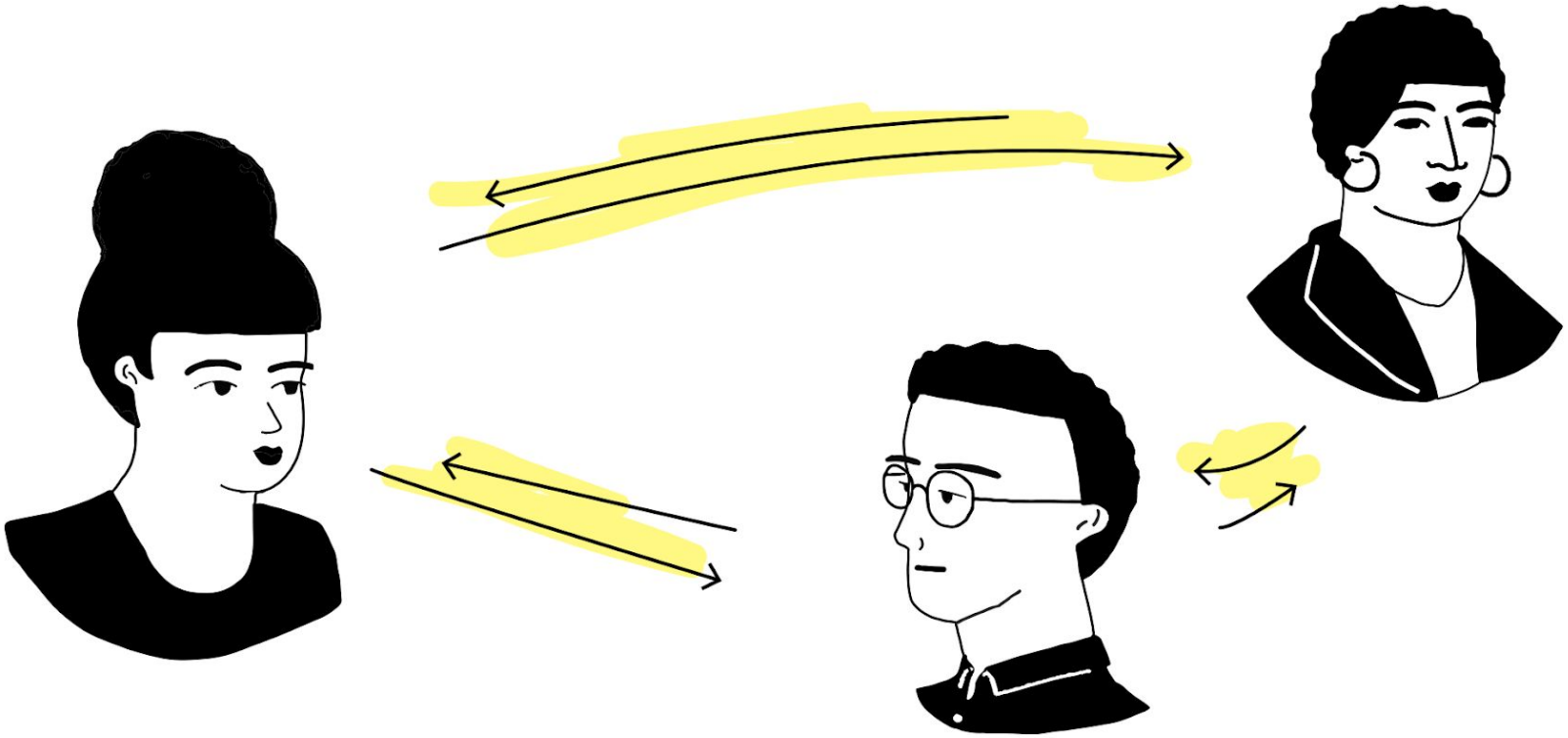


Integration workshop documentation

Re-imagining TA in Nigeria

Abuja, 21.-22.2.2020

Purpose and content of this document

This document summarizes the activities and outputs created at the last workshop of the Re-imagining Technical Assistance project in Abuja from 21 to 22 January 2020.

The document gives an overview of the agenda of the two days and summarizes key activities conducted.

For key activities, raw data of the exercises has been documented where possible and summarized where needed.

Attendants

Ibironke Dada	Pharm Access
Ovuoraye John	FMOH
Nkeiru Onuekwusi	Independent Consultant
Abimbola Williams	JSI
Funke Falade	IHP
Nomtai Tukura	JSI
Chiugo Nwangwu	DAI Nigeria
Ann Akparanta	JSI
Asabe Karagama	FMOH/CHD
Ifeanyi Ume	IHP
Dr. Joseph Sunday	KD, SMOH
James Dominion C.	FMOH/DHPRS
Emeka Ajanwachukwu	Pharm Access
Ugonwa Unaogu	CHAI
Adebayo Oluwatimileyin	BHCPF
Dr. Femi James	FMOH
Aisha Daggash	CHAI
Audu Grema	BMGF
Comfort Booth	BMGF
Ijeoma Iwuora	BMGF
Obidimma Cynthia I.	NPHCDA
Dr. Victoria Agbara	DAI Nigeria
Dr. Joe Abah	DAI Nigeria
Helen M. Envuluanza	FMOH
Ayenowowon Olanrewaju	FMOH
Dr. Cheshi Fatima	UNICEF
Dr. Genevieve Eke	Save the Children
Christiana Asala	White Ribbon Alliance Nigeria
Owolabi Titilayo	Solina
Tinuola Taylor	FMOH
Dr. Dachung Alexander	FMOH
Tajudeen Arowolo	NASS
Dr. Ogbonna Amanze	NASS
Dr. Makusidi Muhammad	Niger State Ministry of Health
Henry Ebenuwah	BHCPF
Oleka A. Maryjane	NPHCDA

Agenda

Day 1: Finalizing the knowledge outputs

- Recap of the project goals and process
- Sharing of outputs generated so far
- Reviewing and refining design principles
- Reviewing and refining actor profiles
  Share out of final products

Day 2: Roadmapping the path to change

- Concepting Future TA
- Presentation of project achievements
- Roadmapping and dissemination pathways

PRESENTATION

Recap of the project goals and process so far

This session was a presentation of the process and outputs (work in progress so far). The following slides are the slides that have been presented to the co-creation team.

What is the background

The Sustainable Development Goals' 2030 vision for children has shifted the global strategy from child survival to Survive, Thrive, and Transform. As a result, the need and scope for technical assistance in child health programs has expanded in low and middle-income countries (LMIC).

For LMIC national governments to implement evidence-based and integrated child health interventions that can achieve the 2030 Survive, Thrive, and Transform vision, the engagement model underpinning how technical assistance is planned, coordinated and delivered needs to change.

Although it is a starting point, the ambition for this project however is not to look at child health solely. The aim is to explore the challenges and opportunities for improved technical assistance across other areas of health service delivery.

With support from The Bill & Melinda Gates Foundation, the Child Health Task Force is supporting the ministries of health in the Democratic Republic of Congo (DRC) and Nigeria to reimagine the engagement model underpinning technical assistance delivery for **MNCH and health systems strengthening.**

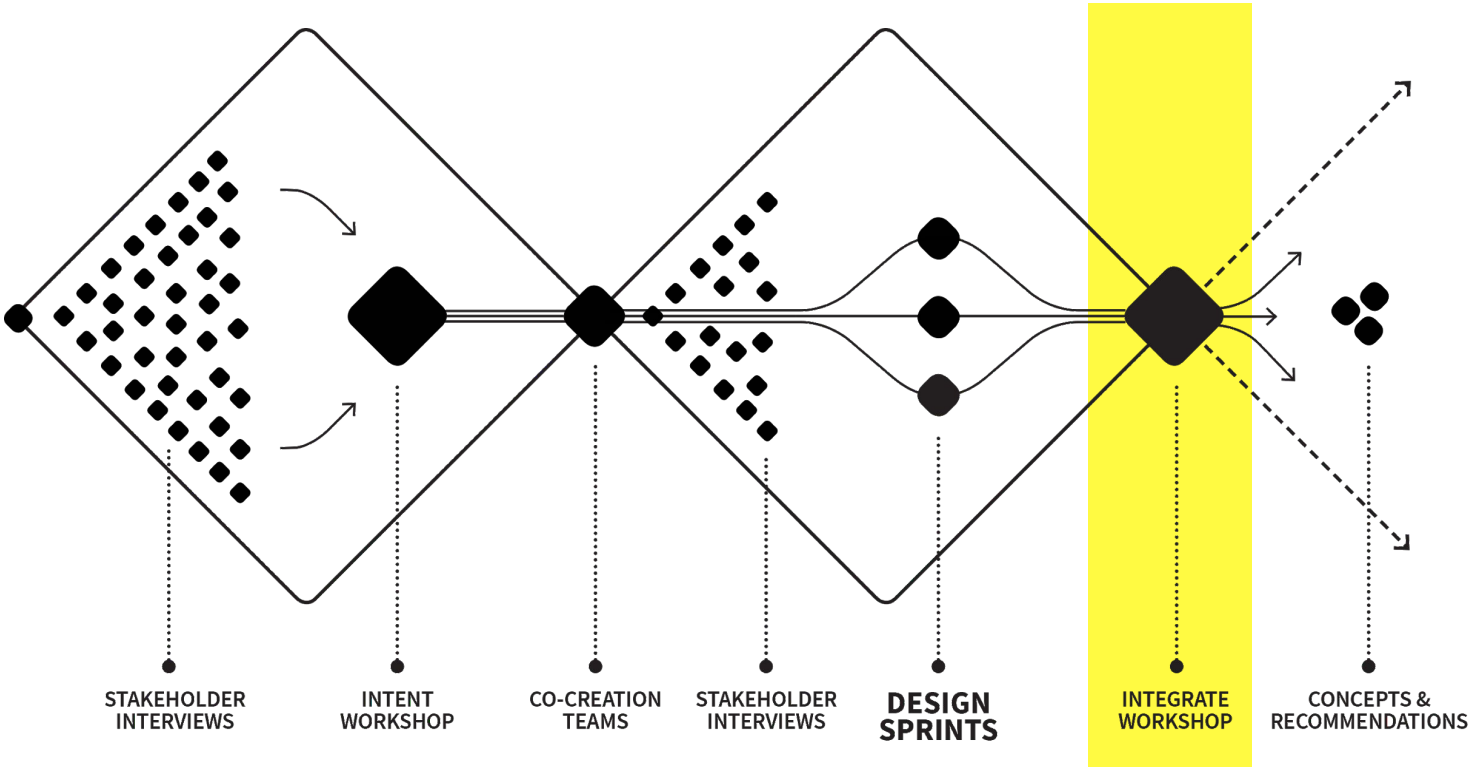
Using human-centered design to do this means starting by exploring the current user experiences of technical assistance and cocreating a new shared vision between all stakeholders. This approach focuses on the needs and motivations of the end users of technical assistance such as MOH, at national and subnational levels, implementing partners and funders.

In the longer term, it is anticipated that a cocreated vision for technical assistance will support improved conditions for countries to provide evidence-based, integrated MNCH health services.

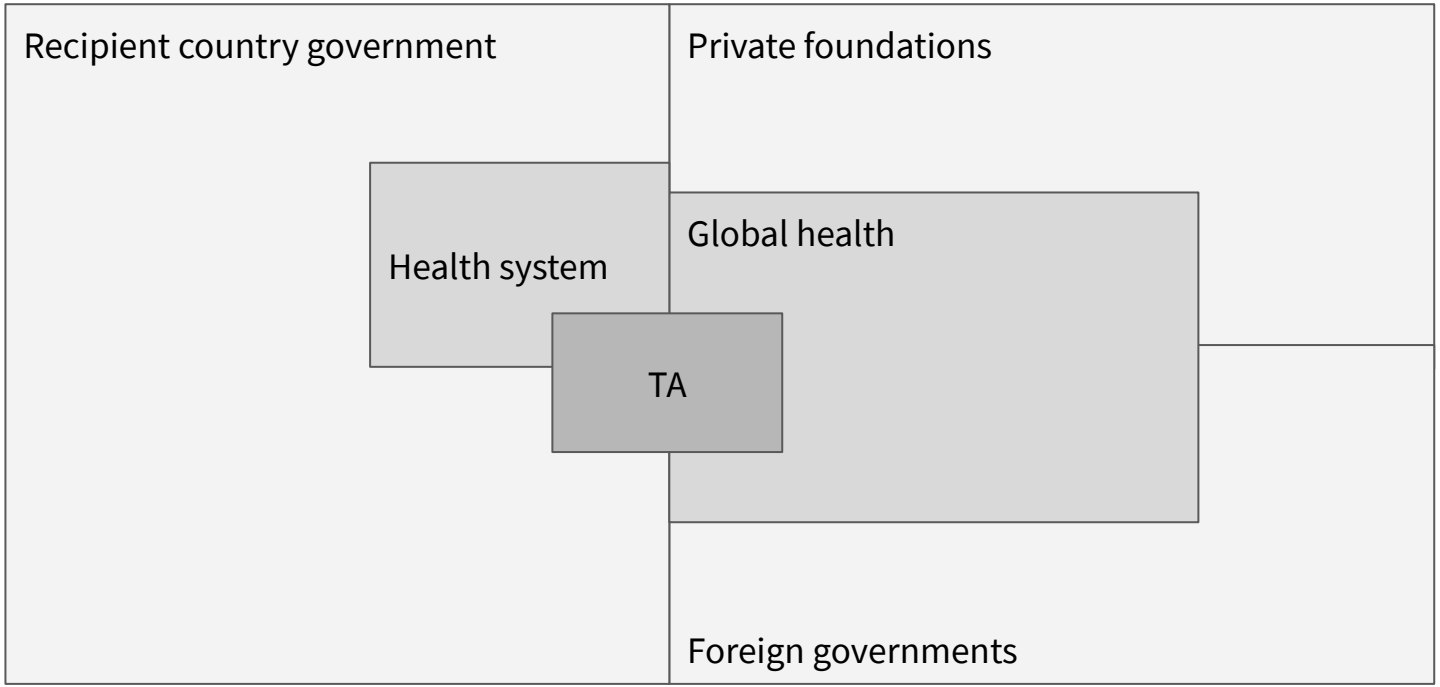
Why to re-imagine technical assistance

What are the current state drivers for change?
Technical assistance has been criticized for being externally imposed, poorly coordinated, disempowering, short-sighted, self-interested and not holistic or systematic in solving for public health challenges.
There is a lot of money being spent on technical assistance – yet, the rate of reduction of maternal and neonatal mortality is slowing down or even, in some places, reversing. It is estimated that 3-4 billion (US) dollars are spent annually on technical assistance, but if these dollars have little enduring impact on saving lives, then there is an opportunity to understand and explore alternative possibilities.

