Reimagining Technical Assistance for Maternal, Newborn, Child Health, and Health Systems Strengthening

Integration Workshop Report

Nordic Hotel - Abuja, Nigeria

January 2020

CHILD HEALTH TASK FORCE

Federal Ministry of Health

JSI

sonder collective

The Child Health Task Force is managed by JSI Research & Training Institute, Inc. through the USAID Advancing Nutrition project and funded by USAID and the Bill & Melinda Gates Foundation.

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Sonder Collective is a co-operative of design professionals working together for a vibrant and sustainable future working with partners and communities on global health, humanitarian, social innovation challenges.

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Acronyms

BHCPF	Basic Health Care Package Provision Fund
CHAI	Clinton Health Access Initiative
CTC	Core Technical Committee
DPRS	Department Planning Research and Statistics
FMOH	Federal Ministry of Health
HCD	Human Centered Development
HRH	Human Resources for Health
IHP	Integrated Health Program
IP	Implementing Partner
JSI	John Snow, Inc.
LGA	Local Government Area
MOH	Ministry of Health
MVP	Minimum Viable Product
NPHCDA	National Primary Health Care Development Agency
RMNCAH	Reproductive, Maternal, Newborn, Child, and Adolescent Health
SDG	Sustainable Development Goals
SOP	Standard Operating Procedures
TA	Technical Assistance

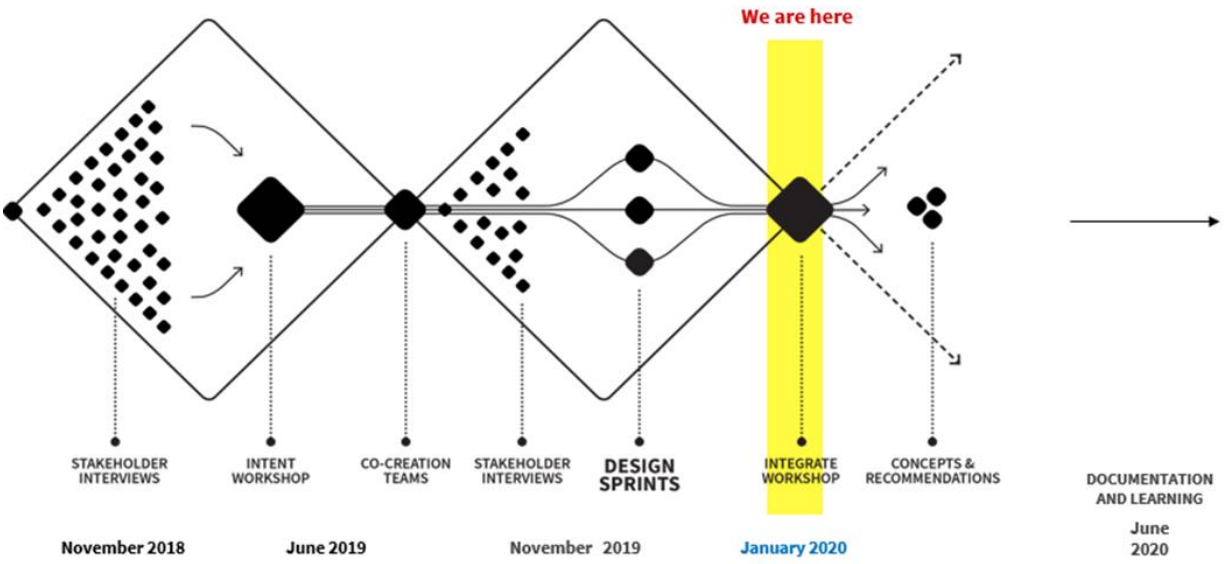
Background

Maternal and child health indicators have stagnated in Nigeria. The current annual rate of reduction in maternal, newborn and under-five mortality is too slow and the country will not achieve the SDG targets. In order to accelerate the annual rate of reduction in maternal, newborn and under-five mortality and support achievement of the SDG targets, Nigeria is re-imagining TA, one of the key drivers of scale and quality of implementation of health programs.

Under the leadership of the Nigeria FMOH, the Child Health Task Force, JSI, and Sonder Collective, are working together to reimagine how TA is planned, coordinated, and delivered for maternal, newborn, and child health and health system strengthening in Nigeria.

The *Re-imagining TA Initiative* started in April 2018.

