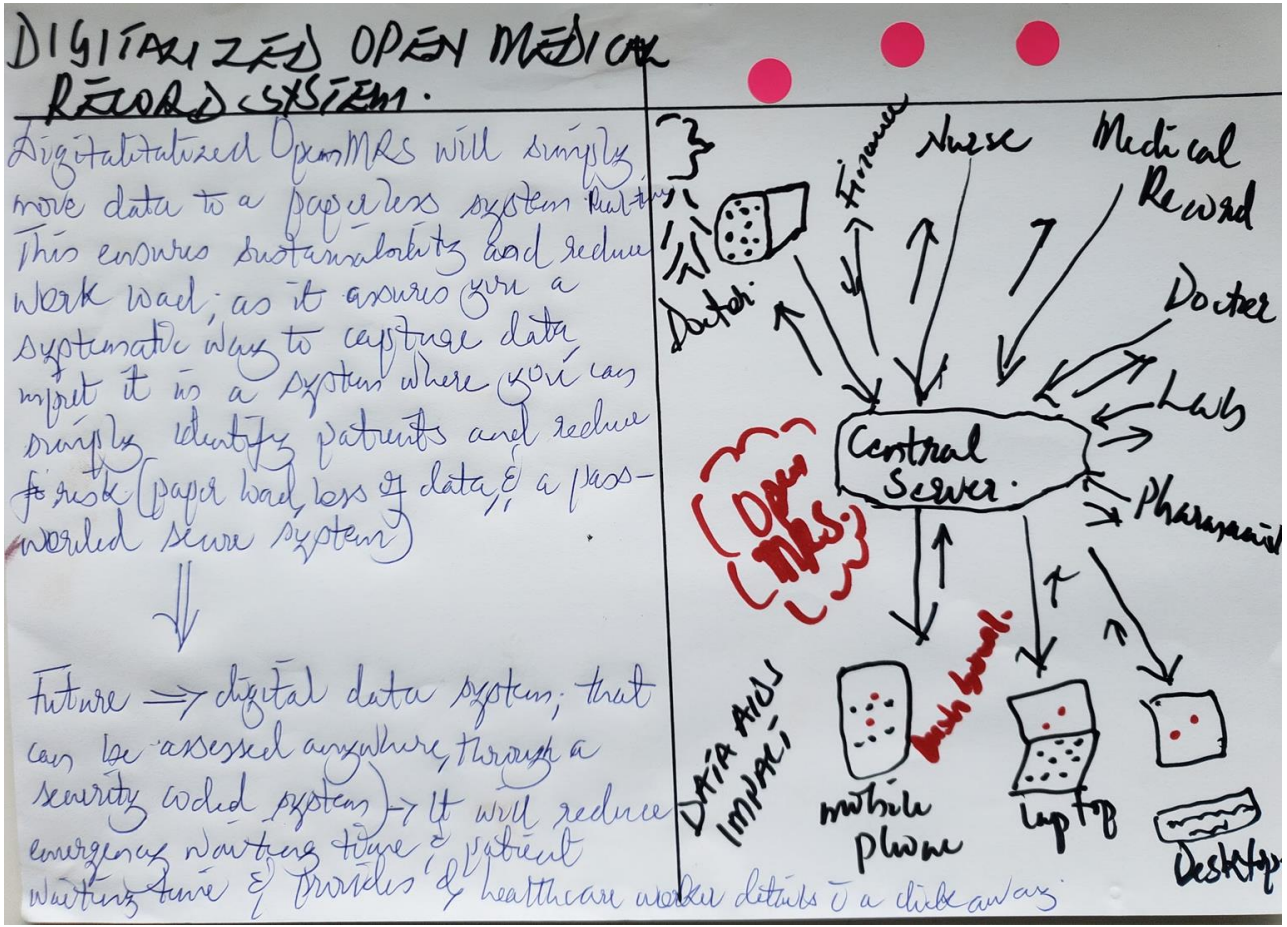
Local resources mobilized for health



Paper free community information system

Electronic tablets at the community level for data capture, automated aggregation and transmission