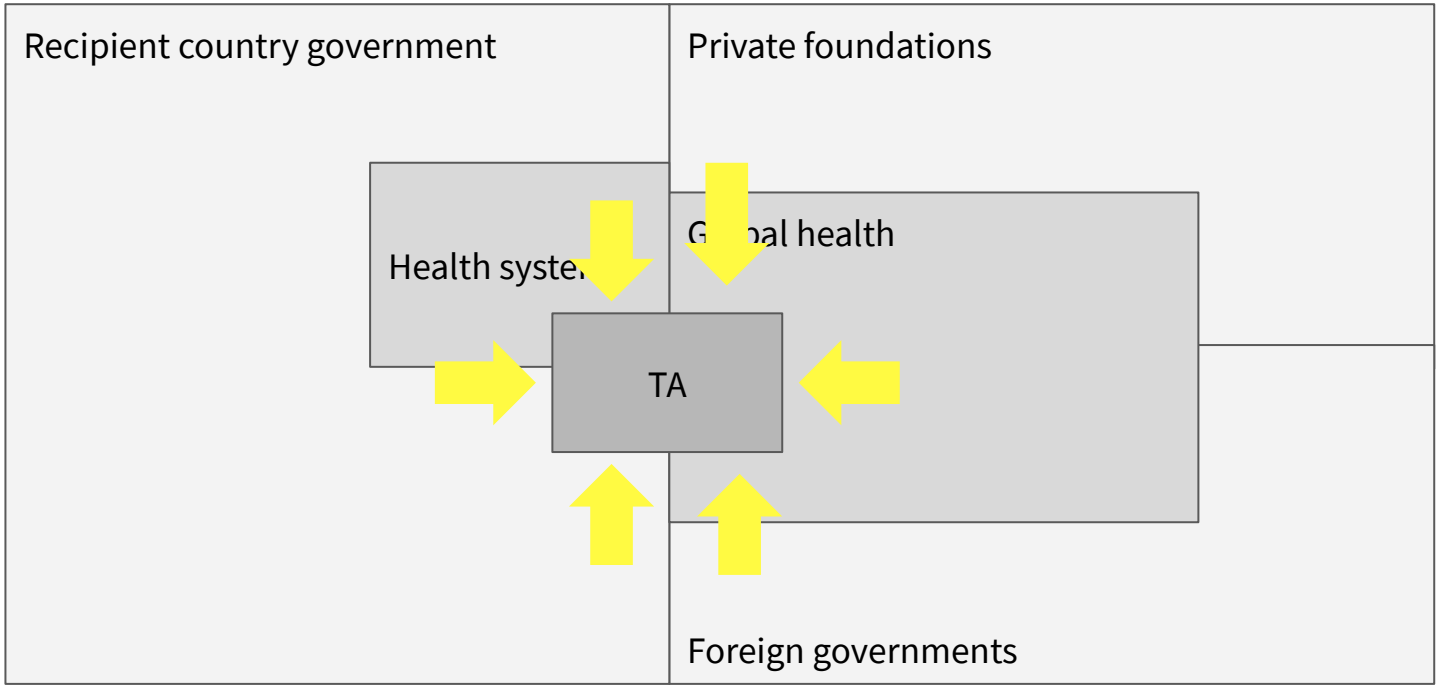
Re-Imagining Process



TA is a complex system sitting within other systems



We have been looking at this system from different angles



Key questions this project has set out to investigate

1 The Strategic Context

- What problem(s) are we trying to solve for?
- What does the future state success look like?

2 The Country Context

- What is the country health system model and how does it work?
- How does technical assistance fit in to the health system?
- What are the different ‘typologies’ and/or ‘functions’ of technical assistance?

3 The People

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

4 The Challenges

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

5 The Opportunities

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

The outputs created will be merged into a set of tools

1 The Strategic Context

- What problem(s) are we trying to solve for?
- What does the future state success look like?

2 The Country Context

- What is the country health system model and how does it work?
- How does technical assistance fit in to the health system?
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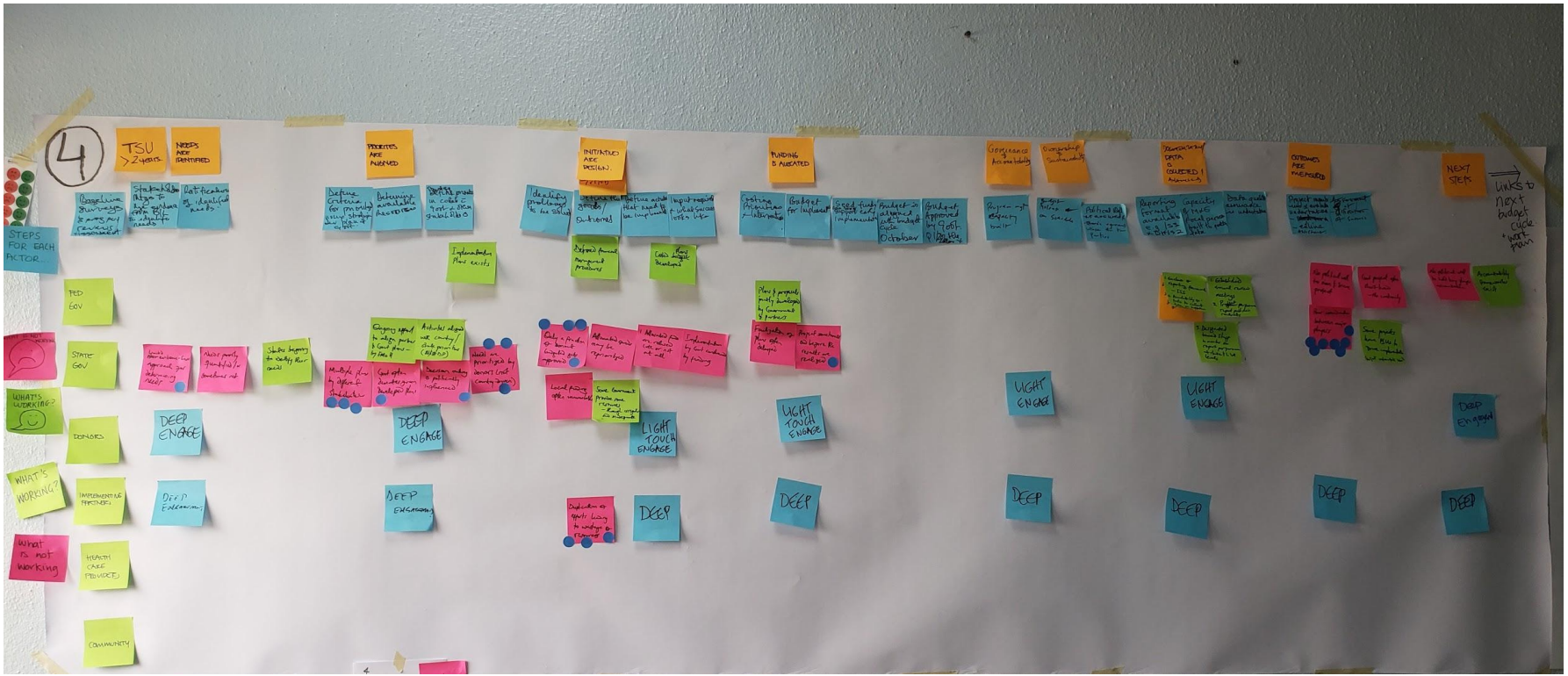
1-1 Problem Definition	**2-1 Health system Map**	**3-1 Actor profiles**	**4-1 TA Journeys**	**5-1 Opportunity areas**
1-2 Critical shifts	**2-2 Definition/Typology**		**4-2 Insights & Quotes**	**5-2 Concepts**
1-3 Future state				**5-3 Design Principles**

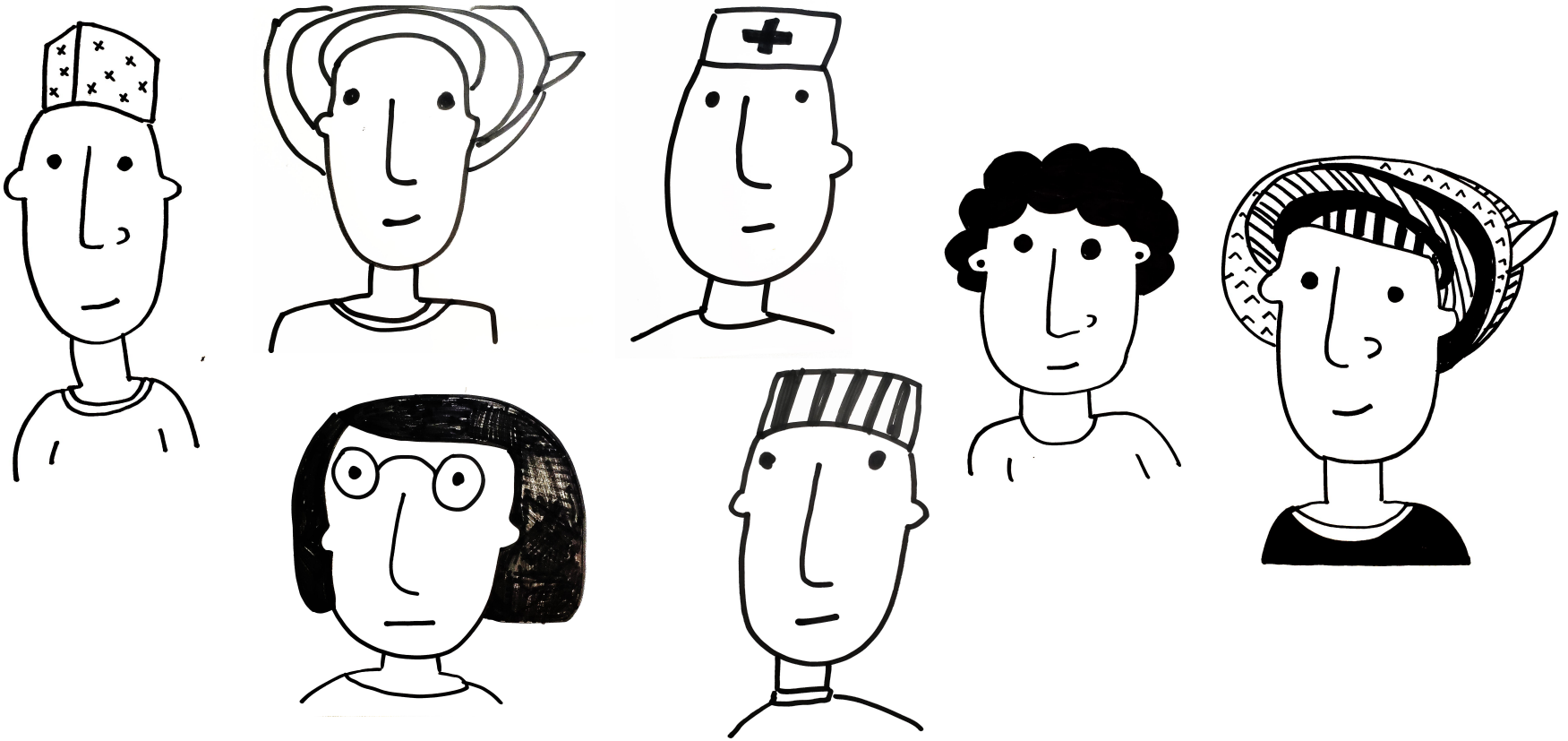
Together we have identified critical shifts

From *What is the problem with TA?*	**To** *Good TA is...*	**Associated Quote**
Donor driven	Country driven and owned	*"We need to move slowly and leave no one behind"* *"The ministry must be actively involved from the onset of the development of the project"*
Creates dependencies	Cultivates Sovereignty	*"We push stronger when we collaborate, we are more effective when we synergise so we don't work alone."*
Lack of trust in institutions and individual motivations	Scales trust	
Unaccountable	Accountable	*"We need an accountability framework that is clear: in plain English. Not legal English, because that confuses a lot of people.*
Fragmented	Considers the system as a whole	*"We can't just focus on child health and leave the greater ecosystem behind"* *"TA should be multi-sectoral, should look at the states as a unit."*
Supply driven	Problem focused	
Short term	Builds for sustainability (and resilience)	
Rigid (one size fits all)	Learning, nimble, diverse	*"How do we become better learners?"*
Up rooted (global)	Contextualized	*"you must tailor your technical approach to fit into the structure or governance"*