Shift from data collection to data use



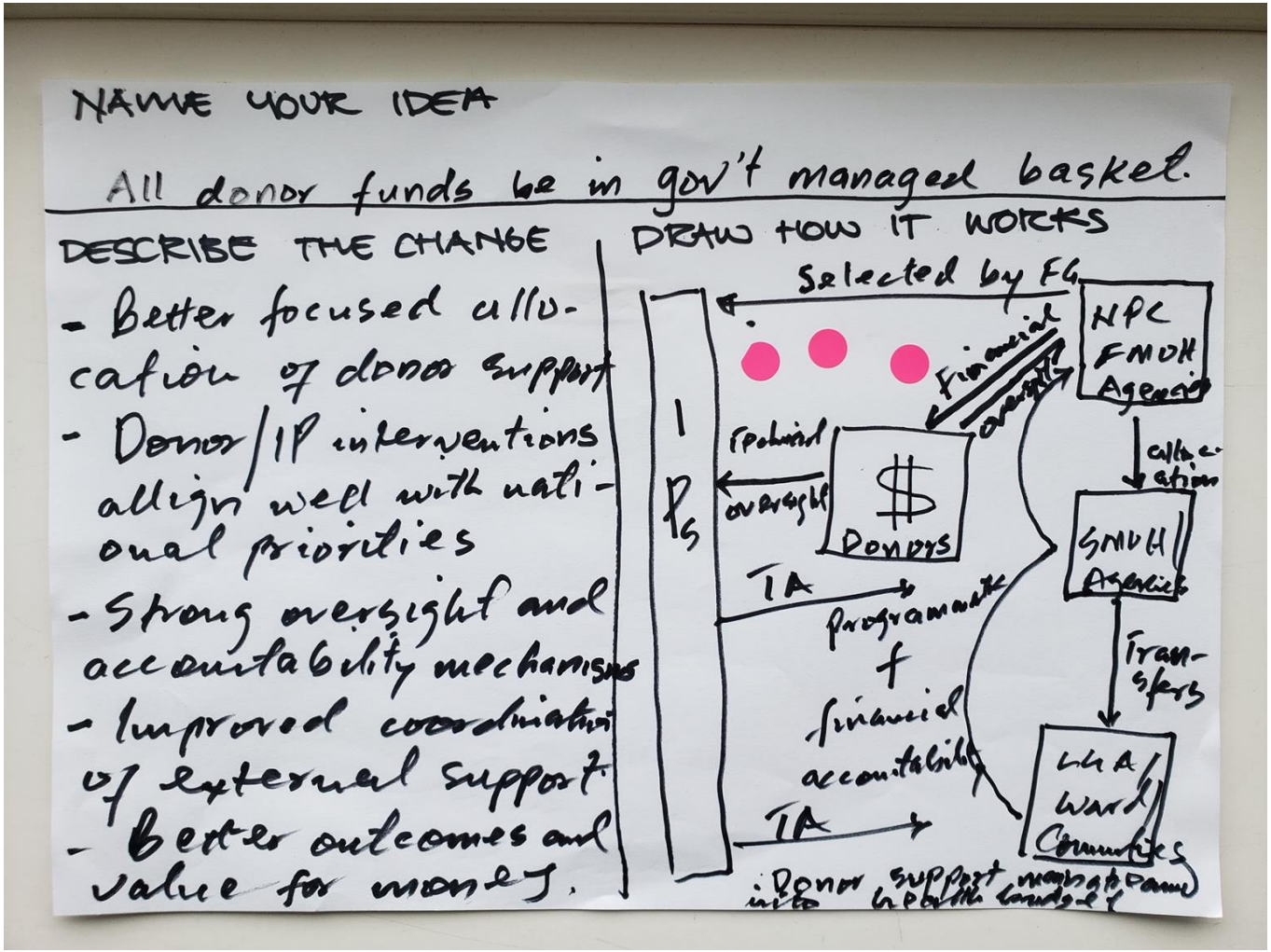
Digitized open record system

Move data into a paperless system

Improve patient care

Reduce workload associated with paper records

Crystalize data for decision making

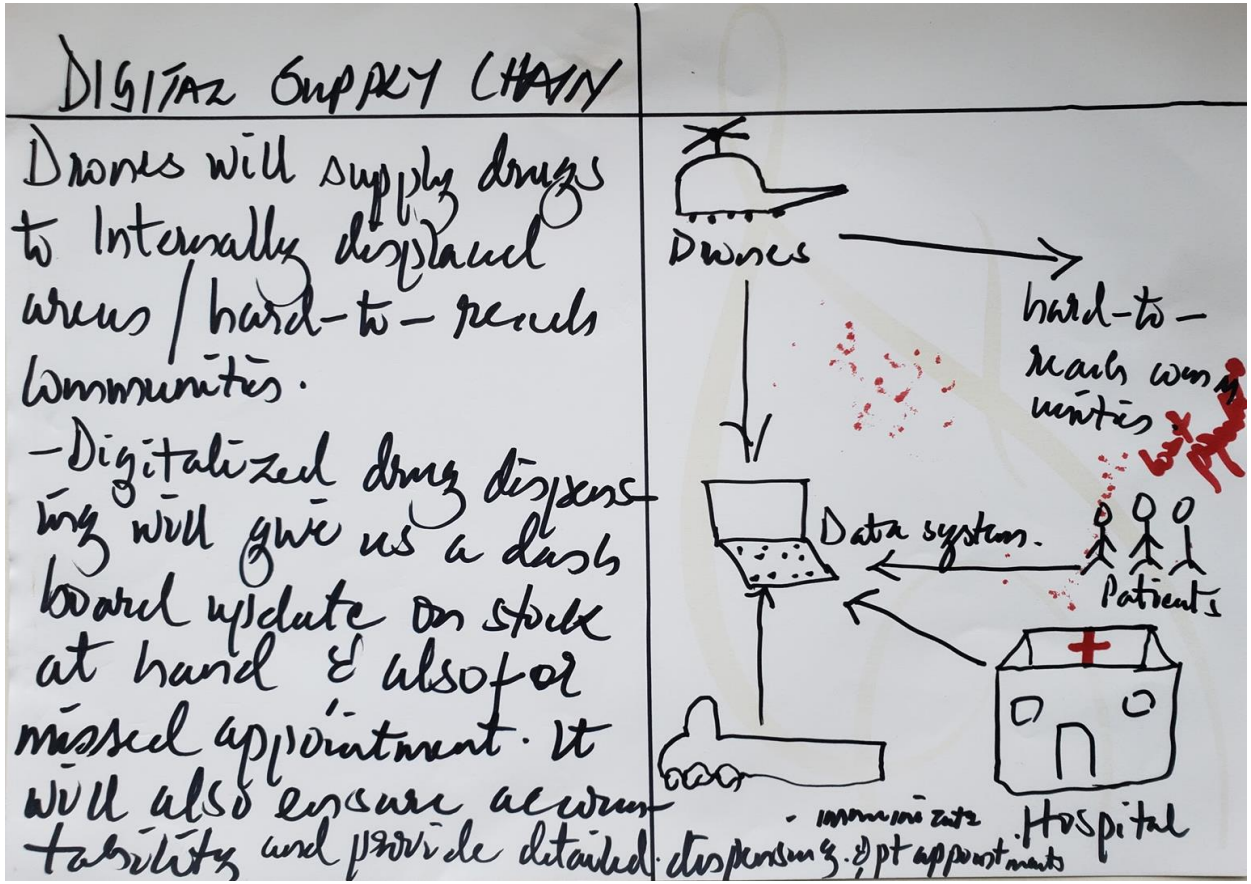


All donor funds into a government managed basket

Better focused allocation of donor support

Donor/ IP interventions align well with national priorities

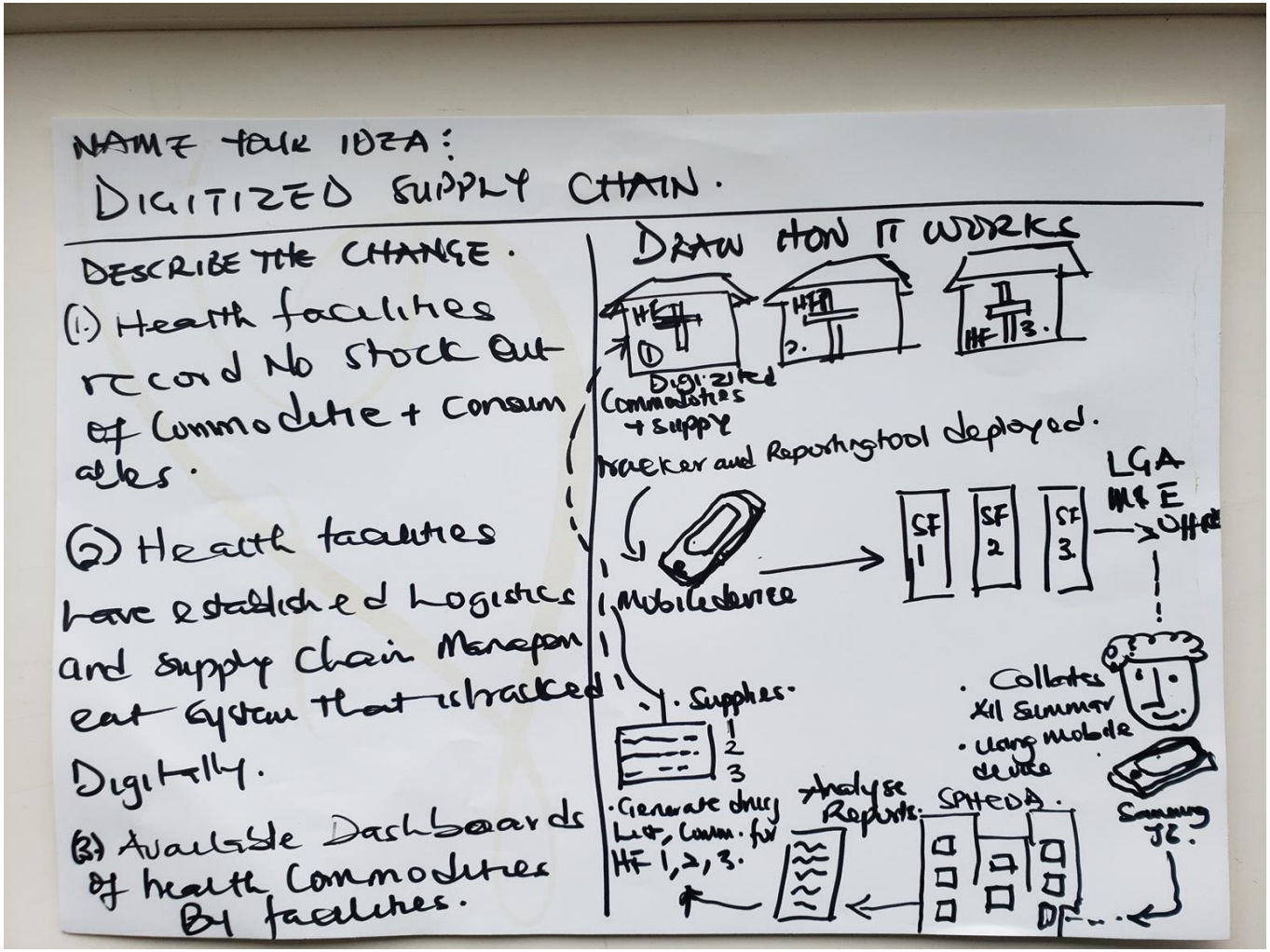
Strong oversight and accountability mechanisms



Digital supply chain

Drones supply drugs to displaced hard to reach communities

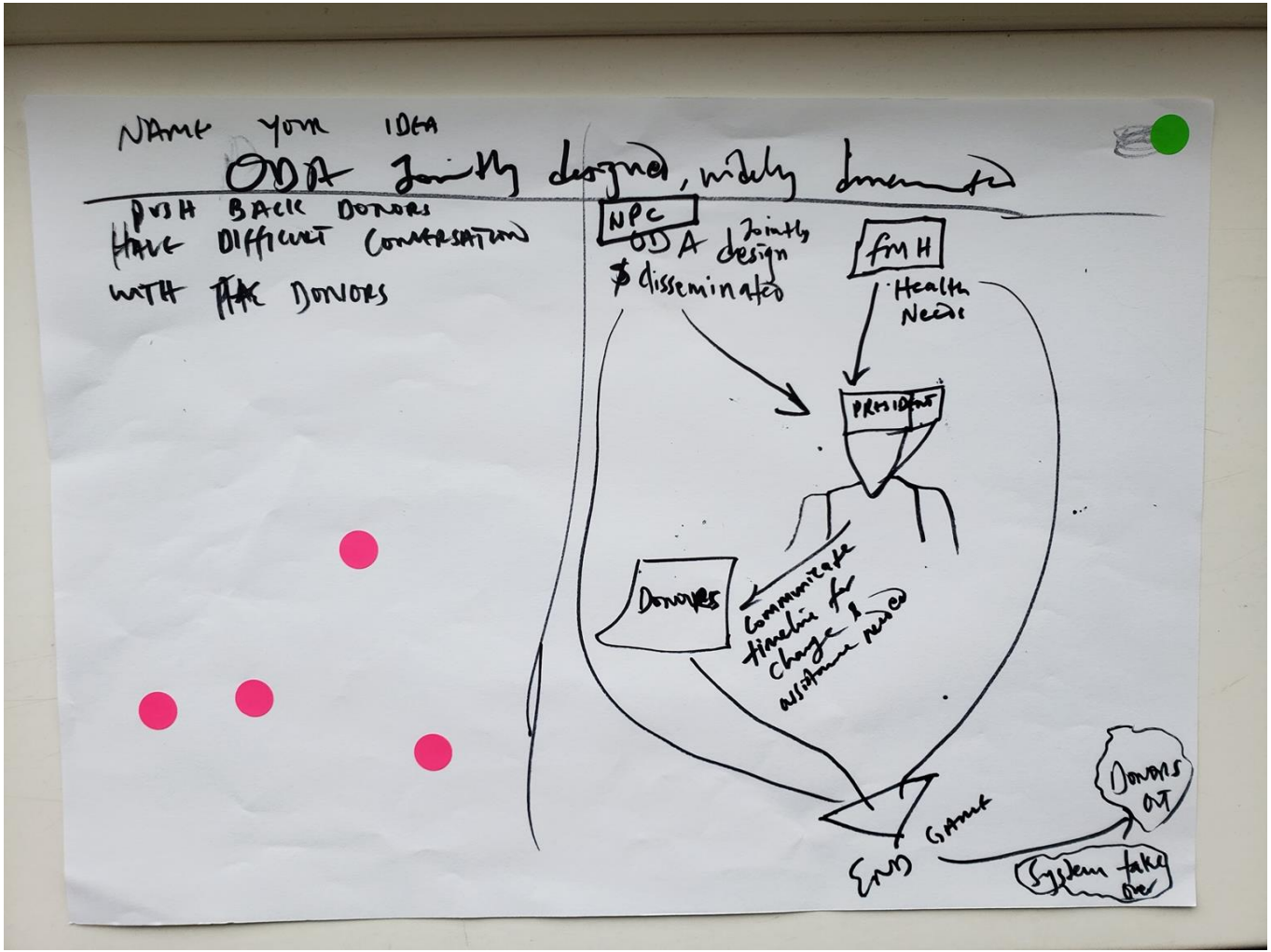
Digitized dispensing will give a dashboard of stock at hand



Digitised supply chain

Health facility record stock out of commodities and consumables

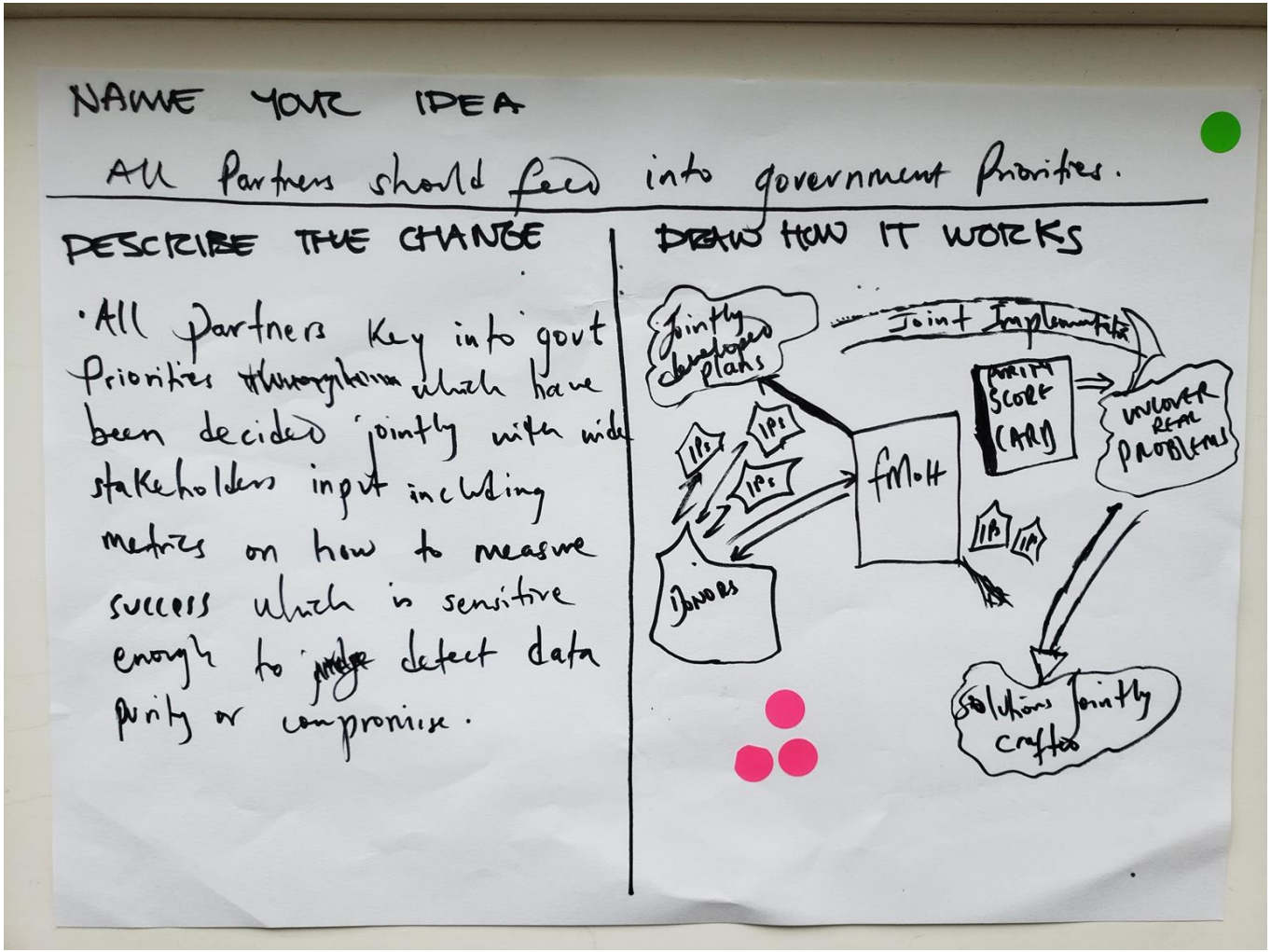
Health facilities have established logistic and supply chain management system that is tracked digitally



ODA jointly designed

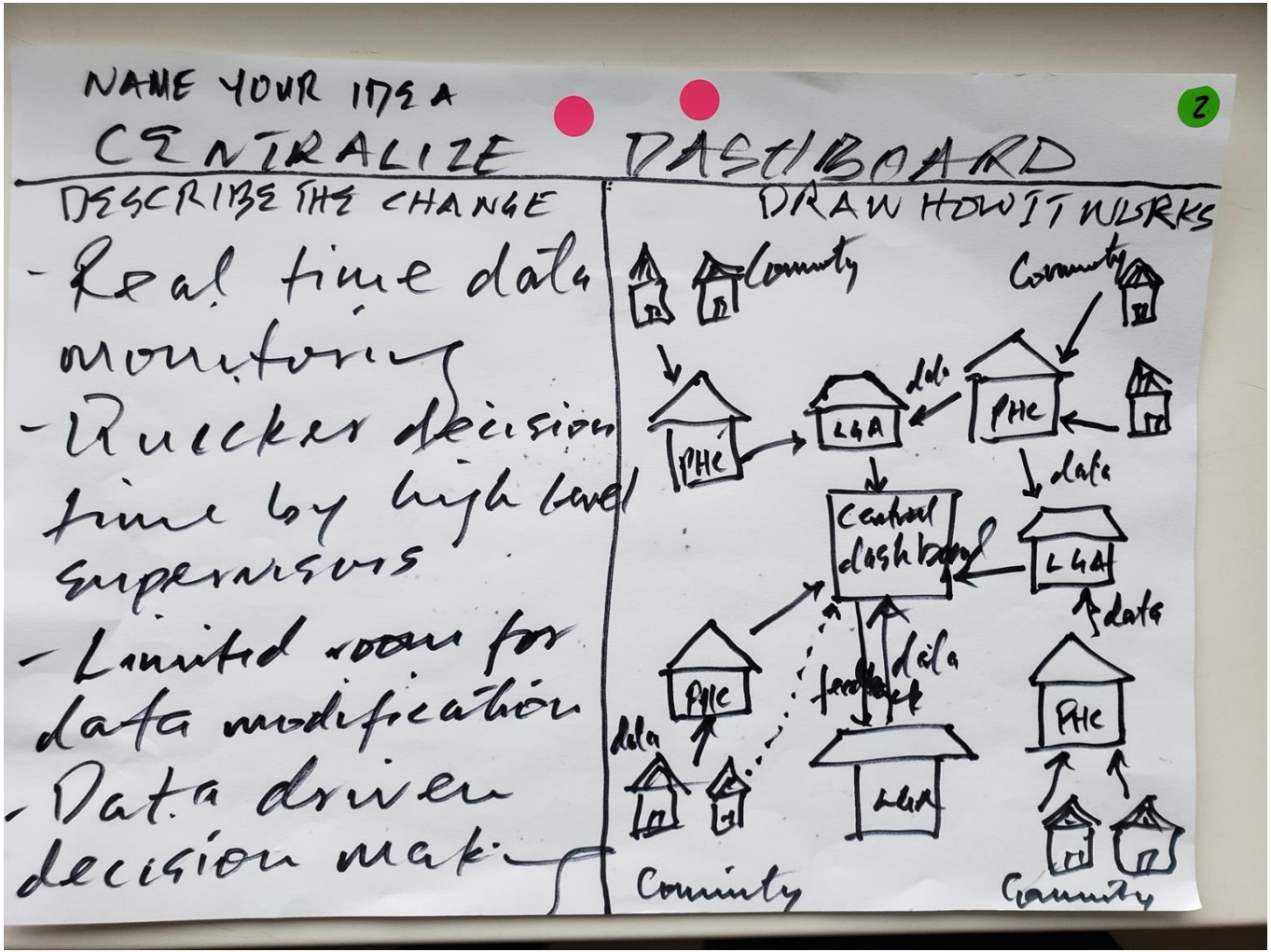
Having different conversations with donors

Including FMoH



All partners should feed into government priorities

All partners key into government priorities which have been decided jointly and include metrics on how to measure success

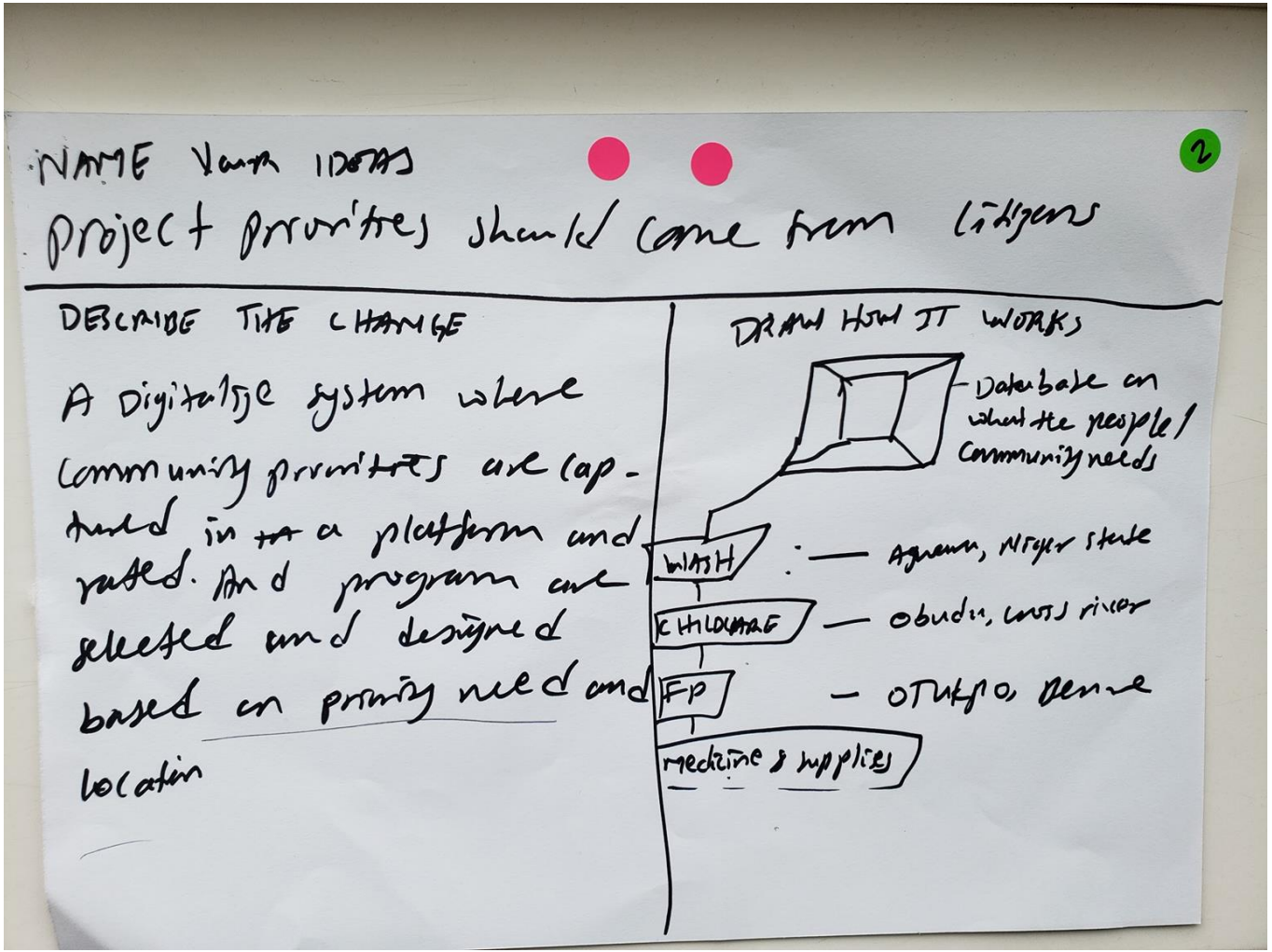


Centralized dashboard

Real time data monitoring

Quick decision time by high level supervisors

Limited room for data modification



Project priorities should come from citizens

A digitized system where community priorities are captured in a platform and rated

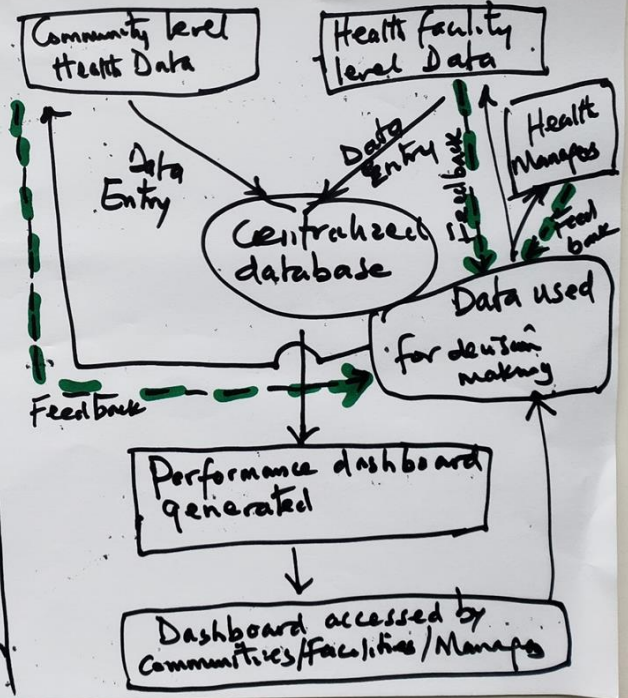
NAME YOUR IDEA : Dashboard access

2

DESCRIBE THE CHANGE

→ Dashboard is available to show performance based on agreed national indicators. Dashboard is simplified for community level and health facility level. Dashboard is accessible to community leaders, Community health workers and health managers/policy makers for viewing on their mobile phones and tablets and there is a channel to report feedback from these levels. Dashboard has simplified metrics with colour-coded to define performance and use the information for decision-making

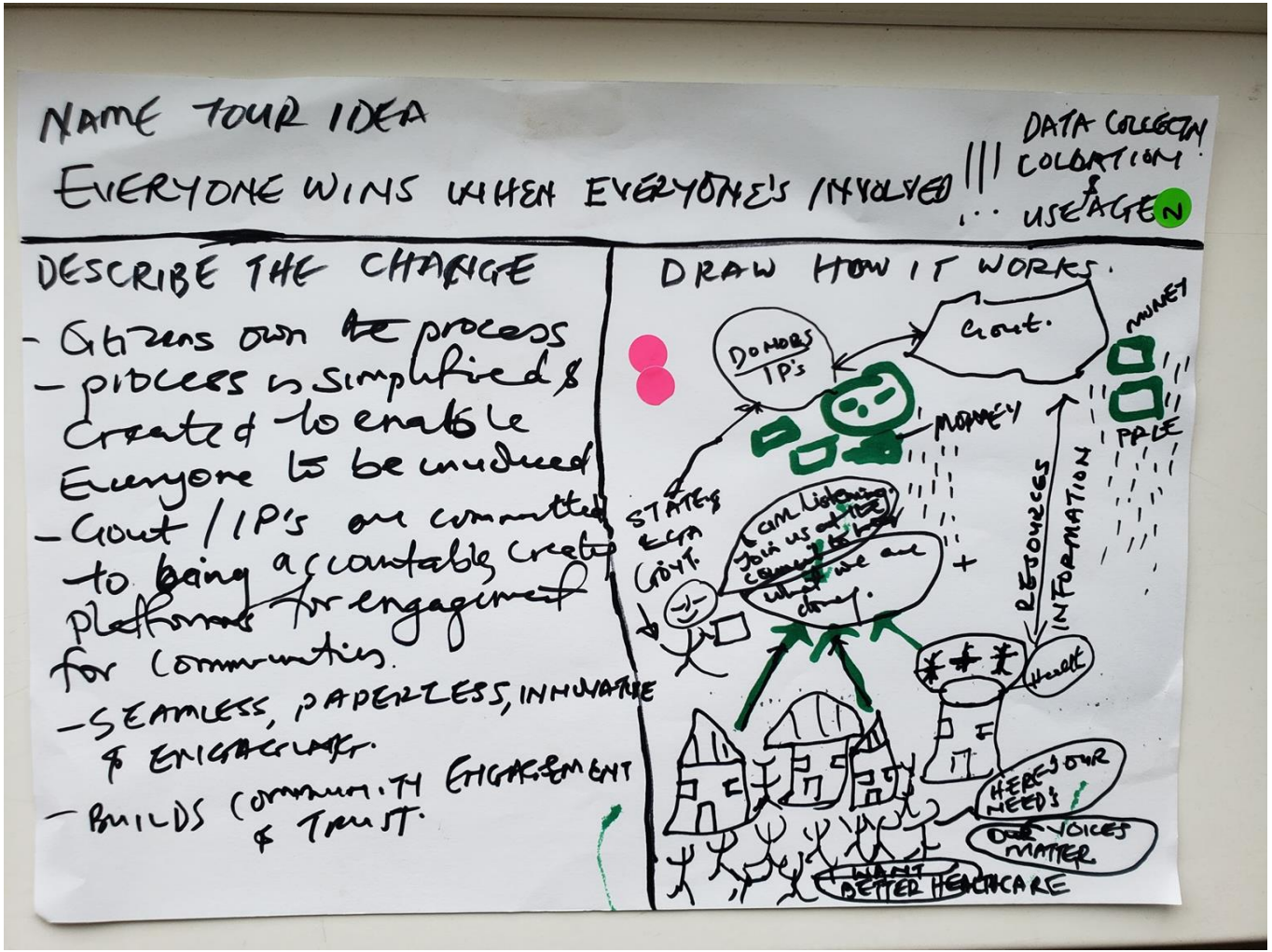
DRAW HOW IT WORKS.