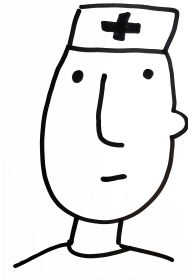
Together we have mapped the challenges along the journey



We have gathered details on the different actors in the system



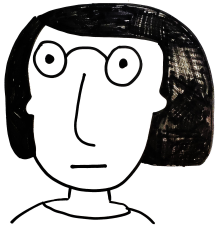
And challenges that arise within their interactions



May prioritize certain areas of work and compromise quality of service

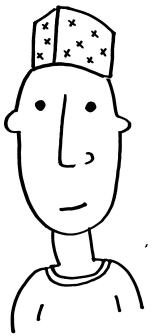
Don't always understand local context and needs

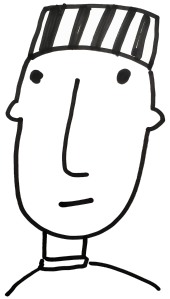
Have different timelines and goals than the government



Bureaucracy often leads to delays

State government benefits from duplication of efforts

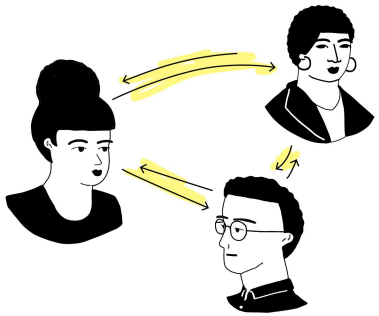




Struggle with often simultaneous initiatives and distraction of routine health work

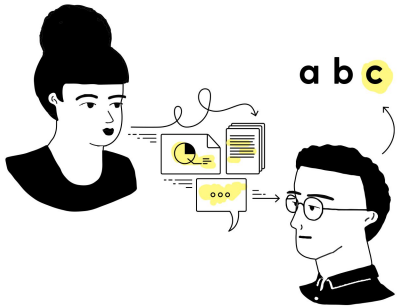
Make decisions based on electibility and pet projects

We have identified opportunities for change



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?

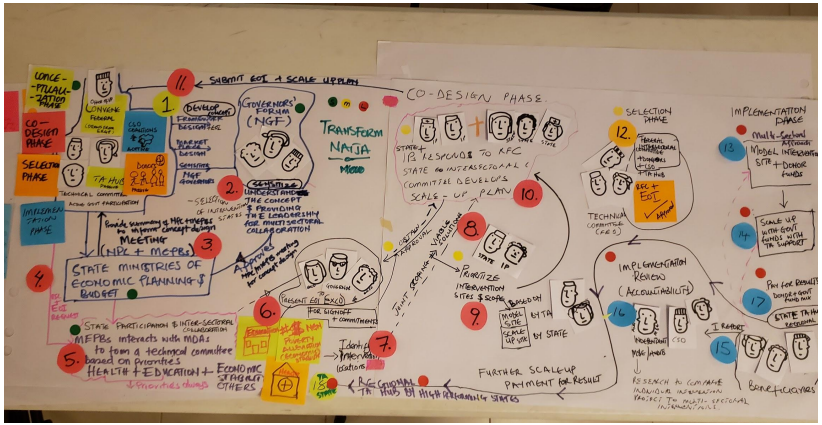
Re-imagining incentives to build greater **workforce capacity** & maximize impact

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?

And come up with ideas: Interactions for local ownership

For Us, By Us (FUBU) Report

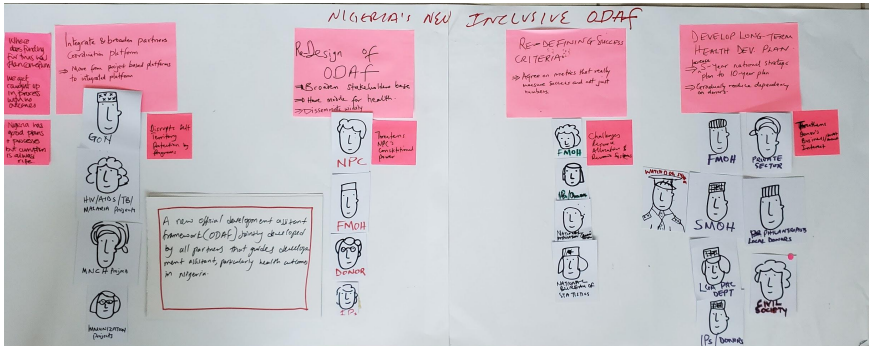
Nigeria develops its own health status report at all levels of the system, not just national, to guide health programming in the country and puts proper mechanisms in place to ensure that local stakeholders are engaged in priority setting, that these priorities are communicated to communities and that they guide donor investment and partner implementation efforts.

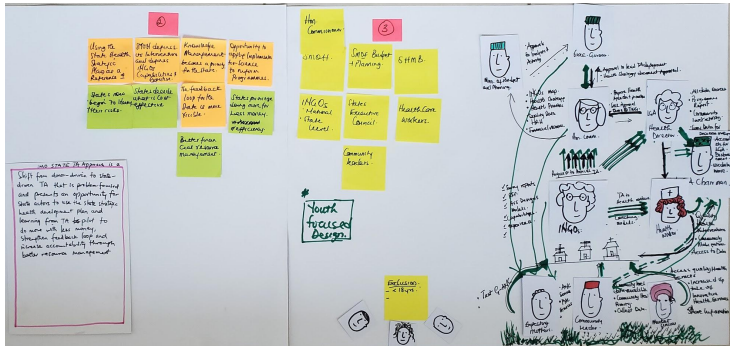


Transforming Naija

A multi-sectoral committee is set up at the federal level to help address systemic challenges and determinants of health with a single strategy. This committee coordinates IPs and states to work together to create implementation plans that follow this strategy. Successful interventions are then submitted back to the federal level for scale up.

And come up with ideas: Feedback Loops for Decision-making





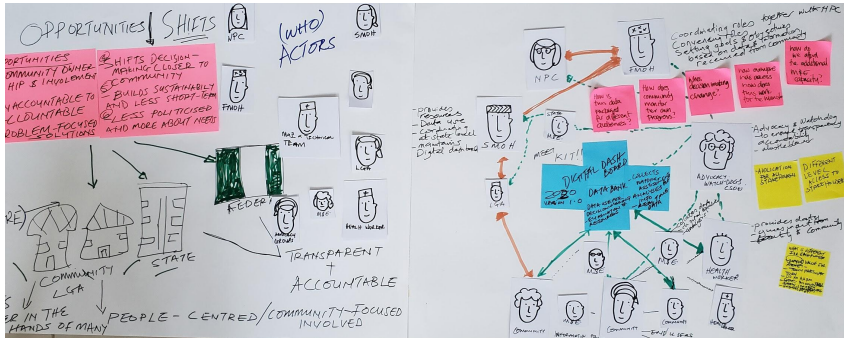
Nigeria's new inclusive ODAEF *(National level)*

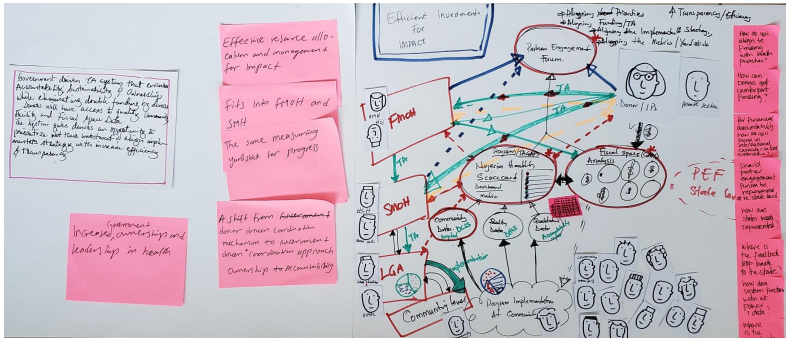
A new official development assistance framework (ODAEF) is jointly developed by all partners and guides development, assistance particularly health outcomes in Nigeria.

IMO State Approach *(State level)*

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.

And come up with ideas: Feedback Loops for Decision-making





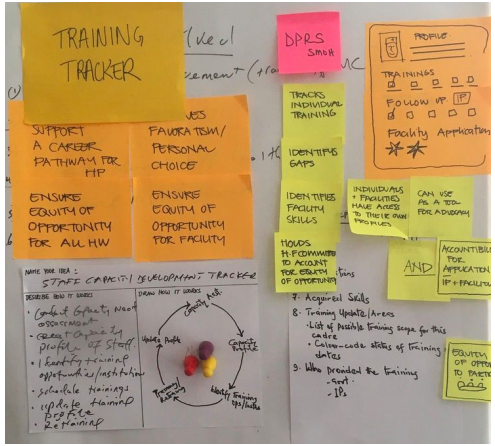
Community Dashboard *(Local level)*

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

Efficient Investment for Impact *(All levels)*

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 efficiency and transparency.

And come up with ideas: Incentives for Workforce Capacity



Training Tracker

Staff career development tracker that will help ensure equity in opportunity for training by creating a capacity profile for staff that will track training and be visible to heads of department, facilities, IPs, as well as HCW themselves.

Welldone Naija

A set of standards or principles for how incentives are awarded as part of the technical assistance process.

What is TA / Voices from Nigeria

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

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

"Technical assistance is a way of **providing capacity building** for health personnel when **gaps are identified** in the health sector service providers."

"Technical assistance means to **provide more guidance or know-how** on how to do things **differently** and achieve targeted results with stipulated timelines."

"Technical assistance is **expertise support** to provide **technical know-how** around subjects which the organization or individual is well rooted or experienced in."

"Technical assistance means a process of sharing information/knowledge, skills, and training for **capacity enhancement.**"

What is TA / Voices from Nigeria

"Technical assistance is that is a form on **financial support for implementation** of work properly carried out to promote the healthy lifestyle."

"Technical assistance is **financial support in country identified intervention** and on which programs are propelled and made to work and be **effective**."

"Technical assistance is **facilitating transfer of knowledge and skills** to others to foster continued development by locals in a sustained manner."

"Technical assistance involves **intellectual guidance** given to an organization by a superior team to guide and aid the achievement of its goals."

"Technical assistance is **non-financial assistance** provided by **local or international expert specialists**. It could be in the form of training, capacity building, consultancy, etc."

We synthesized our learnings into Draft Design Principles

1 Strengthen basic Infrastructure

Shift away from creating dependencies and parallel systems through short term quick fixes. For sustainable change, build instead on the existing infrastructure and capability, even if it means sacrificing immediate gains.

1.1 Increase sustainability and longer term thinking

1.2 Balance individual gain with collective good for mutual benefit

1.3 Reduce dependencies

2 Foster Strong Governance

Shift from implementing donor-driven initiatives to a country-led approach which is guided by local priorities and follows clearly defined and enforced rules of engagement for all.

2.1 Respect local knowledge build shared understanding

2.2 Adjust pace and create a sense of urgency

2.3 Create a participatory and inclusive process

4 Build Trust

Shift from ways of working which perpetuate mistrust in institutions and individual motivations to a more transparent, accountable environment which ensures credibility of its individual actors.

4.1 Build mechanisms of accountability

4.2 Make data accessible

4.3 Strengthen positive feedback loops

3 Cultivate Collaboration

Shift from a competitive to a collaborative environment in which all actors benefit from a shared set of priorities and work together to maximize outcomes.