Dashboard access

Dashboard is available to show performance based on national indicators

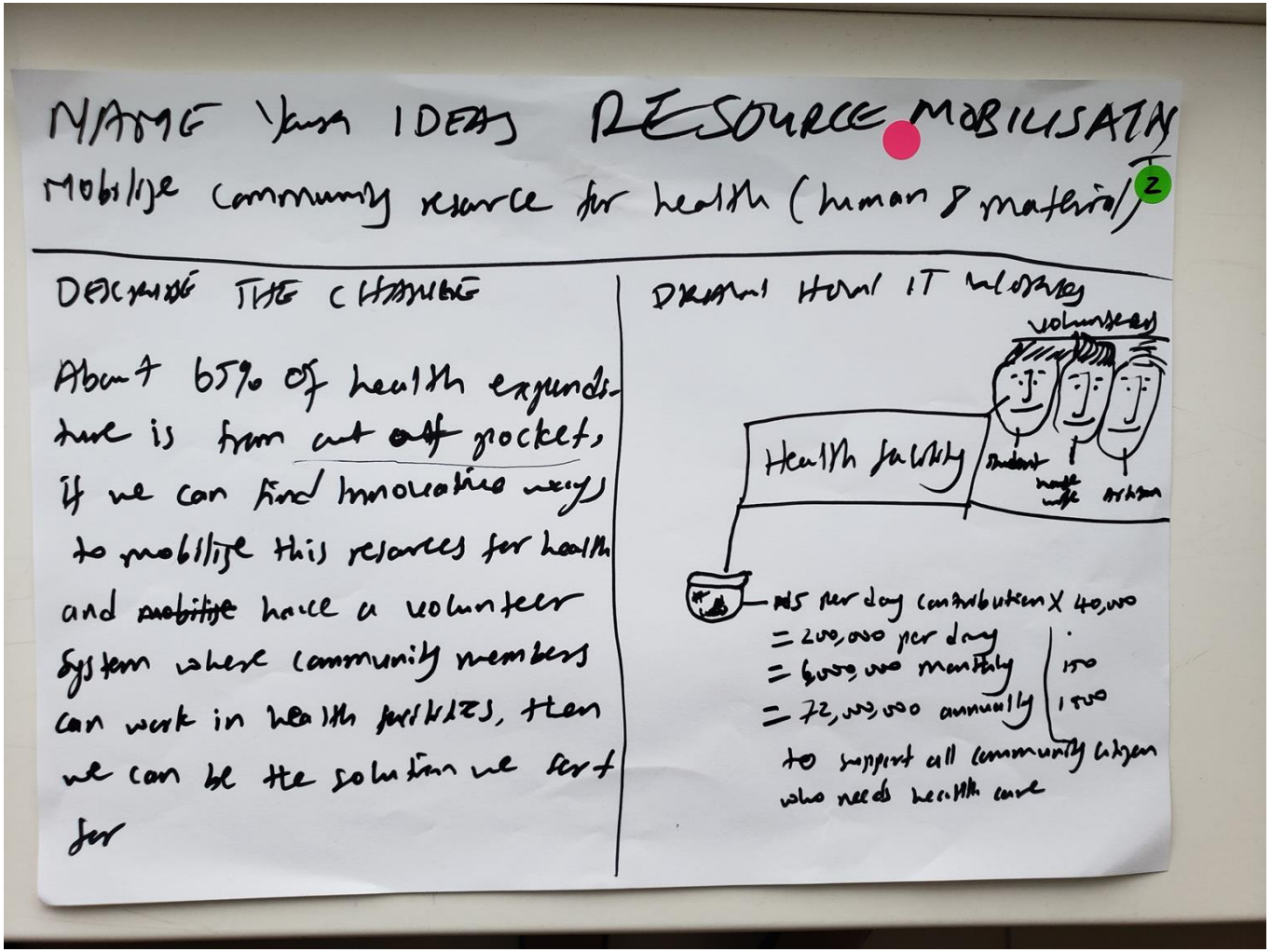
Dashboard is simplified for community level and health facility level



Everyone wins when everyone is involved

Processes are simplified to enable broader participation and engagement

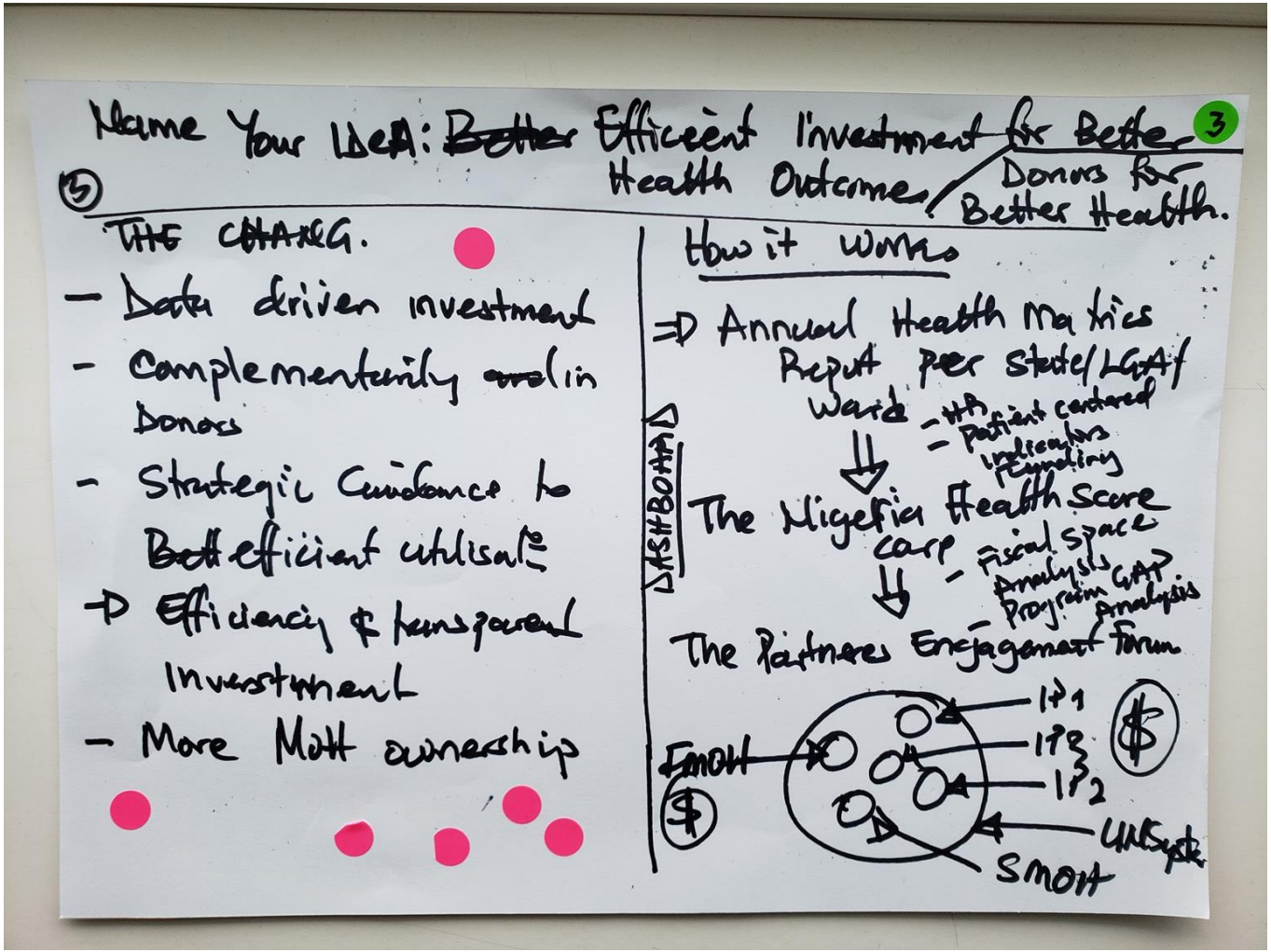
Government and donors feedback data to the community for better accountability and engagement



Resource mobalization

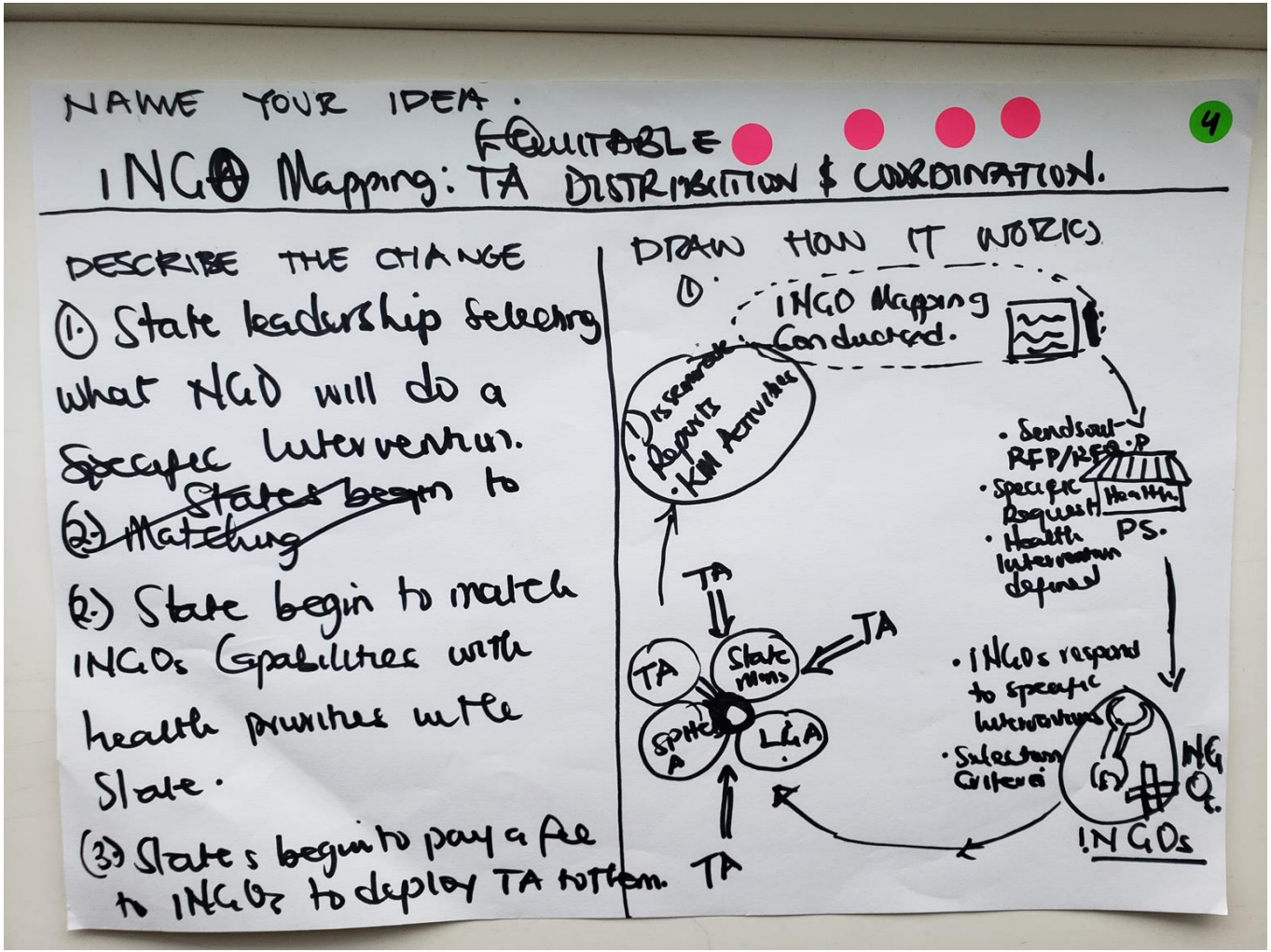
65% of health expenditure is out of pocket- how do we mobilize this contribution?