3.1 Align on common purpose and success

3.2 Plan for an integrated system approach

3.3 Standardize the core without limiting autonomy

Work session

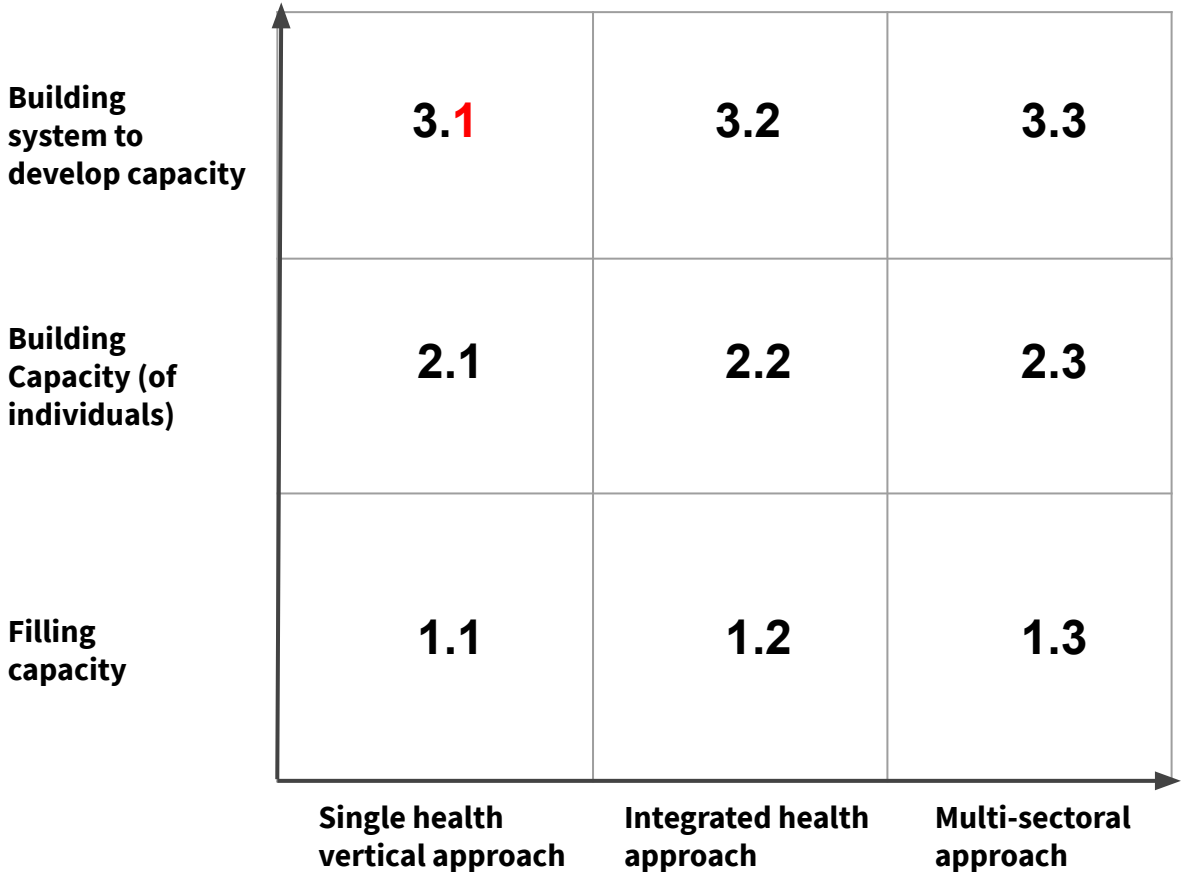
Framing the future of TA

Where is the future of Technical Assistance in Nigeria?

Where do we see TA is going in Nigeria and where should it go and what are the different approaches? In this session we asked participants to map out benefits and drawbacks of current TA approaches matching each quadrant, summarized in the following slides according to the quadrant numbers on the right

Benefits

Drawbacks



1.1

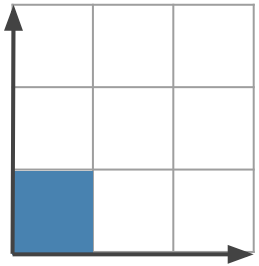
Filling capacity

Single health vertical approach

Group 1		Group 2	
	✖	- Easy to implement.	- Not sustainable. - Short-term. ✖
Group 3		**Group 4**	
- Immediate results (quick wins). - Rapid implementation. - Streamlined interest, hence immediate effect. - Quick way to address gaps.	- Skills are not sustained after TA partner leaves. - Skills transfer may be limited. - No skills transfer for sustainability.	- Time efficiency.	- No sustainability. - Dependence. - Single health approach does not include everyone. - Single health approach weakens the system. ✖

✖ Should be discontinued

✔ Should be continued



1.2

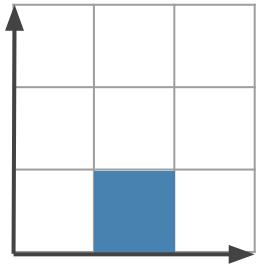
Filling capacity

Integrated health approach

Group 1	Group 2
- To those already engaged, their capacity will be enhanced. - Outright recruitment of competent hands. - Works if based on needs assessment. ✓	✗
Group 3	**Group 4**
- External TA may not readily transfer capacity.	✗

✗ Should be discontinued

✓ Should be continued



1.3

Filling capacity

Multisectoral approach

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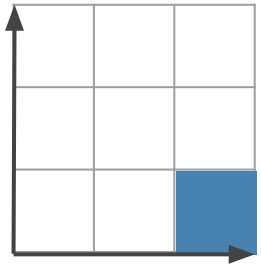
✔ Should be continued



Group 1	Group 2
- Works better for policy level persons than for core civil servants. - Crowding in of excess capacity in another sector. - Positive linkage between WASH and health. ✔	✖
Group 3	**Group 4**
- Cross fertilizing of ideas reduces costs. - Addresses determinants of health not just illness. - Builds on external best practices for various sectors.	✖

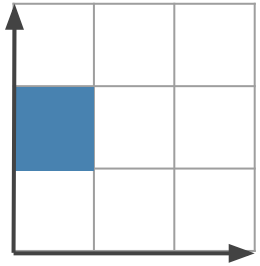
2.1

Building capacity

Single health vertical approach

✖ Should be discontinued

✔ Should be continued



Group 1		Group 2	
- Works if capacity of the right set of officers are built . - Works if the right training is given to the right set of officers. ✖	- Officers must be constantly and consistently engaged in order to avoid knowledge loss. - Performance tracker should be introduced in order to monitor growth and otherwise.	✖	
Group 3		**Group 4**	
- Transferring skills – technical & managerial.	- Immediate results. - Availability of human resources for health.	- Cost saving. - Skills and knowledge. ✖	- Not sustainable. - Capital intensive. - Depending.

2.2

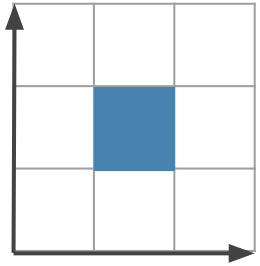
Building capacity

Integrated health approach

Group 1	Group 2
- Need for capacity building on integrated health approach. - Cost effective. - Shared resources and reduction in duplication.	
Group 3	**Group 4**
- Reduction in cost. - Harmonization.	- Skills gap among health workers. - Poor governance and accountability. - Limited by dearth of resources.

✖ Should be discontinued

✔ Should be continued



2.3

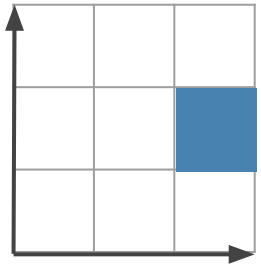
Building capacity

Multisectoral approach

Group 1	Group 2
- Works if there are policies supporting or backing it up. *- Consider health technical persons into health e.g. nutrition driven by MOF under budget and planning.*	- Embedded TA externally funded by a donor creates lack of accountability. - Embedded TA creates a sharp rivalry between HNA's office and civil service.
Group 3	**Group 4**
	- Poor linkages between TA efforts across sectors. - Complexity.

✖ Should be discontinued

✔ Should be continued



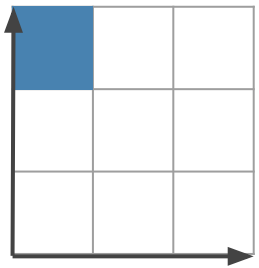
3.1

Building system to develop capacity

Single health vertical approach

✖ Should be discontinued

✔ Should be continued



Group 1		Group 2	
- Need for qualitative practice to improve health in Nigeria.	- Too expensive and starting from the scratch. - Way forward to achieving on health in 2020.		
Group 3		**Group 4**	
- Sustainability. - Ensures sustainable institutions and programs. - Sustainability could be achieved.	- Takes /weeks' time to see results. - Long-term results (impatient).	- Cost efficient. - Repository skill and information. - Focused and strategic.	- Too micro. - High administrative cost.

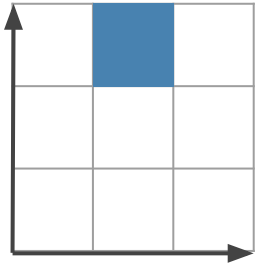
3.2

Building system to develop capacity

Integrated health approach

✖ Should be discontinued

✔ Should be continued



Group 1		Group 2	
- Need for multi-sectoral approach on health professionals. ✔	- It's expensive. - Slow in attaining wider coverage. - Gain good health to practice on health professionals.	- Sustainable. - Prevents duplication of efforts and parallel interventions while promoting cross learning. - All services aid, under one roof. - Allows for special skill to be developed. - Multiple layers of stakeholders making it somewhat difficult to manage. ✔	- Might be too much and certain aspects get lost or unmanageable. - Requires lots of trust and accountability. - Deal with frequent changes in leadership at country /state/LGA levels. - Takes a lot of time and effort.
Group 3		**Group 4**	
- Processes are institutionalized. - Linkages between health systems are strengthened. - Skills are gained.		- Wholistic. - Strategic alignment. - Enhance organizational development . - Greater efficiency. - Strategic alignment. - Cost effective. - Ease of transferring knowledge.	

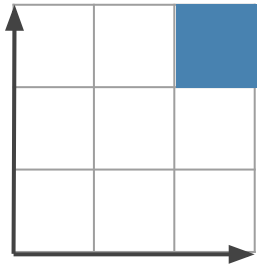
3.3

Building system to develop capacity

Multisectoral approach

✖ Should be discontinued

✔ Should be continued



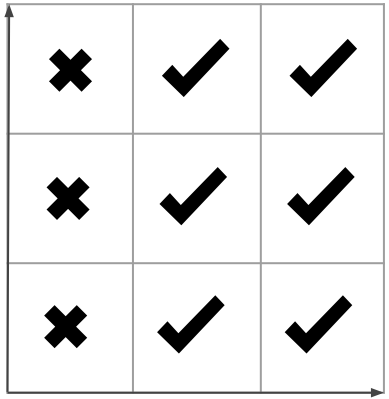
Group 1		Group 2	
- Leveraging on capacity and existing infrastructure from the states.	- Lack of synergy. - Difficult to align thought. - Embedded TA creates tension between INA and senior civil service.	- Multi-faceted approach to solving problems. - Addresses diverse parts of the same problem. - Aligns all sectors and position the country to achieve its SDGs.	- Lack of synergy. - Difficult to align thought. - Embedded TA creates tension between INA and senior civil service.
Group 3		**Group 4**	
- Self-sustained. - Synergistic. - Ensure multi-sectoral collaboration.	- Everyone onboard. - Take longer to establish. - Complex and diverse stakeholder interests. - Complex.	- Multisectoral addresses all determinants of health. - Considers the system as a whole. - Sustainable. - Country driven and owned. - Ensure sustainability.	- Operationalizing the strategic plans. - Leadership priorities clashing. - Political differences – priorities of each political party.

What is the future of Technical Assistance in Nigeria?

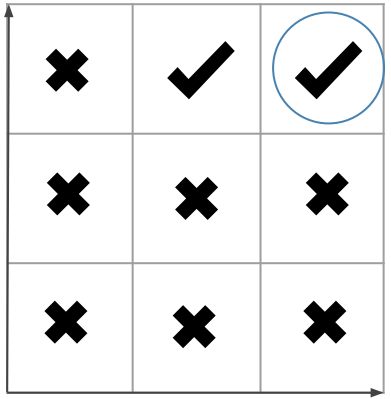
✖ Should be discontinued

✓ Should be continued

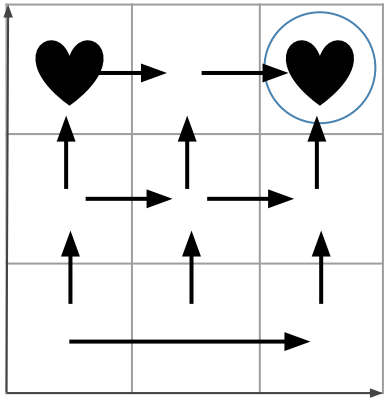
Group 1



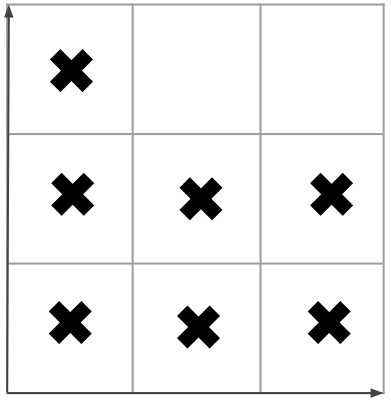
Group 2



Group 3



Group 4

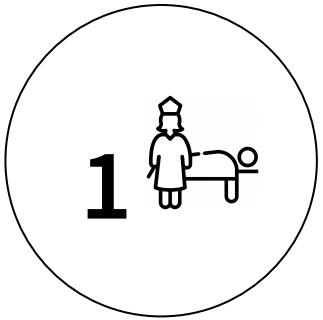


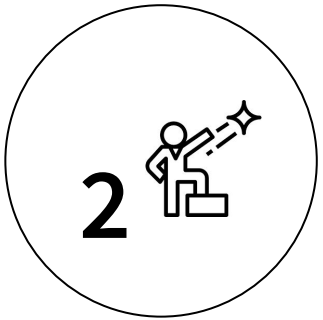
Work session

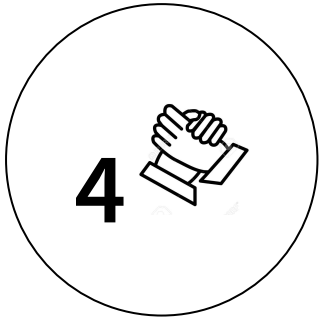
Design Principles

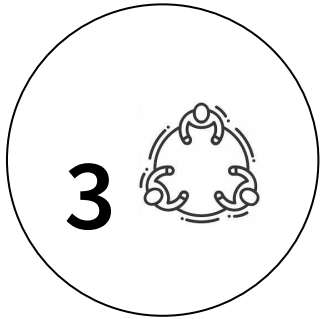
What they mean in action

Design Principles









Groups split among 4 tables. The 4 principles groups have been divided among each table.