How might we have a volunteer system where community members can work with health professionals



Efficient investment for better health outcomes

Data driven investment, complementary to donors



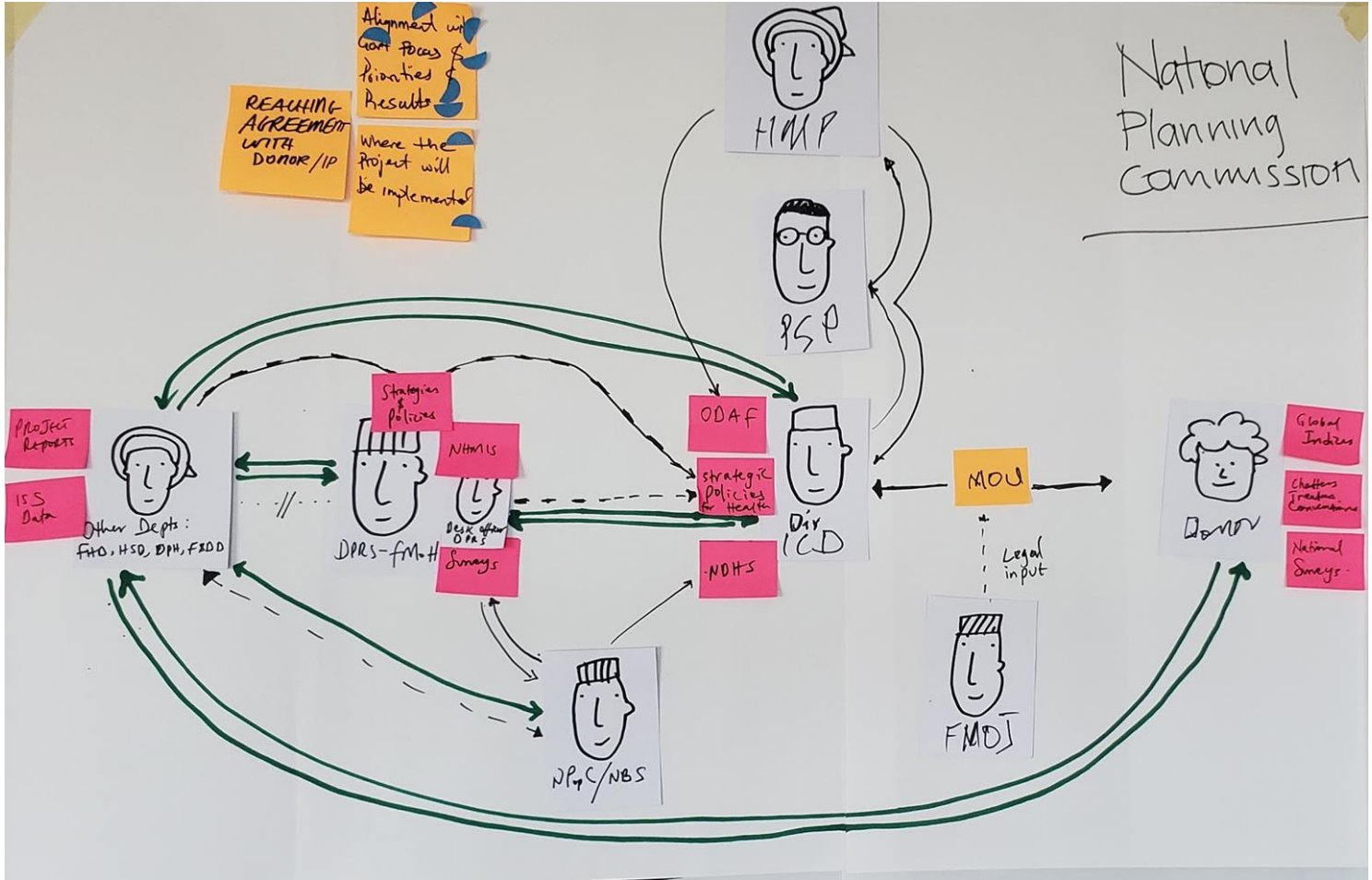
INGO mapping for distribution and coordination

State leadership steering what NGO's will do in a specific intervention

State begins to map INGO capabilities with health priorities in the state

State begins to pay a fee to INGO's to deploy TA to them

National Planning Commission - reaching an agreement with Donors



Why we need to re-imagine this decision making

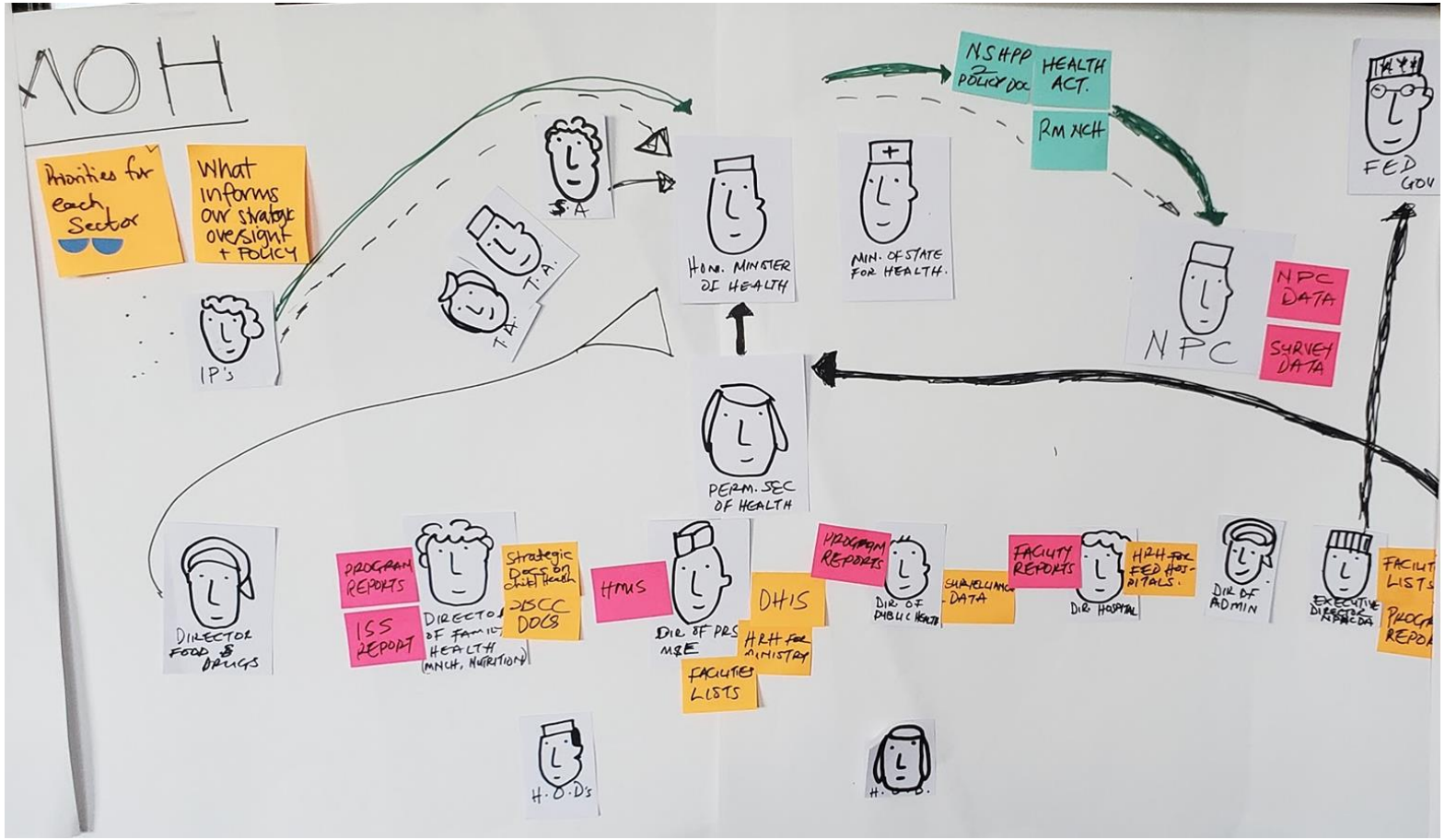
The current system does not adequately capture the inputs of the FMoH at the preconception// conception stage

This results in decisions that do not fully align with the strategic direction and priorities of the health sector as articulated by the FMoH

Gaps and challenges

- Limited interaction between FMoH and the data agencies NBS, NPOPC
- PRS planning desk is not connected with program departments
- ODAF solely developed by NPC
- No interaction between FMoH and Donors

MOH - What informs our strategic oversight and policy



Why we need to re-imagine this decision making

The current approach is not working

We need to ensure we target the right stakeholders at the right time

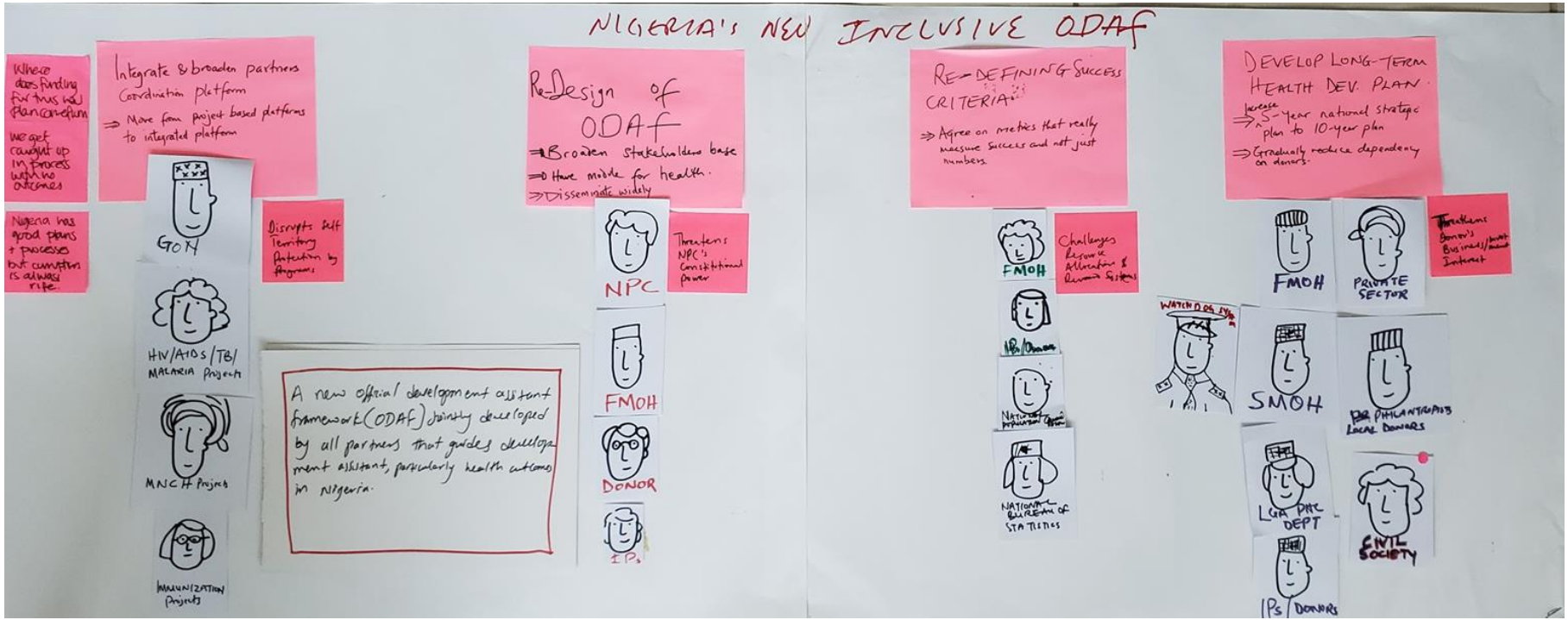
We need accurate and timely data to inform decision making at the National level

Resources are not being allocated to the TA we need

Gaps and challenges

- Week coordination mechanisms
- Fragmented data sources
- Fragmented measuring standards
- Poor data use for decision making
- Resource allocation does not align with program gaps
- Financial data is not shared

Future state - Nigeria's new inclusive ODAEF

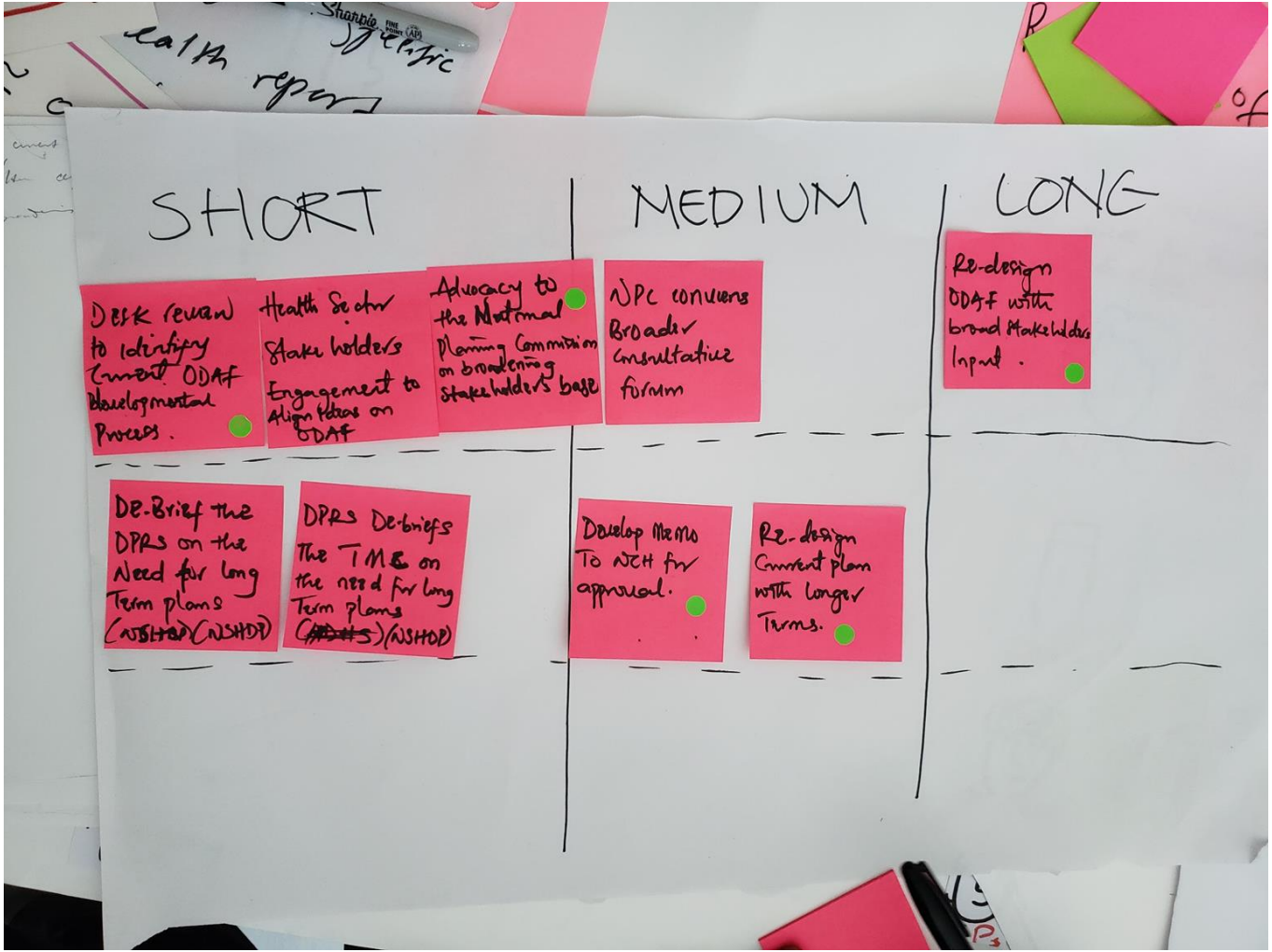


Future state - Nigeria's new inclusive ODAEF

A new official development assistance framework (ODAEF) is jointly developed by all partners and guides development assistance particularly health outcomes in Nigeria

Key shifts

From current state		To Future state
The current approach to planning is not inclusive of key stakeholders		ODAF design process should be more inclusive of all stakeholders, donors, IP's , private sector, technical MDAS
Timeframes are too short to address bold goals		Shift health development plan from 5 years to 10 years with increased time for ownership and implementation
Internally within the FMoH there is little interaction between different program health areas		More structures internal and external coordination mechanisms within FMoH and government led coordination of partners and programs for stronger government ownership and leadership



Short

- **Desk review to identify current ODAF developmental process***
- Health Sector stakeholders engagement to align ideas on ODAF
- **Advocacy to the national planning commingo on broadening stakeholder base***
- Debrief the OPRS on the need for long term plans
- DPRS debriefs the TMC on the need for long term plans

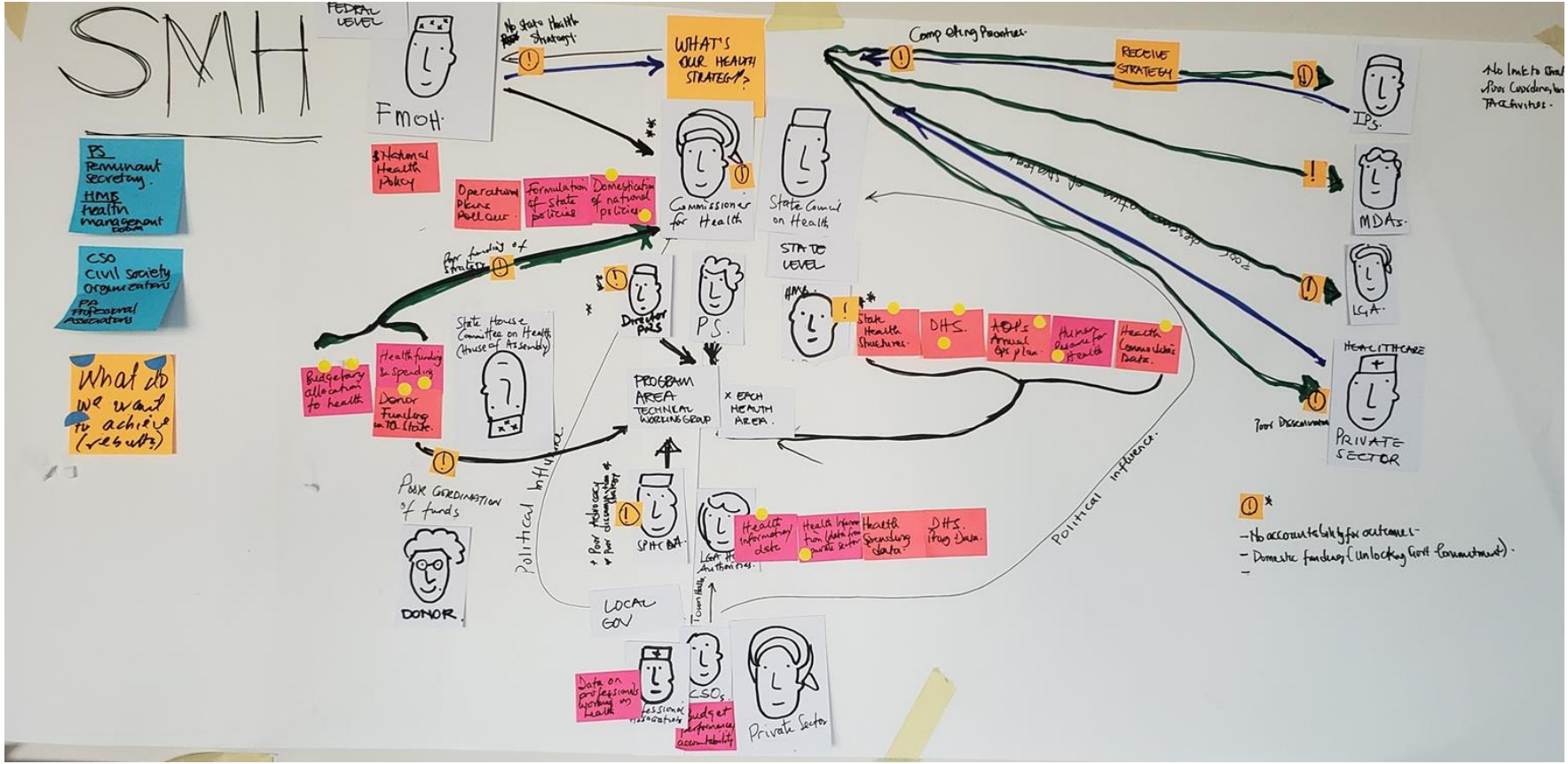
Medium

- NPC conveans broader consituate forum
- **Develop memo to NCH for approval***
- **Redesign current plan with longer terms***

Long

- **Redesign ODAF with broad stakeholder input***

MOH - What is our health strategy?



Why we need to re-imagine this decision making

States receive different funding for health programs that are not well coordinated

States do not know and understand the IP's agenda and how it aligns with the state health agenda

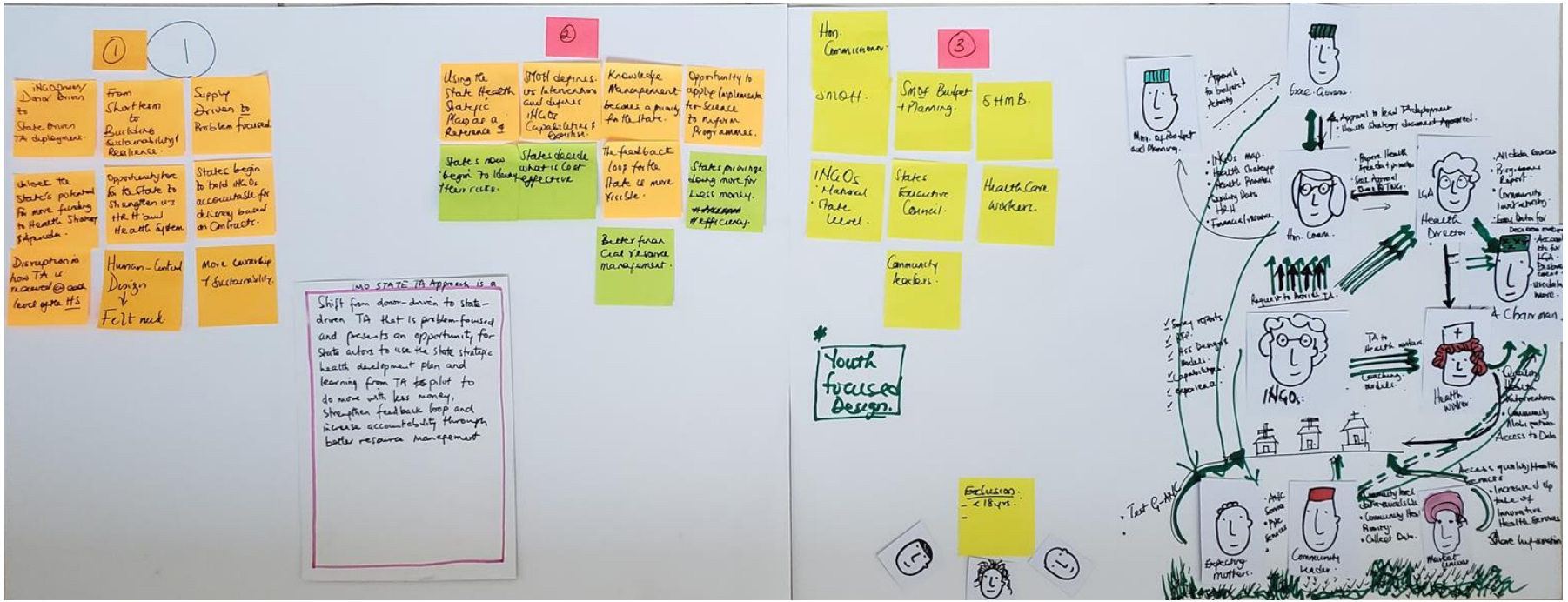
Competing influences and agendas affect the state health strategy

Poor dissemination of the state health strategy

Gaps and challenges

- Week communication and influence of state priorities
- Poor funding of the state strategy
- Paper based documentation slows information flow
- Poor use of data sets at all levels
- Poor tech skill sets and capacity gaps
- Poor release of domestic funding
- Poor coordination of donor funds
- Poor dissemination of the health strategy
- No accountability for outcomes

Future state - IMO state approach



Future state - community dashboard

Shift from donor driven to state driven TA that is problem focused and presents an opportunity for state actors to use the state strategic development plan and learning from TA to pilot to do more with less money, strengthen feedback loops and increase accountability through better resource management

Key shifts

From current state		To future state
The state health strategic plan is not well disseminated or costed		TA should create a system that is consultative, iterative and considers an efficient accessible dissemination approach for the SHSP document
The state domestic financing has not fully unlocked its potential it is still reliant on donors, Ip's partners		The state unlocks its funding potential by committing resources to health priorities and having budget lines that are evidence informed - go a step further by releasing funds and tracking utilization
The state still lacks capacity across various programs and orginizational areas. There is weak leadership and governance across all tiers in the state health system		Capacity building should be institutionalized, inservice training, nursing schools - target state training institutions and embed these skills for sustainability and cost eficiency

Short

- **Partner mapping and commitment setting ***
- Consultative annual operational planning
- **Own your problems and commit to solutions ***
- Capacity needs assessment
- State owned health priorities with funding sources identified
- Gov planning/budgeting their domestic funding