STEP 1 10min
Reflect individually what the three principles on the table mean to yourself in action: Write each action on the worksheet.
- What actions do they inspire?
- Which behaviors do they promote?
- What can be done differently?

STEP 2 20min
As a table group reflect on what everyone has written, add possible missing points and bring them to the joint worksheet.

STEP 3: Repeat Step 1 and 2 at the next table: 10+20min

STEP 4: Share out of

Design principles draft

1 Strengthen basic Infrastructure

Shift away from creating dependencies and parallel systems through short term quick fixes. For sustainable change, build instead on the existing infrastructure and capability, even if it means sacrificing immediate gains.

- **1.1 Increase sustainability and longer term thinking**
- **1.2 Balance individual gain with collective good for mutual benefit**
- **1.3 Reduce dependencies**

2 Foster Strong Governance

Shift from implementing donor-driven initiatives to a country-led approach which is guided by local priorities and follows clearly defined and enforced rules of engagement for all.

- **2.1 Respect local knowledge build shared understanding**
- **2.2 Adjust pace and create a sense of urgency**
- **2.3 Create a participatory and inclusive process**

3 Cultivate Collaboration

Shift from a competitive to a collaborative environment in which all actors benefit from a shared set of priorities and work together to maximize outcomes.

- **3.1 Align on common purpose and success**
- **3.2 Plan for an integrated system approach**
- **3.3 Standardize the core without limiting autonomy**

4 Build Trust

Shift from ways of working which perpetuate mistrust in institutions and individual motivations to a more transparent, accountable environment which ensures credibility of its individual actors.

- **4.1 Build mechanisms of accountability**
- **4.2 Make data accessible**
- **4.3 Strengthen positive feedback loops**

Scoring the importance

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1

Strengthen the existing system and Infrastructure

Shift away from quick-fixes that create unhealthy dependencies and sidestep systems challenges by generating parallel systems. For sustainable change, build on the existing system, infrastructure and capability instead, even if it means sacrificing some immediate gains.

"Why are you spending your budget on SUV's and laptops? We need to understand the gap that will make a difference, if you're delivering services to pregnant women you may need to provide plastic chairs for them to sit on." -- TA HUB

"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

"In reality when you go to people and ask what do you need the requests are not for innovation, new treatments... it is for rent, basic things." -- MSH

1

Principles	
1.1 Increase sustainability and longer term thinking Progress requires time, but programs are often caught up in reaching short term targets and end before they can achieve meaningful results. Prioritize sustainable development over short term gains by extending the planning periods beyond the typical 5 year mark and ensure the targets meet realities on the ground. Ensure local stakeholders are involved early and equipped to take over once the funding dries up.	Stakeholder collaboration +7 ● This means that from the planning stage of program development, we think sustainability by ensuring that all relevant stakeholders are carried along and are involved as the program evolves ● Collaboration with partners and government ● Involving and equipping local stakeholders so as to ensure sustainable development ● It means ownership, co-funding, implementing and tracking of programmes jointly for sustainability ● Local stakeholder and beneficiaries should determine long term needs and develop a plan for intervention and lead implementation ● Local stakeholder, country leadership and state should begin to prioritize their development agenda(set the agenda and lead it) ● Donor parties should work with the stakeholders in country in order to identify health challenges and timelines for intervention

1

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1

Principles	
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1

Principles	
1.2 Balance individual gain with collective good Individual incentives help to ensure that project targets are met on time, but they often end up undermining the system by diverting scarce funds. Favor collective and standardized incentivization that creates a fair playing field for all. When possible, invest in infrastructure that can be reused (think refurbishing a meeting space over renting a venue).	Incentives +6 ● Set incentives to reward long term sustainable results ● Standardization and harmonization of incentives ● Policies driving incentives should be in place ● Alignment of incentives & motivation policies by government ● Emphasize the use of collective incentives ● Reward hard work Maximize available resources +6 ● Proper utilization of resources ● Harness technology (mobile) for better gains. ● Maximizing benefit and minimize cost ● Cost standardization ● Meetings, travels, logistics should be ....and harmonize for standard ● Explore the most cost effective ways for monitoring

1

Principles	
1.2 Balance individual gain with collective good Individual incentives help to ensure that project targets are met on time, but they often end up undermining the system by diverting scarce funds. Favor collective and standardized incentivization that creates a fair playing field for all. When possible, invest in infrastructure that can be reused (think refurbishing a meeting space over renting a venue).	Systemic thinking +3 ● This means that a systems thinking has more gains than the silo/individual thinking which destroys the system ● Aligning self interest with the overall goal of the program ● Stakeholders should .... and use already available structures for greater gains Funds channeling +2 ● TA funds should be used for funding sustainable projects that impact the community ● Collectively more can be done and there will be transparency, funds should be channeled appropriately

1

Principles	
1.3 Reduce dependencies TA initiatives without clear exit strategies can sometimes create dependencies, leaving behind gaps in basic health services when the funding dries up. Rather than coming with ready solutions, design with government and local partners to ensure initiatives play to the strengths and weaknesses of existing capacity and infrastructure. Build self-sustaining systems powered by available internal resources. TA should aim to strengthen health systems, not replacing them.	Strategic TA +6 ● Strategic TA ● TA should work with existing structure & systems to improve them not to replace them. There should be no parallel structures & systems ● TA should be used to fund gaps within the system ● Sustainability of technical assistance ● Set goals that can be achieved with available resources ● Plan for exist/exit? ● There should be no parallel structures Local focus +4 ● Alignment of developmental priorities objectives with the local needs ● Involvement of local stakeholders to ensure sustainability ● Foster ownership ● Begin to use the community structures from the beginning up to programme cycle

1

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2

Foster Strong Governance

Shift from following a country external agenda to a country-led approach which is guided by local priorities and follows clearly defined and enforced rules of engagement for all.

“When partners come into the country, they have already decided, they come to inform us.” -- FMOH

“The ideal state is that partners slow down to work hand in hand with government while government increases its sense of urgency and adopts more flexible processes.”

“The biggest challenge is time. The government is slow and cannot move at the pace of the private sector. The partners are not patient with government because funding will laps.” -- FMOH

“Don’t say because of this being a 3 year project it must finish in 3 years, let it run. Time frames need more flexibility, they will do anything just to spend their money and submit reports.” -- FMOH

“At times, the problem with us in the government is policy summersaults. The director there, this is part of their baby, and he wants it to succeed. But they might appoint a new director tomorrow, this may not be his focus and this may just fizzle out. We've been having a lot of good initiative like that, it goes with the initiator.” -- TSU

2

Principles	
2.1 Respect and build on local knowledge Data can tell us which communities need TA, but it doesn't tell us exactly what the problem is or what is the best solution. Local TA resources often get passed on in favor of more respected international experts, regardless of actual qualifications. Amplify the voice of local wisdom to ensure better understanding of local context and needs.	Recognize local knowledge. +3 ● Sustainable development can only happen in Nigeria, when it is driven by Nigerian in terms HR. ● Recognise the benefits of local knowledge. ● Using the local specific knowledge rather than what you think it is because you are familiar with the problem. Foster inclusion of local talent. +3 ● Identify, map and engage local TA. ● Local TA should lead in delivery of projects at each level or output. ● Meet with local authority to discuss proposed intervention. Strengthen local capacity. +3 ● Strengthen the local capacity to deliver TA understanding that they have a better knowledge of the local context and are able to adapt external propositions to fit the local context. ● A need for community strengthening interventions to build by capacity of the people to tell their stories. ● Intentional investment to strengthening skills of local TA.

2

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2

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2.1 Respect and build on local knowledge Data can tell us which communities need TA, but it doesn't tell us exactly what the problem is or what is the best solution. Local TA resources often get passed on in favor of more respected international experts, regardless of actual qualifications. Amplify the voice of local wisdom to ensure better understanding of local context and needs.	Local context centered design. +3 ● The local context and realities are crucial to designing and implementing projects at scale and for impact. ● Understanding their needs, the local context and involving them as program designs' leveraging on their stories. ● Engagement at design stages with target communities to identify local resources and design solutions with a good understanding of the local context.

2

Principles	
2.2 Adjust pace but keep up a sense of urgency Working in alignment with the government needs a greater elasticity of time for program design, implementation and dissemination. International partners need to slow down or adjust their pace to meet timelines and processes of the local health system but keep a sense of urgency so priorities and activities do not get sidetracked or dropped.	Collaborate with local government on design +5 ● Involve the government from the get go! During the design phase, during that phase agree on timelines collectively. ● Agree on timeline with the government in attendance. By commitment. ● Work with government partners to align interventions with existing planning (government) cycles. ● Built government and partners should consider time and work together for the common good. ● Advocate for aligning time with action and why it is imperative to make.

2

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2

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2

Principles	
2.3 Ensure a participatory and inclusive process A truly participatory and inclusive process involves committing to opening up to new ways of working, making decisions and even may involve change of course. It also means roles have to be clarified carefully and rules for participation and engagement set. Recognise local nuances and structures with a view to strengthening them.	Involve all stakeholders +5 ● Recognize and commit to working with local communities, "beneficiaries" as true partners. Involve them in planning, decision making and review processes on every stage. ● All these meetings should be inclusive and at across all levels. ● Work with the government from program planning to evaluation to ensure ownership. ● Involvement and participation of stakeholders will make them accept whatever assistance being given. ● How to deal with the challenge of relevant stakeholders actually showing up during the process to be engaged?

2

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2

Principles	
2.3 Ensure a participatory and inclusive process A truly participatory and inclusive process involves committing to opening up to new ways of working, making decisions and even may involve change of course. It also means roles have to be clarified carefully and rules for participation and engagement set. Recognise local nuances and structures with a view to strengthening them.	Flexibility +3 ● Nothing should be set on stone. Be flexible as a partner and have regular check-ins with the government. ● Maintain a high level of flexibility and adaptability to support and strengthen local structures as needed. ● TA needs to be flexible, existing nuances and structures may need to be strengthened. Government leadership ● Coordination mechanism led by the government that brings all together.

3

Cultivate Collaboration

Shift from a competitive to a collaborative environment in which all actors benefit from a shared set of priorities and work together to maximize outcomes.

"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. Donors should explore partnerships for an integrated approach to problem solving the multidimensional problems of education, economic empowerment, health and security."

"One reason we don't have much outcome is that collaboration is poor. Partners come in with donors, distinct mandates that are not flexible. Every IP wants to do what their funding has mandated." -- Dept HPRS, FMOH

"We must review our project design strategies. Project design is poor and projects are not integrated... 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

"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

3

Principle	
3.1 Align on common goals and own them Poor alignment on priorities leads to missed opportunities, wasted effort, and underutilised funding. Short-term projects by partners coming and going also stifle progress, even when the objectives are clear. Align on a single set of priorities and create partnerships to ensure continuous, long-term funding, even as individual players come and go.	Systematize +6 ● Coordination through a unified system that supports a streamlined and collaboration approach. ● Set performance metrics for collaboration. ● Develop indicators for tracking achievement of the goal and set the meeting with the partners interested. ● Government should have a centralized / standardized evaluation / implementation. ● Build sustainability mechanisms into program design. ● xxxxx to encourgage collaboration and revision of achievement. ● Ensure comprehensive exit / project close out. Involve all key persons in close out.

3

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3

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3

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3

Principle	
3.2. Consider the system as a whole Health issues can rarely be treated in isolation. Shift away from investing in individual health verticals to strengthening the system as a whole. Explore partnerships for an integrated approach to problem solving.	Integrate to deliver +7 ● Work through existing health structures to integrate new interventions. ● Integrate health programs TA in a way that seeks to strengthen PHC system. ● Integrated approach amongst implementing partners. ● Integration of implementation. ● A systematic approach to health care provision. ● Encourage integration at the implementing agencies xxxxxx maybe an integrated AOP process? ● Stop quick wins. Implement multisectorial interventions which impact on the system as a whole.

3

Principle	
3.2. Consider the system as a whole Health issues can rarely be treated in isolation. Shift away from investing in individual health verticals to strengthening the system as a whole. Explore partnerships for an integrated approach to problem solving.	Co-create +4 ● Identify different stakeholders that are likely to bring reasonable solutions to the table. ● Bring all relevant people to the table and discuss solutions. ● Organize a few days retreat / workshop with spelt out agenda with the sectors involved. ● Develop points of resolution from this retreat, develop action points with time frame attached to each task for each task for each sector. Redefine the problem +3 ● Exploring partnerships for an integrated approach to problem solving because most health problems are cross-cutting. ● Broader problem solving. ● Identify the different parts of a particular problem. (outline all possible issues / problems)

3

Principle	
3.2. Consider the system as a whole Health issues can rarely be treated in isolation. Shift away from investing in individual health verticals to strengthening the system as a whole. Explore partnerships for an integrated approach to problem solving.	Strengthen partnerships +3 ● Strong partnerships with the ministries, agency, etc are envisage. ● Partnerships provide avenues and opportunities for broader systems strengthening. Also avenues for more investments. ● Regular sector wide engagements led by the government providing TA. New partnership relations +3 ● Explore multi-sectoral partnerships. ● Expand partnerships to involve other relevant sectors. ● Explore partnerships to leverage on finding expertise. Consider the government also as an implementing partner. Practical +1 ● Ensuring availability of skilled HRH, equipment, tools, supplies and enabling environment.

3

Principle	
3.3 Standardize without limiting autonomy For best performance, streamline core TA functions while preserving the ability to customize and innovate around the edges. Allow for flexibility of approach when it comes to context and implementation of TA.	Standardization Process +5 ● Figure out what you need to standardize. ● Set up a standard system for TA delivery (from assessing TA needs to delivering TA to different actors) ● Develop a TA standards operating (sop) principle / framework that can be adapted depending on a request / need. ● Set-up process to guide the functionality and systems. ● Budgets and activities should be flexible. Changes should not require protracted approval processes. Principles +4 ● Focus on capacity building. ● Principles 3.1 and 3.2 need to be closely adhered, so that even when TA is flexible, the priorities are similar. ● Having a minimum standard in place and enabling creative and innovative approaches to service delivery. ● Drive healthy competition across different intervention areas.

3

Principle	
3.3 Standardize without limiting autonomy For best performance, streamline core TA functions while preserving the ability to customize and innovate around the edges. Allow for flexibility of approach when it comes to context and implementation of TA.	Government leadership +3 ● The government should develop a guiding principle (MOU) that will give the partners guide to run in alignment with the objective of the state. ● Government takes the lead in defining and classifying core TA functions. ● The federal level should standardize the process of partners to key in. If they need the government to review strategic documents, SOP, etc. Partners can sponsor such activity. Local adaptation +2 ● Standardize TA functions of a central level, recognizing and allowing for adaptation at a local level. ● Allow for local adaptation.

4

Build Trust

Shift from a system which perpetuates mistrust in institutions and individual motivations to a more transparent, accountable environment which promotes openness and ensures credibility of its individual actors.

"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

"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

"Data needs to flow in two directions. Currently, data has only one direction -- going up. Feedback doesn't go back down. The community needs to know themselves, often they don't even know why you are coming with a certain intervention, why children are dying."

"We need to rethink the whole feedback loop, from what results we are expecting to who we are accountable to."

"Trust is a major problem in TA. Government thinks that IPs have a hidden agenda. Communities don't think donors will bring money without wanting something in return. Even IPs that come to work, what is the need for them? The government themselves is not trustworthy. IPs can't follow government if they can't see commitment." -- Workshop Participant

4

Principle	
4.1 Build mechanisms of accountability Lack of accountability breeds mistrust in a system as a whole and creates an over-reliance on personal, local connections which are time consuming to develop and have to be frequently re-established. Invest in systems that keep their users accountable and leverage them to scale trust.	System features +6 ● It means that there would be mechanisms that address accountability: a mechanism that tracks actions of stakeholders and holds them accountable to a given assignment / tasks. ● At every level of the process there should be an accountability mechanism to evaluate or double check. ● Partners collect additional data specific to their project and outside of the HMIS and only share with their office and donor. ● Develop a system that directly tracks the accountability of each task with respect of set indicators. ● Setting processes that guide government systems and work, that way no one gets to cut corners. ● Activate civil society and media to ask hard questions. (But who will do this?)

4

Principle	
4.1 Build mechanisms of accountability Lack of accountability breeds mistrust in a system as a whole and creates an over-reliance on personal, local connections which are time consuming to develop and have to be frequently re-established. Invest in systems that keep their users accountable and leverage them to scale trust.	Co-create +5 ● It means transparency. It means planning together, agreeing on a workplan and budget. ● Co-design and planning of activities. ● Develop concepts together. ● Codesign and planning by all actors. ● All actors put in place a performance strong monitoring system. Project management tactics +4 ● Establish roles and responsibilities at government level. ● Performance frameworks within the government. ● Expand / implement programme accountability. ● Develop indicators and tracking systems. Behavioral +4 ● Taking full responsibility in one's actions and inactions. ● Focus on the office and not the person. ● Efficient use and application of resources. ● Identify collectively sources of funds, technical assistance and resources.

4

Principle	
4.1 Build mechanisms of accountability Lack of accountability breeds mistrust in a system as a whole and creates an over-reliance on personal, local connections which are time consuming to develop and have to be frequently re-established. Invest in systems that keep their users accountable and leverage them to scale trust.	Circularity in reports +2 ● Donors publish reports that are accessible to the government on progress, results and findings (detailed reports). ● Government commits to reporting to donors on previously agreed commitments. Affirmations +2 ● A systems approach with clear accountability structures and framework will enshrine trust in the system, and improve efficiency in time management. ● Accountability for data sharing will improve trust of IP and governments. ● No trust is building capacity on health systems and accounts on scale trust.

4

Principle	
4.2 Make data accessible Purposeful opaqueness between actors as well as issues with data accessibility are preventing open flow of information, which limits ability to make data-driven decisions. Shift incentive structures to improve data sharing across actors and vertically within each organization. Work to remove accessibility barriers for decision-makers, recognizing that needs and skill sets might be different across the various levels of the system.	Data and information +4 ● Improve data sharing. ● Improving credibility of data sources and transmission from facility / community donor to national level (DHIS2) ● Data quality and easy access. ● Preparing reports, utilize dissemination workshops with key parties. System / platform + 4 ● This means that there would be a consolidated data framework / platform that enables all stakeholders to fetch the necessary data needed for decision making at all levels; LGA, state and federal. ● Develop a dashboard / system that would be downloaded by everyone involved which makes the data visible to every individual at any point in time. ● Platforms to share knowledge and learn from each other, donor, partners, government. ● What are some of the inventive structures donors can put?

4

Principle	
4.2 Make data accessible Purposeful opaqueness between actors as well as issues with data accessibility are preventing open flow of information, which limits ability to make data-driven decisions. Shift incentive structures to improve data sharing across actors and vertically within each organization. Work to remove accessibility barriers for decision-makers, recognizing that needs and skill sets might be different across the various levels of the system.	Transparency +3 ● Incentivize transparency. ● Transparency among partners. ● Openness, transparency. Affirmations +3 ● Accessibility. ● Data accessibility is very important. ● Yes is an open way on health accessibility to health sectors. Decision making +2 ● A timely data collection, action, analysis and reporting and dissemination is essential for decision making. ● Knowledge sharing is key to decision making processes set up. Behavioural ● Shift from being competitors to partners.

4

Principle	
4.3 Strengthen positive feedback loops Build systems which provide feedback on performance and reinforce good behaviors.	Actionable feedback process +5 ● Feedback is key as it helps to know where we need to improve. This could be through proper documentation of finding and even archiving them for future references. ● Set up processes to ensure feedback on performance. ● Mark out time for re convergence of the partners and the government possibly the donors. Maybe quarterly for assessment of the tasks done. ● Implement feedback on all activities. Some of the feedback may be encouraging and others discouraging but take feedback and build on it. ● Feedback to data generators is very important. Trust and communication +3 ● There would be a strong communication link amongst all players / stakeholders. It would help in improving and developing performance. ● Two way communication that is effective and efficient. ● If there is trust among all health sectors brief and performing to strengthen on health systems it will.

4

Principle	
4.3 Strengthen positive feedback loops Build systems which provide feedback on performance and reinforce good behaviors.	Metrics +2 ● FG incentivizes states on transparency and performance metrics for IPs for collaboration (can be punitive for negative competition) ● Include KPIs to track progress. Reinforcement +3 ● More difficult in government because of the structure. But maybe good award ceremonies, etc. ● Reward good behaviour / performance. ● How can donors reinforce good behaviours amongst partners?

Work session

The Actors of the TA system

Refining the data

Implementing Partner (IP)

We work with FMOH and local governments to implement donor-funded initiatives. Our goal is to complete these initiatives within a set timeline & budget and to demonstrate the impact our work has had on health outcomes.

ROLES I PLAY IN TA

Work with donors and gov to design plans

Receive and manage funds

Coordinate & deliver TA

Track & report on outcomes

WHAT DRIVES ME

- Delivering on targets within set budget and timeframe
- Gaining visibility and a good reputation with donors, government and other partners
- Demonstrating impact in line with our mission and strategy

WHAT I NEED TO SUCCEED

- Predictable/consistent source of funding
- Alignment on priorities between key stakeholders
- Engagement and collaboration from all stakeholders
- Enabling environment for implementation (clear protocols and guidelines, supportive political climate, security)
- Reliable, knowledgeable workforce

WHAT I STRUGGLE WITH

- Under pressure to deliver quickly, but working with the current system “the right way” takes time. Bureaucracy and protocols often cause delays.
- Taking on all accountability for how money is spent. Balancing responsibility to donors with pay-to-play attitude of stakeholders (participation incentives and requests that are outside program activities such as rent, vehicles, internet).
- Lack of donor flexibility to adjust to the needs and priorities on the ground.
- Lack of alignment on goals and priorities between the donors and the government.
- Lack of clear guidelines, procedures, policy, standards, and ownership from the government.
- Lack of a local skilled workforce.
- Lack of trust from local stakeholders.

CHALLENGES I CREATE

- Take shortcuts, which deliver on short-term targets but undermine the system in the long run.
- Accountable to the donors, so end up prioritizing their interests over those of other stakeholders.
- Tend to bring in external capacity as opposed to developing it locally.
- Don’t always understand local context and needs.
- In competition with other IPs.

INTERACTIONS I HAVE:

- Writing proposals & creating project plans
- Scoping trips and planning meetings with government, community leaders and civil society
- Advocacy to raise awareness of key issues and gain support for initiatives
- Delivering technical assistance
- Conducting research and M&E
- Reporting on project performance & outcomes

DECISIONS I MAKE:

- How programs are designed and where they are implemented
- How to allocate available project funds
- Identify funding opportunities
- Who to partner with

DATA I HAVE:

- Routine M&E data
- Program data
- Funding data and cost effectiveness
- Surveys
- Human interest stories
- Implementation stats

INCENTIVES I GET:

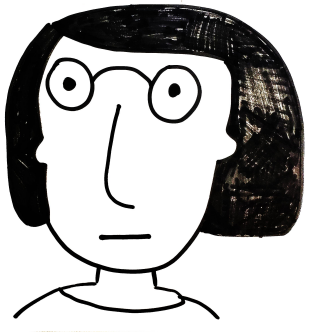
- Impact & outcomes
- Financial compensation
- Recognition and growth

IPs: Already being done

1 • Sustainability and transition plans started in year 0 • Financial planning for transition phase starts in year 0 • Integrated approach with linkage to existing systems and other sectors • Public-private sector linkages for resource mobilization and service delivery	**2** • Project TA driven by local teams who understand the context • Contribute to the laws and policies that govern health system • Improve co-creation of projects
4 • Using technology to improve data accessibility, visibility and performance reporting	**3** • Project steering committees with gov, donors and IPs • Multi-sectoral (both public and private sectors/players) approach leveraging telecoms to expand access

IPs: Opportunities

Make data accessible ● Provide TA to deploy a dashboard on aggregate KPIs for all levels ● Build out capacity and performance metrics ● Collaboration with other TA partners to standardize data definition and sharing	**Align on common goals and own them** ● Broker discussions between gov and donors ● Implement POC to test results and engender buy-in ● Involve gov in scoping and baseline studies



Donor

We set a country strategy which fits our global agenda and make agreements with the FMOH and state governments to fund specific initiatives. Most of our work is delivered through Implementing Partners.

ROLES IN TA SYSTEM

- Identify priorities and set strategies
- Galvanize resources
- Provide funding for chosen initiatives
- Sign MOUs with government
- Oversee IPs to deliver

WHAT DRIVES ME

- Improving health indicators by bringing in global expertise and building capacity in-country
- Seeing return on investment -- measurable results that fit within strategy cycles (5 years maximum)
- Maintaining brand and good reputation globally
- Desire to make an impact,

WHAT I NEED TO SUCCEED

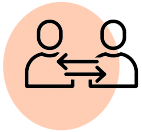
- Monetary accountability and efficiency
- Enabling environment for implementation (responsive gov, clear guidelines, security etc.)
- In-country resources, local capacity, and counterpart funding to scale up proven approaches
- Reliable, up to date information

WHAT I STRUGGLE WITH

- Lack of accountability mechanisms: Have to be accountable and transparent to taxpayers, but local governments may not be able to meet the same standards
- Lack of clear country priorities and plans
- Lack of commitment from the local stakeholders to close the gap once the funding runs out
- Lack of government ownership: Donor funding is meant to be catalytic, with the others stepping in to scale. Often, when the funding dries up, all activities cease.

CHALLENGES I CREATE

- Not transparent to in-country stakeholders on how money is spent. Rarely held accountable.
- Drive for results: Too much emphasis on short-term, measurable results over long-term change.
- Not flexible: Set too many restrictions on how money can be spent, lock in project duration, no room to adjust objectives to reflect local context.
- Not always guided by country policies & regulations.
- Emphasis on globally proven over locally grown initiatives.
- Not always aligned with government priorities. Instead of building on what the country is doing, create parallel efforts that undermine systems.
- Create unhealthy competition.