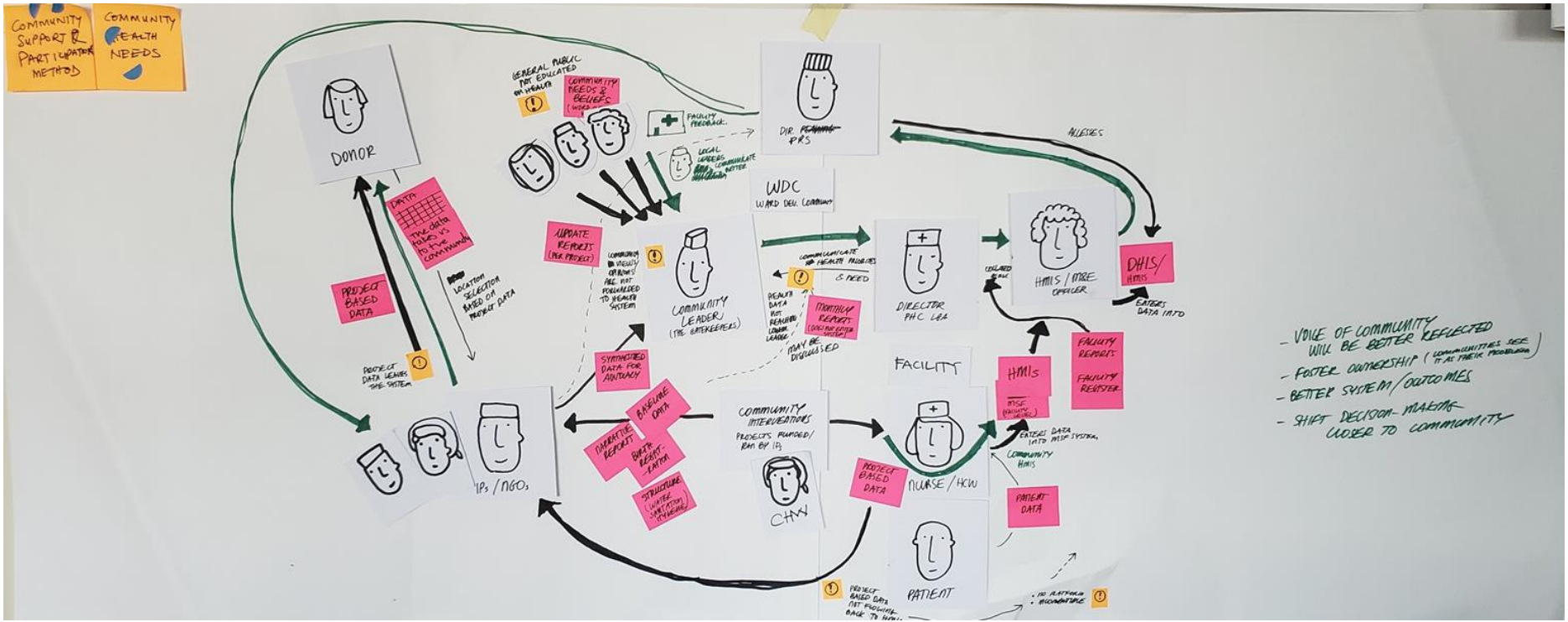
Medium

- Quality service delivery with clear milestones
- **Joint planning and implementation of state health strategic plan ***
- **Partner coordination led by gov ***
- Well designed call for TA
- Move from piloting to scale
- INGO and gov accountability
- Mapping state domestic financing and sources. Institute state funding basket to pool all sources of funds.
- Use of quality data for planning and decision making
- Joint supportive supervision
- Data should follow into the HMIS

Long

- **Disseminated and easy to use state health strategic plan ***
- Clear state joint monitoring plan
- Well funded and operationalized strategic plan
- Contracts and MOUs with a pool of TA partners

Community leader - what are our community health needs



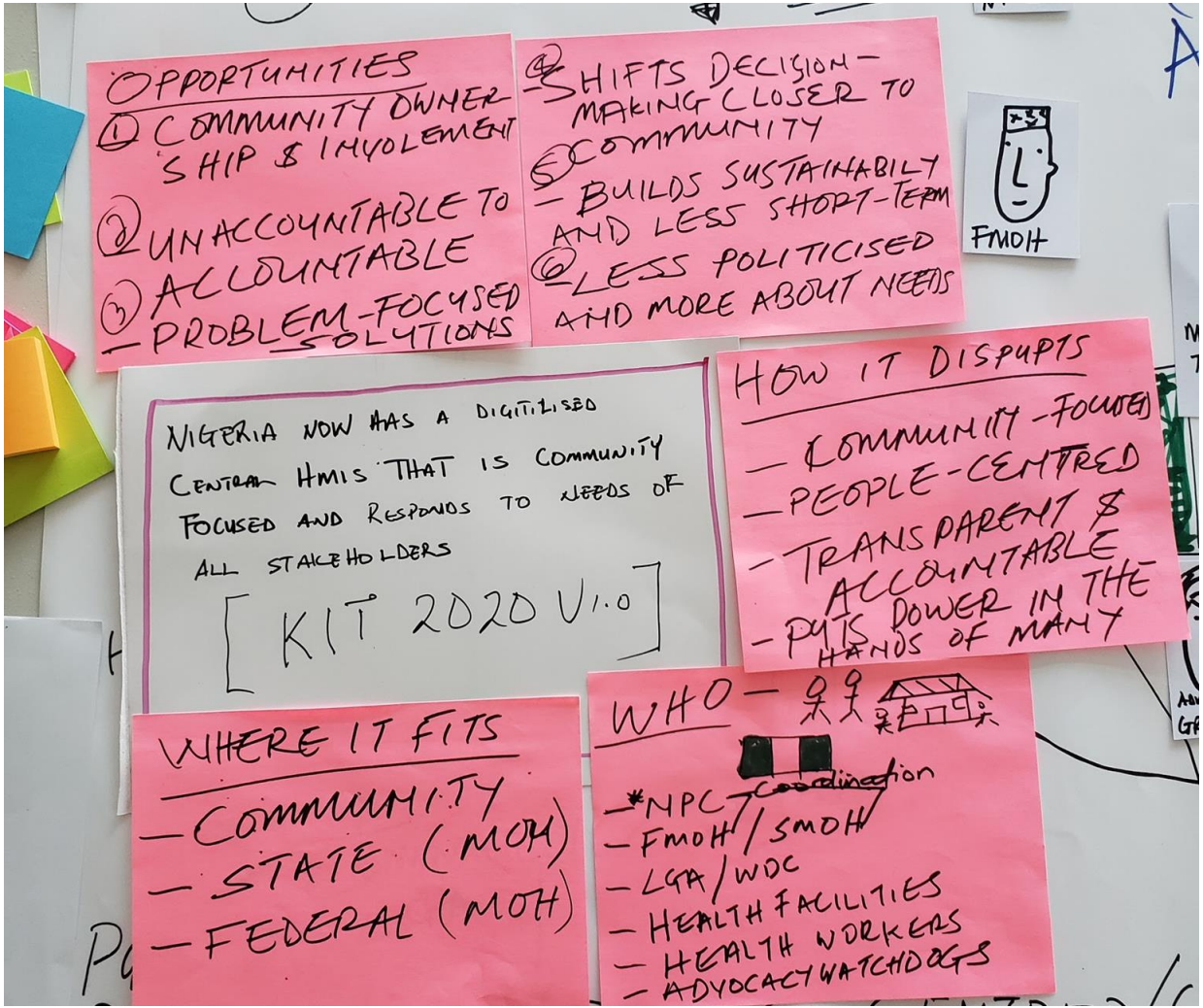
Why we need to re-imagine this decision making

The community leader influences access to and engagement with the community yet does not have access to understandable health data

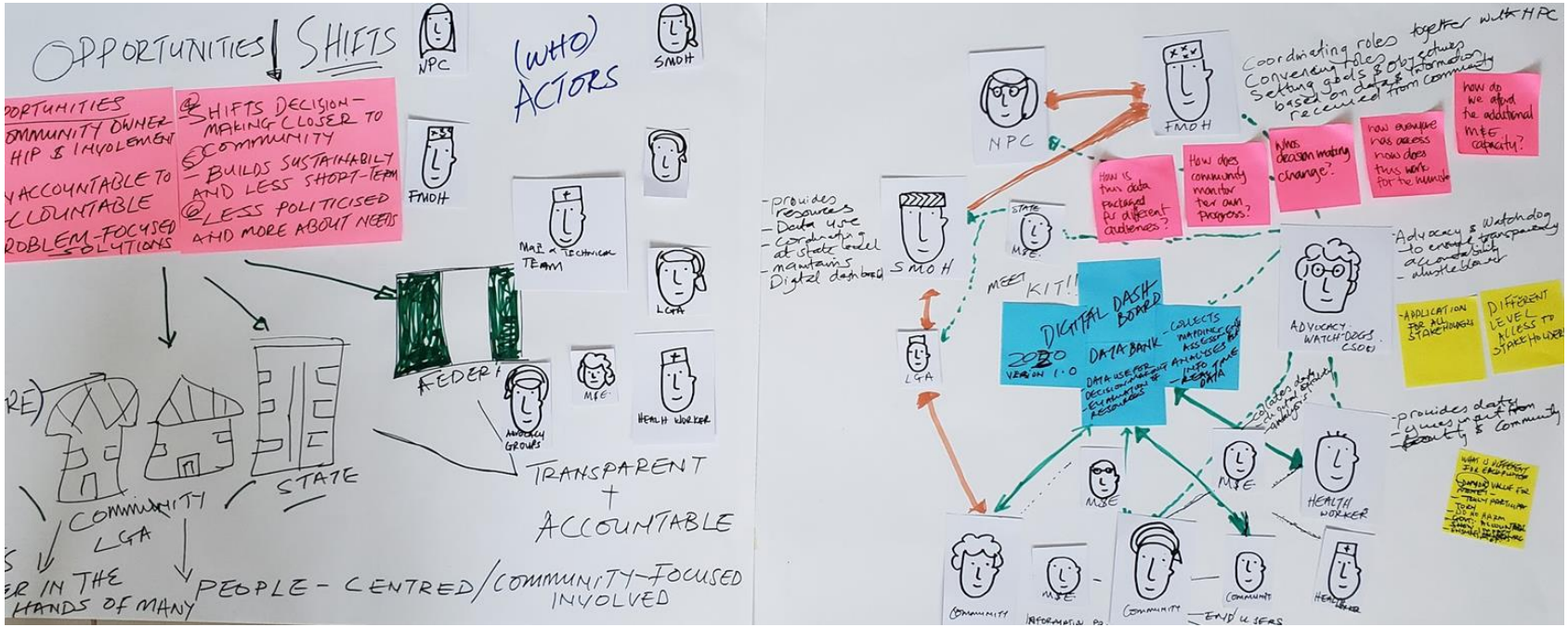
Much health data goes out of the community to the DHIS and back to donors while there is little feedback to communities to allow them to understand their own needs or track their own performance

Gaps and challenges

- Health data does not reach the community- no feedback
- Project data leaves the community
- Information gathered is not comprehensive
- Community needs and beliefs are not taken into consideration
- Interventions are not data driven
- There is no capacity at the community level to collect or collate data
- Limited capacity of community leaders to understand data and reports
- Limited resources are available at the community level


OPPORTUNITIES
1. COMMUNITY OWNERSHIP & INVOLEMENT
2. UNACCOUNTABLE TO ACCOUNTABLE
3. PROBLEM-FOCUSED SOLUTIONS
SHIFTS DECISION-MAKING CLOSER TO COMMUNITY
BUILDS SUSTAINABILITY AND LESS SHORT-TERM
LESS POLITICISED AND MORE ABOUT NEEDS
FMOH
NIGERIA NOW HAS A DIGITILISED CENTRAL HMIS THAT IS COMMUNITY FOCUSED AND RESPONDS TO NEEDS OF ALL STAKEHOLDERS
[KIT 2020 V1.0]
HOW IT DISRUPTS
- COMMUNITY-FOCUSED
- PEOPLE-CENTRED
- TRANSPARENT & ACCOUNTABLE
- PUTS POWER IN THE HANDS OF MANY
WHERE IT FITS
- COMMUNITY
- STATE (MOH)
- FEDERAL (MOH)
WHO -
Coordination
- NPC
- FMOH / SMOH
- LGA / WDC
- HEALTH FACILITIES
- HEALTH WORKERS
- ADVOCACY WATCHDOGS

Future state - community dashboard



Future state - community dashboard

Nigeria now has a digitised central HMIS that is community focused and responds to the needs of all stakeholders

Key shifts

From current state		To Future state
Top down decision making based on political ideology and little to no data - usually made by the community leader and/or ward development council		Community driven decision making by the community leader who is well informed by the data he understands
No accountability to the community leads to their inability to trust - the community does not have access to data or reasons for why programs are being implemented		Improved accountability and trust between the community and state
Fragmented data collection based mostly on quantitative data with no inputs from the community		Robust accessible data informs decision making
A short term and fragmented way of working - program based with short term implications		A community based strategy that is sustainable working towards ownership and addressing the root cause of problems - the community is well informed and take the lead

Short

- Feedback loop from donors/IPs to community
- Ensure community leaders have data to make decisions
- **Increase coordination between community, state, and federal***
- Develop information products in local languages
- Build capacity for data analysis
- **Strengthen capacity for data analysis***

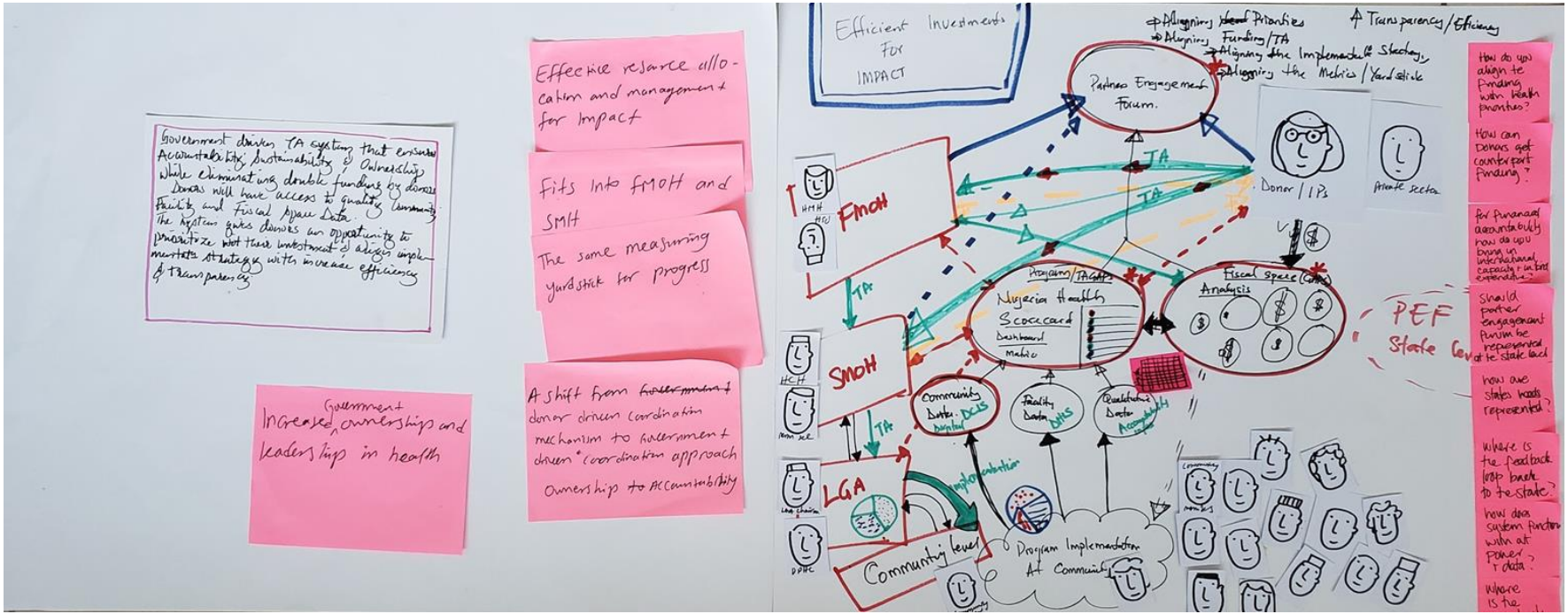
Medium

- **Increase coordination between communities, state and federal***
- Develop SOP for CHMIS
- **Build community HMIS registers***
- Strengthen advocacy watch dogs

Long

- **Digital data bank***
- Digital dashboard (community data)
- Increase coordination between community, state and federal

Future state - efficient investment for impact

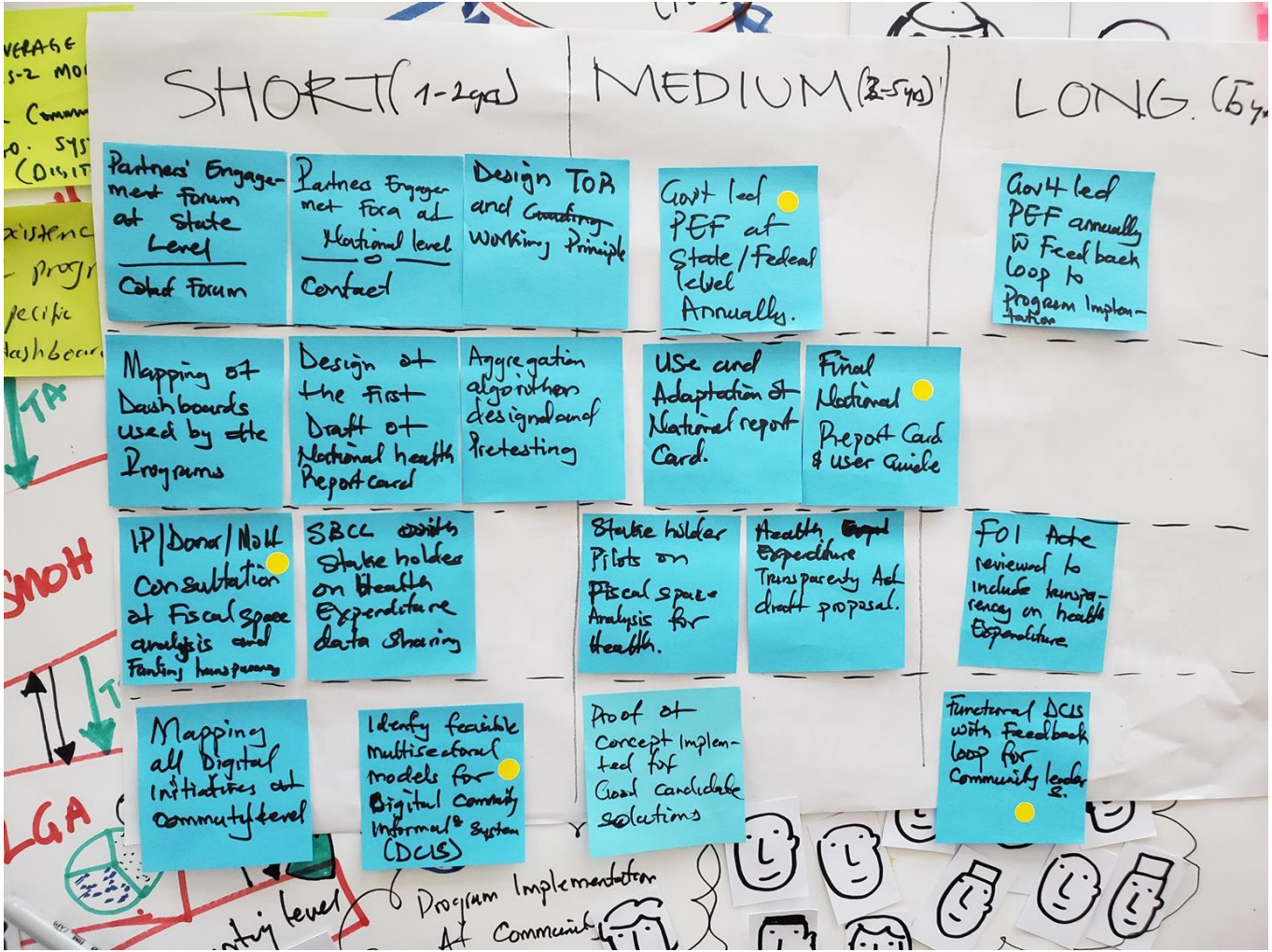


Future state - efficient investment for impact

Government drives at TA system that ensures accountability, sustainability and ownership while eliminating double funding by donors. Donors will have access to quality community, health and fiscal space data. The system gives donors the opportunity to prioritize their investment and align implementation strategies with increase efficency and transparency

Key shifts

From current state		To Future state
Community data generation only		Feedback loops that generate and use data for decision making
A fragmented program specific dashboard		A national health report card leveraging on FOI act - open financial reports build accountability and trust
More donor driven partner engagement forum		Not stopping partner forums but strengthening government led forums



Short

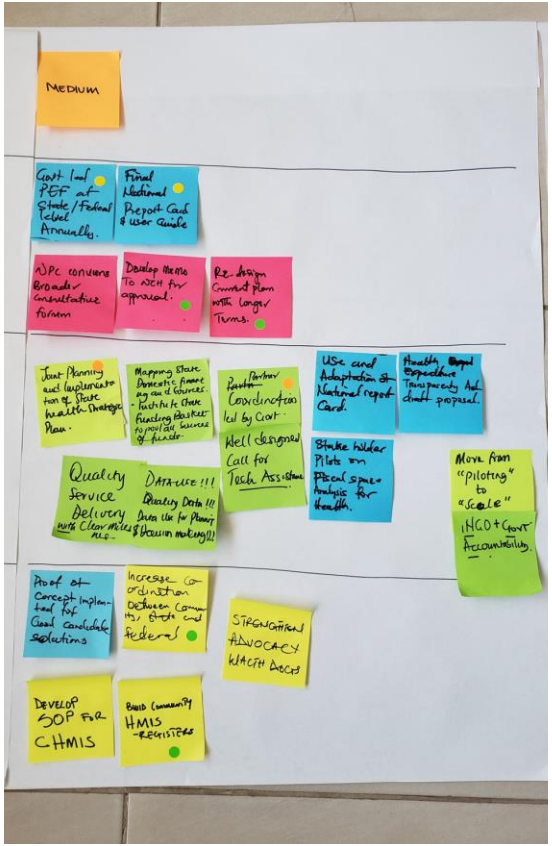
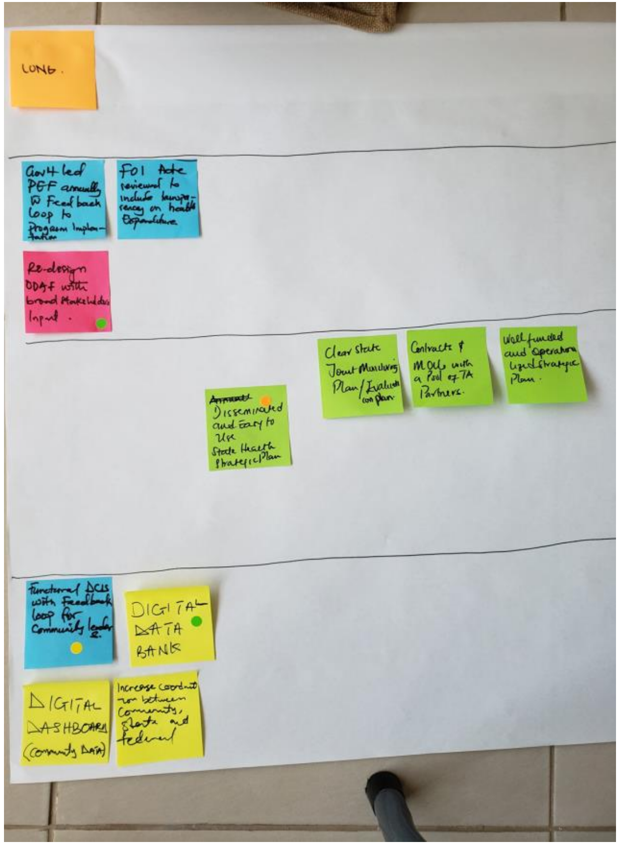
- Partners engagement forum at state level (co-led forum)
- Mapping of dashboards used by programs
- **IP/donor/MOH consolidation of fiscal space analysis and financial transparency***
- Mapping all digital initiatives at community level
- Partners engagement forum at a national level
- Design of the first draft of national health report card
- SBCC with stakeholders on health expenditure data sharing
- **Identify feasible multisectoral models for digital community information system (DCIS)***
- Design TOR and working principles
- Aggregation algorithms design and pretesting

Medium

- **Gov led PEF at state/fed level annually ***
- Use and adoption of national report card
- Stakeholder pilots on fiscal space analysis for health
- Proof of concept implemented for good candidate solutions
- **Final National Report card and user guide***
- Health expenditure transparency act draft proposal

Long

- **Functional DCIS with feedback loop for community leaders***
- Gov led PEF annually with feedback loop to program implementation
- FOI act reviewed to include transparency on health expenditure


SHORT
FED GOV
STATE GOV
COMMUNITY
Design at the First Draft of National health Report card
Aggregation algorithm design and Pretesting
Design TOR and Coordinating Working Principle
Health Sector Stake holders Engagement to Align these on ODAF
PARTNER MAPPING & Commitment Setting
Own your Problem & Commit to Solving it
Mapping of Dashboards used by the Programs
CONSULTATIVE ANNUAL OPERATIONAL PLANNING
CAPACITY NEEDS ASSESSMENT
State Owned Health Priorities with Funding Sources Identified
FEED BACK LOOP FROM DONORS/IP TO COMMUNITY
DEVELOP INFORMATION PRODUCTS IN LOCAL LANGUAGES
STRENGTHEN REFERRAL SYSTEM
Mapping all Digital initiatives at Community level
INCREASE DATA ANALYSIS FOR ACCESSIBILITY
ENSURE COMMUNITY LEADERS HAVE DATA TO MAKE DECISIONS
BUILD CAPACITY FOR DATA ANALYSIS

MEDIUM
Final National Report Card & User Guide
Develop Memo To NCH for approval.
Quality Service Delivery
DATA USE!!!
Use and Adaptation of National report Card.
Move from "piloting" to "scale"
INGO + Govt Accountability
Proof of Concept Implemented for Good candidate solutions
Increase Co-ordination between Community, State and federal
STRENGTHEN ADVOCACY
DEVELOP SOP FOR CHMIS
Build Community HMIS - REGISTERS

LONG.
Govt led PEF annually w Feedback loop to Program Implementation
Re-design ODAF with broad stakeholders Input.
Clear State Joint Monitoring Plan/Evaluation Plan
Contracts & MOUs with a Pool of TA Partners.
Well funded and Operational State Strategic Plan.
Disseminated and Easy to Use State Health Strategic Plan
DIGITAL DATA BANK
DIGITAL DASHBOARD (Community Data)
Increase coordination between Community, State and federal