INTERACTIONS I HAVE:

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

DECISIONS I MAKE:

- Funding
- Investment size
- Location
- Health area priority
- Scale
- Project duration
- Program priority
- Implementation strategy

DATA I HAVE:

- Global health indices
- Global declarations
- Program data
- Commissioned research
- Political economic analysis
- National surveys
- Baseline data

INCENTIVES I GET:

- Political interest
- Economic opportunity
- Priority shifting
- Business opportunity

Donor: Already being done

1 • BMAF • Strengthening PHC mgmt services • BHCDF • Revitalization of PHC • MOU with structured financing and state ownership	**2** • The governors forum • TA hub
4 • Measure evaluation DHIS	**3** • Forging partnerships to unlock state potencial

Donor: Opportunities

Foster strong governance / Create a participatory and inclusive process Donors should insist that RF-funding (docs) should have evidence of deep engagement with stakeholders at all levels	**Cultivate Collaboration / Align / Standardize the core** ● Donors should have an RFA that responds to the national plan ●
Build Trust -- Building accountability mechanisms Donors should insist on an operation plan that speaks to gov budget and is revised annually	

FMOH

Our core function is to set national health policies and provide technical support to the overall health system. We also coordinate donor activities in the country, but we don't get input into the MOUs. Donors often keep us in the dark.

ROLES IN TA SYSTEM

- Identify priorities and set strategies
- Allocate FMOH funding
- Provide strategic oversight and coordination
- Monitor and evaluate

WHAT DRIVES ME

- Setting guidelines and regulations
- Working towards SDGs and country targets
- Providing oversight to ensure priorities are being followed
- Effective coordination of partner/donor activities to ensure resources are being used effectively
- Capacity strengthening

WHAT I NEED TO SUCCEED

- Observing protocols
- Access to complete & up-to-date data
- Timely budget approval and release
- Donor support to supplement public funding
- Adequate HRH
- Clear policies, guidelines, and manuals

WHAT I STRUGGLE WITH

- Minimal visibility into donor and IP activities
- Not involved in discussions with donors. By the time a project reaches a director, most decisions, such as locations, have been made.
- Funding allocated & released late, if at all.
- Not enough resources to perform basic functions within the ministry – desks, computers, etc.
- Favouritism by donors to support parallel systems.
- Brain drain: Loss of trained staff to IP and donors with a better environment.
- Weak systems and structures make basic activities a challenge.
- Not enough say into the resources being assigned the the office by partners
- Not enough technical tools (eg. performance tracker)

CHALLENGES I CREATE

- Reliance on bureaucratic processes that are time-consuming and not well defined
- Overlapping, poorly defined roles within the ministry – efforts are often duplicated, communication is poor
- Rigid, resistant to change
- Institutional knowledge: Capacity gaps in workforce and high turnover.
- Lack of knowledge step-down
- Lack of consistent capacity building

INTERACTIONS I HAVE:

- Development of policies and guidelines
- Co-creation of work plans with implementers
- Resource mobilization (funding and TA requests, counterpart funding where needed)
- Advocacy to state government
- Capacity building on state level
- Coordinating donors, IPs and other stakeholders
- Monitoring and evaluation, research, and evidence generation
- Interaction with other MDAs

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

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
- MICS
- HIA data
- Multiple indicator cluster summary

INCENTIVES I GET:

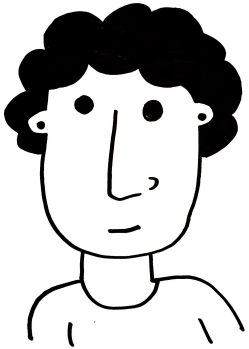
- Events
- Training by IP's on management and institutional capacities
- Human resources
- Infrastructure for special programs (office space, cars, etc.)
- Financial compensation (per diems, accommodation etc.)

FMOH: Already being done

1 • ARIN • BHCPF • NSHIP	**2** • NSHDP
4 • DHIS2	**3** •

FMOH: Opportunities

Increase sustainability and longer term thinking ● Make strategic plans to be longer term (5-10 years) ● Transition plans should be developed before implementation	**Reduce dependencies** ● Advocate for increased domestic funding
Build mechanisms of accountability ● Develop progress tracking tools across the program cycle ● Increase two way transparency between gov, donors, and IPs	**Make data accessible** ● Create a module on the FOMH website, showing dashboards/performance ● Integration of program specific dashboards ● Create module for orphan priority programs



SMOH

We try to coordinate the activities of all the partners in this state, but there are so many competing projects, it's hard to keep track. We know what we need for TA, but we're not included in decisions and most resources are invested outside government.

ROLES IN TA SYSTEM

- Identify priorities and set strategies
- Allocate SMOH funding
- Provide strategic oversight and coordination
- Monitor and evaluate

WHAT DRIVES ME

- Setting guidelines and regulations
- Working towards SDGs and country targets and state priorities
- Providing oversight to ensure priorities are being followed
- Capacity strengthening

WHAT I NEED TO SUCCEED

- Clear coordination mechanisms
- Resources
- Policies and guidelines
- A strong accountability mechanism
- Partnership engagement frameworks
- Guidelines
- Coordinated partners/donors

WHAT I STRUGGLE WITH

- Minimal visibility into donor and IP activities
- Not involved in discussions with donors. By the time a project reaches a director, most decisions have been made.
- Funding allocated & released late, if at all.
- Not enough resources to perform basic functions within the ministry – desks, computers, etc.
- Favouritism by donors to support parallel systems.
- Brain drain: Loss of trained staff to IP and donors with a better environment.
- Weak systems and structures make basic activities a challenge.
- TA activities may take over regular functions
- Not enough say into the resources being assigned the the office by partners

CHALLENGES I CREATE

- Reliance on bureaucratic processes that are time-consuming and not well defined
- Overlapping, poorly defined roles within the ministry – efforts are often duplicated, communication is poor
- Rigid, resistant to change
- Institutional knowledge: Capacity gaps in workforce and high turnover.
- Not always meeting targets
- High turnover, lack of replacement

INTERACTIONS I HAVE:

- Development of policies and guidelines
- Co-creation of work plans with implementers
- Resource mobilization (funding and TA requests, counterpart funding where needed)
- Coordinating donors, IPs and other stakeholders
- Monitoring and evaluation, research, and evidence generation

DECISIONS I MAKE:

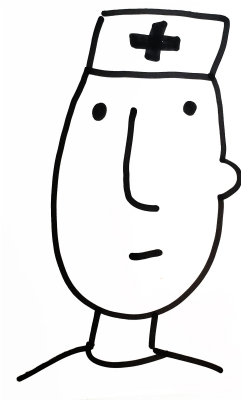
- What is our health strategy
- Funding allocation and release
- What policies to adopt/ adapt
- Siting locations for programs
- How to coordinate partners
- Priority data and information

DATA I HAVE:

- Baseline data
- ISS data
- HMIS data
- DQA
- Financial data

INCENTIVES I GET:

- Financial compensation - Salaries, per diem
- Equipment and supplies- motorbike, computer
- Recognition
- Infrastructure - office space
- Promotion



Health Care Worker

We are overworked and underpaid. We often rely on TA to provide us with basic supplies and training. Partner projects add extra work to our job, but also come with incentives which we have come to rely on to supplement our income. They are the direct implementers on programs & projects.

ROLES IN TA SYSTEM

- Receive training/ supervision
- Adopt new protocols
- Collect/report Project data
- Request TA

WHAT DRIVES ME

- Providing quality services to improve health outcomes of the local community and saving lives
- Improving quality of care
- Recognition for job well done
- Enabling environment: Money and job security, good sanitisation, equipments and supplies
- Ability to make decisions
- Prestige and recognition in the community

WHAT I NEED TO SUCCEED

- Getting paid in a timely manner
- Tools to work (good infrastructure and equipment)
- Funding (operating expenses)
- Mentoring, on the job training, and certification

WHAT I STRUGGLE WITH

- Lack of capacity strengthening and basic equipment to work
- Non payment of salaries
- Insecurity
- Competing priorities between regular job and incentivized project work
- Unhealthy competition between nurses and between programs
- Lack of demand for services (vaccines and uptake of FP) which are outside the scope of what a HCW can do
- Poor health seeking behavior by clients
- Program officers at state and LGA level are the ones who request for TA

CHALLENGES I CREATE

- Resistance to change
- Staff turnover
- May prioritize certain areas of work and compromise quality of service
- Sometimes driven by personal needs, may look to maximize earning from donor funded activities
- May participate in trainings that they can not apply back in the facility
- Expectation of incentives to do work
- Don’t always follow protocols and guidelines
- Not always accountable
- Training is hard to track
- Poor patient experience -- lack of IPC/bedside manners/ gender or age biases

INTERACTIONS I HAVE:

- 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
- Receiving supervision
- Receiving instructions around guidelines and protocols
- Participate in TA training, sometimes serve as master trainers

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
- How to access potential beneficiaries that are usually overlooked (ex unmarried women)

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

INCENTIVES I GET:

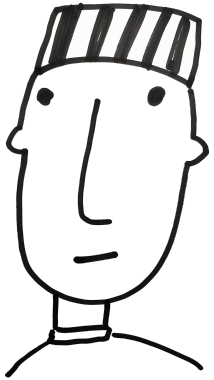
- Training
- Financial compensation - supplementary salary,
  per diem
- Recognition
- Promotion
- Equipment and supplies
- Human resources
- Infrastructure

HCW: Already being done

1 • x	**2** • HCW needs to work with more urgency in treating/attending to patients • Involve patients in decision making for their health • Making decision regarding health with WOCs as an inclusive process • Bottom up programme development
4 • Incorporate feedback mechanism between HCWs and patients	**3** • Working within a framework for best practices and best conduct

HCW: Opportunities

Balance individual gain with collective good ● Development and use of a digital training tool ● HCWs should only attend trainings based on needs/job description and give room for other HCWs to be trained too	**Involve patients and community in health decisions** ● Solar powered feedback system ie patient gives/selects quick responses on services on a screen
Consider system as a whole ● Well train/capable HCW that is able to offer integrated services to patients ● All interventions and strengthening services offered in health facility so less program is focused in health facility	**Build mechanisms for accountability** ● Implement accountability framework and SOPs ● Strengthen community engagement to hold policy makers and healthcare workers accountable
Make data accessible ● Data accessibility for community/HF programs etc	**Strengthen positive feedback loops** ● HCWs should be open to receiving feedback from patients and not just from supervisors during ISS



State Government

We allocate and release the state funds for health. We juggle many competing priorities and often don't have all the information to make health policy decisions. Donors often come directly to us to advocate and sign MOUs.

ROLES IN TA SYSTEM

- Sign MOUs with donors
- Provide counterpart funding to projects
- Provide oversight and coordination
- Request TA

WHAT DRIVES ME

- Getting re-elected
- Measurable impact and seeing physical improvements
- Keeping my constituents healthy and happy, especially as compared to other states and previous administrations
- State reputation at national level

WHAT I NEED TO SUCCEED

- Data to understanding the needs of the population
- Political will to get things done

WHAT I STRUGGLE WITH

- Inadequate funding
- Insecurity
- Poor accountability of donors and lack of transparency into their activity in my state
- Minimal technical knowledge on health
- Inadequate information on status of the state
- Opposition

CHALLENGES I CREATE

- Will say yes to any opportunity for more funding, but doesn't have matching funds and political will to follow thru on promises
- Not accountable to anyone
- Operates with chromic budget overcommitments & late fund releases which make meeting commitments close to impossible.
- Resistant to change
- Doesn't provide strategic plans and clear policies
- Making funding decisions without a health background, might not be sensitized on why issues are important
- Not owning project and not coordinating
- Make decisions based on electibility and pet projects

INTERACTIONS I HAVE:

- 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

DECISIONS I MAKE:

- Allocation of state funds for health
- Timing and amount of funds released
- Determine state priorities
- Which projects to support
- Sanction all donor and IP activities in the the state

DATA I HAVE:

- Population data
- Health data
- HR data
- Partners working in the state

INCENTIVES I GET:

- Awards

HCW: Already being done

1 • BHCPF • MOU between donors, gov, and private sectors • Revitalization of PHCs	**2** • Coordination mechanisms (ex TWG) • N/SSNDP II • Government policies and guidelines
4 • State health account studies • Publishing budget performance	**3** • PPP • Multi sector approach to some programs • MOU between gov, donors, and private sector • Integrated Service Delivery

HCW: Opportunities

Increase sustainability and long term thinking ● Develop sustainability plan ● Building system and not individuals ● Shift from traditional capacity building approach to motivated staff	**Build mechanisms for accountability** ● Enforcement of set rules
Respect and build on local knowledge ● x	**Align on common goals and own them** ● x
Create a participatory and inclusive process ● x	**Reduce dependencies** ● x

National Planning Commission

We sanction and help coordinate donor activities in the country, ensuring that work fits under the National Strategic Plan.

ROLES IN TA SYSTEM

- Has power to convene
- Provide oversight and coordination
- Sign MOUs with donors
- Select implementation sites

WHAT DRIVERS ME

- Ensuring that donors follow the National Strategic Health Plan
- Minimizing activity redundancy and gaps
- Keeping everyone accountable

WHAT I NEED TO SUCCEED

- Up to date information on FMOH strategy and clarity around current activities
- Transparency from donors
- Collaboration between ministries and MDA
- Functional health desk linking with relevant MDA for clear understanding of projects

WHAT I STRUGGLE WITH

- Limited access to information to base decisions on
- Donors are not always forthcoming with their full plans at the state level (actively try to work around my authority)
- Donor alignment, poor planning and strategies
- Alignment with gov government guidelines by donors and IPs

CHALLENGES I CREATE

- FMOH is often not consulted during the discussion with donors. Decisions may not reflect department strategy or address areas of need.
- Decisions at this level cannot be easily changed, even if additional information becomes available.
- Lack of trust

INTERACTIONS I HAVE:

- Negotiate with donors and sign binding agreements
- Inform FMOH of agreements made
- Interface with key officials to understand priorities and strategic plans

DECISIONS I MAKE:

- Reaching agreements with the donor
- Partner eligibility
- Government agencies to involve
- State selection

DATA I HAVE:

- Bilateral agreements and contracts
- National and international conventions, declarations and treaties
- Development assistance database (DAD) policies
- Gov priorities/ sector
- NAtional surveys and routine data

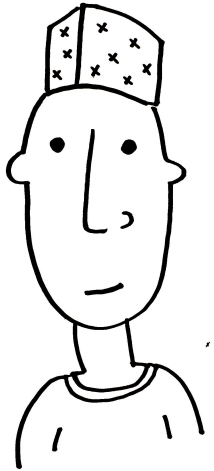
INCENTIVES I GET:

HCW: Already being done

1 • x	**2** • NSHDP II (budgetary & release) • Create participatory and inclusive process
4 • Performance for Results (SOML Project) • Build mechanisms for accountability	**3** • x

HCW: Opportunities

Create a participatory and inclusive process ● Stakeholder meeting to agree on decision (gov, donors, stakeholders) ● They should lay down TOR and implementation plan we should strictly adhere to ● Create social media platform to enhance interaction (donors/IPs)	**Build mechanisms for accountability** ● Regular monitoring and supervision of implementation progress ● Deployment of technology to enhance monitoring and supervision ● Deployment of technology (in term of payment, reporting of activities and progress of implementation -- scorecard) ● Digital tool to aid in state selection on projects to ensure MOH department priorities are followed
Increase sustainability and long term thinking ● Long term implementation plan (10 years) ● Involvement of key opinion leaders and community members in the planning, execution, and ownership of projects	**x** ● x
x ● x	**x** ● x



Community Leader

I am the gatekeeper to my community. I sanction and help coordinate implementing partner activities. I have won the local election and I am seeking to demonstrate the impact I can make for my community.

ROLES IN TA SYSTEM

- Identify community health needs
- Provide approval for work in community
- Influence community participation & mobilization
- Assure accountability on community level

WHAT DRIVERS ME

- Seeing impact in the community
- Receiving recognition for achievements
- Being heard/ listened to
- Political opportunity promise

WHAT I NEED TO SUCCEED

- Background information and training
- Participation/ inclusion in the design of initiative
- Respect and recognition
- Flexibility to incorporate local priorities and special considerations
- Availability of local resources (human and material)

WHAT I STRUGGLE WITH

- Political pressures and juggling many competing priorities
- Lack of per diem or other compensation for performed work
- Unclear roles and responsibilities
- Absence of accountability mechanisms
- Lack of trust from community members
- Inflexibility of implementing partners
- Reliance on others to provide access to health data key for decision-making
- Lack of data

CHALLENGES I CREATE

- Solving health issues does not win elections, so unlikely to be prioritized
- In the quest for data may lose sight of health issues
- May be incentivised to under/over-report data to gain recognition or receive future funding for community
- Not always aligned with the strategic plan
- Infrastructure investment is usually politically motivated, the facility may be built where is not needed and may provide no service. It creates something the community sees, may just be the infrastructure, not resourced to function
- Not leading development of community development plan to set community priorities
- Nepotism in influencing staffing

INTERACTIONS I HAVE:

- Sanction implementing partner activities
- Facilitate community participation/mobilization
- Work with Director of PHC to identify community health needs

DECISIONS I MAKE:

- Identify community health needs
- Community activities to drive implementation
- Determine how best to use available resources
- Determine who to work/ not work with
- Location and scale of programs

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

INCENTIVES I GET:

- Recognition by community and by other communities
- Infrastructure (water well, facility, school, market place)
- Human resources - good expertise that is trusted
- Training opportunities
- Per diems

HCW: Already being done

1 • PHCUOR (for all 4 areas) • Existance of community health workers/volunteer health workers (CHIPs) already embedded within communities to provide healthcare • COmmunity capacity strengthening for integration of different health programmes (13 states)	**2** • Participation of community leaders in social mobilization for routine immunization and other health programmes/campaigns.
4 • In some cases, community leaders are held accountable for data on immunization and other campaigns • Community leaders hold HCWs accountable for services at the PHC, CWOC/VDC	**3** • x

HCW: Opportunities

Balance individual ● Performance based funding of comm activities	**2.3** ● Participate in AOP and ST processes ● Integrate with community development plan
4.1 ● Townhall meetings that encourage feedbacks from state community leaders	**4.3** ● x
2.1 ● Use local resources (individuals, materials) in TA interventions and programs	**3.3** ● WDC/VDC at the entry point for involvement

Day 2

Refined concepts

Selected concepts for refinement

Three concepts developed in the earlier design sprint workshops were selected by the group for further refinement:

NIGER STATE TA MODEL

FUBU REPORT

TRAINING TRACKER

Each group was given a set of key questions and templates to guide a refinement exercise. The groups were asked to fill out the templates and present their ideas as pitches to the larger group.

Training Tracker

0 Refine your idea

What are the tree areas of concern/aspects to be improved?

- Dashboard reporting for aggregate data
- Individual reporting for staff
- Need for training requests and approval (accountability system)

1 Elevator Pitch

Digital solution that connects to the state/FMoH Human resource system. Its functionality includes:

- Training staff tracking status of the aggregate and individual level.
- Its an equity implementing training opportunity base on strategic objective of FMoH/SMoH.
- It advice policy makers on cost effective approach

It ensures accountability and transparency in training process.

2 How will it be different from the status quo

It ensures training is base on need assessment
It ensures equity in training
Policy makers are well informed about training needs of staff for decision making

Training decisions are approved at the central level

3 Select 3 design principles this concept will address and how?

Balancing individual goal with collective gain
Reduce dependencies
Build mechanism for accountability

4 Who needs to be involved?

Who owns it? Collective ownership (FMOH, DPRS). Appoint a project manager – IP or technology company
Who makes decisions? - TWG of HRH
Who facilitates? – Project manager/IP (proven track record in technology development and implementation)
Who co-ordinates? – Facilitator
Who build and develops – UX designer, programmer, business system analyst
Who promotes? – Technical team, FG Govt/donor (funding and orientation)

5 What are the trade offs and risks?

Tradeoffs: Equitable and transparent process vs. favoritism

Risks:
Lack of political will
Delay contracting and disbursement
Availability of key actors for interviews and solution design and co-creation
Lack of effective IT support services

6 What is your MVP and how will you test it?

What is the smallest viable thing you can test to proof your idea is good?
Upload KYC information of employee of health MDAs
Track training status per staff
Provide basic reporting such as aggregate data on numbers of staff training
Percentage of business management training/clinical training

How will you test and prototype your idea? How long will it take to produce and test?

Driven by feasibility and usability study.
Clickable prototype will be tested with a group of user development panel
24 months
I year development

Niger State TA Model

1 Elevator Pitch

We propose a TA model which is state led, with the state providing clear guidelines and rules of engagement with partners to ensure they align with all their interventions and TA to the state

TA should be provided based on priorities, identified by the state using local resources while building local capacity. TA should be structured to allow knowledge transfer and capacity building to ensure sustainability at the end of the project.

2 How will it be different from the status quo

1. Increased ownership by the state
2. SOPs to guide all TA in the state
3. Harmonised incentive which ensures sustainability
4. Institutionalize a funding mechanism that taps into a variety of funding mechanisms i.e. counterpart funding, state basket fund, SHIS

4 Who needs to be involved?

Who owns it? State government
Who makes decisions? Joint decision making
Who facilitates? State government
Who co-ordinates? State government
Who build and develops? Joint
Who delivers? State & Partners
Who promotes? State, Partners, Donors

3 Select 3 design principles this concept will address and how?

Incorporate a detailed terms of engagement that is signed by the designated authorities
The approach we model will only use expertise were available
A consultative and collaborative process of developing the state strategic health plan document

5 What are the trade offs and risks?

Tradeoffs: IPs need to trade off on control, planning and implementation speed
Government should trade off usual civil service working style. More prudent, results driven and transparent.

Risks:
Resistance to change
Reduced efficiencies and longer timelines

6 What is your MVP and how will you test it?

What is the smallest viable thing you can test to proof your idea is good?
All states should have a signed terms of engagement with partners
SOPs to guide engagement with partners for TA delivery

How will you test and prototype your idea? How long will it take to produce and test?

Pilot in Niger State for 3 months

For us by us (FUBU)

0 Refine your idea

What are the tree good elements of this idea that works?
It is generated by the community and speaks to their needs
Local ownership
Comprehensive report

What are the three areas of concern/aspects to be improved?
Timeliness
Institutionalization/who drives the process
Stakeholder alignment

1 Elevator pitch

Our refined idea is to house a government coordinated comprehensive, timely and indigenous health report that speaks to the needs of the community and inform decision making and investment.

2 How will it be different from the status quo

Timely, comprehensive, indigenous report

4 Who needs to be involved?

Who owns it? All stakeholders
Who makes decisions? All stakeholders
Who facilitates? Government
Who co-ordinates? Government
Who build and develops? Technical Team
Who delivers? All stakeholders
Who promotes? All stakeholders

3 Select 3 design principles this concept will address and how?

Build trust: ensures accountability and credibility
Cultivate collaboration: maximize outcomes
Foster strong governance: by implementing country led approaches guided by local priorities, that follows clearly defined rules of engagement for all

5 What are the trade offs and risks?

Tradeoffs: Foregoing individual stakeholder report for comprehensive National report; all stakeholders.
Trading off donor/partner interest for government priorities; partner donors

Risks:
Withdrawal of fund/support by donors

6 What is your MVP and how will you test it?

What is the smallest viable thing you can test to proof your idea is good?
Quarterly report from selected LGAs

How will you test and prototype your idea? How long will it take to produce and test?

Develop an acceptable tool to test our hypothesis over a year period in the selected LGAs.

Key next steps for concepts

NIGER STATE TA MODEL

1. Advocate to SMOH, Governor, Traditional institution, legislators, House Committee on Health and the Media on the new concept (Responsible: Commissioner of Health, Timeline 3 weeks)
2. Develop and validate and disseminate SOP for state engagement with partners (Responsible SMOH, Timeline 2 weeks)
3. Kick off pilot (Responsible SMOH, Timeline 6 months)

FUBU REPORT

1. Submission of report of this meeting to the HMH, introducing the framework.
2. Advocacy and sensitization of stakeholders on data and report
3. Enlightenment/strengthening of data collection at all level and accurate/timely transmission to the next level of the FMOH.

TRAINING TRACKER

1. Develop a concept note (2 pager) to get buy in from FMOH/SMOH.
2. Identify funding opportunity
3. Engage health market innovator and co-ordinate the project

Day 2

Commitments

Commitments / Voices from Nigeria

1. Apply the learnings from this workshop on reimagining technical assistance.
2. Propagate the knowledge from this workshop.

Dr Henry Elenuwah, Basic Health Provision Fund

To create advocacy and strengthen the activity of health care to meet on the next level to all human lifestyles.

Helen M Envuluanza, FMOH

Advocate to FMOH to key into the concepts of technical assistance and implementation.

Asabe Karagama, FMOH

Build community ownership through sensitization / awareness process to meet the need of the people.

Oleka Maryjane, NPHCDA

Ensuring the development and implementation of TA that has the needs of the local community in mind.

James Dominion, FMOH

Yes committed to part of the co creation platform tih the right conditions.

Emelca Ajanus-Personal-

Commitments / Voices from Nigeria

I will take the outcome of this workshop to the National Emergency Maternal and Child Health Intervention Center. I as a person would like to render volunteering services within my capacity to the effectiveness and actualization of this concept.

Obidimma Cynthia I. , National Primary Health Care Development Agency

I am committed to be part of the co-creation team. This is dependent on the continuity and documents.

Genevieve Eke -Personal

Fully support and implement the new ideas for TA in Nigeria and particularly in Niger State.

Dr Makusidi M. M, Niger State Ministry of Health

To brief the head of my division on the outcome of the meeting and to ensure that the division gives her full support.

Dr Dachung Alexander Bitrus, Federal Ministry of Health

Promote the initiative by valuable contributions.

Adebayo Olunaiimileyin, Basic Health Care Provision Fund

Promote the process by gaining buy in from all stakeholders.

Dr. Joseph S, SMOH Kaduna

Commitments / Voices from Nigeria

I intend to; apply the core design principles in my approach to delivering the TA hub interventions. The new concept will inform state engagements going forward. Commit to sensitizing DAI on.

Chiugo Nwangwu, DAI

Join and participate in activities of co-creation team

Dr. Victoria Agbara, DAI Nigeria

Continue as part of co-creation team.

Dr. Femi James, FMOH

Advocate for best TA practice to be adopted.

Ayenowowon OA, FMOH

To support this to achieve a more effective and efficient model of technical assistance for Nigeria.

Nkeiru Onuekwusi, Independent

1. Join the co-creation platform.
2. Share lessons and relevant information on the co-creation platform.

Ugonwa Unaogu, CHAI -Personal-

I commit to share ideas and lessons learnt from this workshop with colleagues and other government offices I have the opportunity to work with.

Owolabi Titilayo A, SCIDar