Figure 1: Nigeria Re-imagining TA Process – Milestones and Timeline



The Minister of Health in Nigeria approved the initiative in June 2018 and the first wave of interviews of stakeholders took place in November 2018. The information gathered during interviews was validated at a two-day Intent Workshop held in June 2019 in Abuja with participation from FMOH, NPHCDA, donors, IPs, and independent consultants who were former senior staff of the FMOH. Representatives of Niger State MOH and LGA were also present. Participants in the June workshop prioritized challenges to TA that were identified both by interviewees and during the workshop. Three opportunity areas were prioritized *(Figure 2)*. The workshop participants had the chance to join task teams (co-creation teams) that would co-create solutions to each of the opportunity areas.

In November 2019, additional interviews were conducted with stakeholders to gather more perspectives on the challenges, underlying motivations of actors in the TA space, and barriers to change. Following the interviews, teams met to co-create solutions to the opportunity areas of re-imagining TA.

Figure 2: Opportunity Areas

The Integration Workshop: January 2020

Table 1: Organizations Present During the Integration Workshop

Participating Organizations	
FMOH	Solina
Niger SMOH	DAI Nigeria
Kaduna SMOH	CHAI
NPHCDA	PharmAccess
NASS (Office of the Chair of the Senate Committee on Health)	USAID IHP/Palladium
Bill & Melinda Gates Foundation	Save the Children
The Child Health Task Force/JSI	UNICEF
Sonder Collective	The White Ribbon Alliance (WRA)

Building on the November 2019 design sprints, stakeholders from the donor community, IPs the State and Federal MOH, and NPHCDA convened for the final touch point – the Integration Workshop.

Workshop Objectives

1. Prioritize and refine together the knowledge outputs of the Re-imagining TA process
2. Frame and finalize a joint understanding of (reimagined) TA
3. Develop future TA concepts applying the knowledge outputs
4. Roadmap the path to initial steps of change

Workshop Approach and Outputs

Mrs. Tina Taylor, the acting Head of Child Health, opened the meeting on behalf of the Head of the Family Health Department, Dr. Adebimpe Adebiyi. She welcomed everyone and invited participants to contribute ideas for improving TA in Nigeria.

During the first session, concepts and ideas generated during the June and November sprints were presented. A discussion of the design principles followed to clarify what TA challenge each principle addresses and the required action – behavior change – from the actors in order to realize the desired shift *(see Figure 2)*. Following the comments on the design principles, participants divided into groups and applied the design principles to three solutions or concepts identified during the November design sprints (*see detailed concept development below)*. This work session ended with co-creation teams defining MVPs and timelines for testing the hypothesis, or validity, of the concept. The Hon. Commissioner of Health for Niger State MOH committed to advocating that Niger State implement the proposed approach as a complement to efforts already under way to align donor support with state priorities, with an emphasis on local ownership and inclusiveness in TA engagement.

This workshop also marked the end of the *Re-imagining TA Initiative* in Nigeria. Dr. Ogbonna Amanze gave concluding remarks on behalf of the Chair of the Senate Health Committee, Dr. Oloriegbe. In his remarks, the Chairman thanked the team for addressing the challenges of TA, a matter that is also under discussion in the Senate Committee on Health. Dr. John Ovuoraye, the Deputy Director and Head of the Newborn Branch, Child Health Division, closed the meeting by thanking the participants for contributing solutions to current TA challenges and reiterated the commitment of the government of Nigeria generally, and the FMOH specifically, to improving service delivery through better TA. He also thanked JSI and Sonder Collective for facilitating the initiative.

Session One: *Sharing Key Knowledge Products of the Re-imagining TA Process*

The key outputs created under this process and shared during the Integration Workshop include:

1. A list of identified key challenges with TA and opportunities for change;
2. A set of critical shifts desired to move from the current problems of TA to a future vision of good TA;
3. A set of design principles for future TA; and,
4. A set of ideas and concepts to improve TA and put the design principles into action.

Figure 3: Critical Shifts for TA to be Effective

From *What is the problem with TA?*	To *Good TA is...*	Quotes from Key Informants/participants
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)	
Static	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"

Figure 4: The Design Principles – Four Domains and 12 TA Principles

Session Two: *Applying the Design Principles*

Three concepts emerged as solutions to the identified challenges and were further prototyped using the proposed TA principles. Each concept is presented below indicating why it is a compelling idea, how it can be refined, risks associated with it, and the MVPs that will be developed and implemented to test it.

Figure 4: Three Concepts for Prototyping

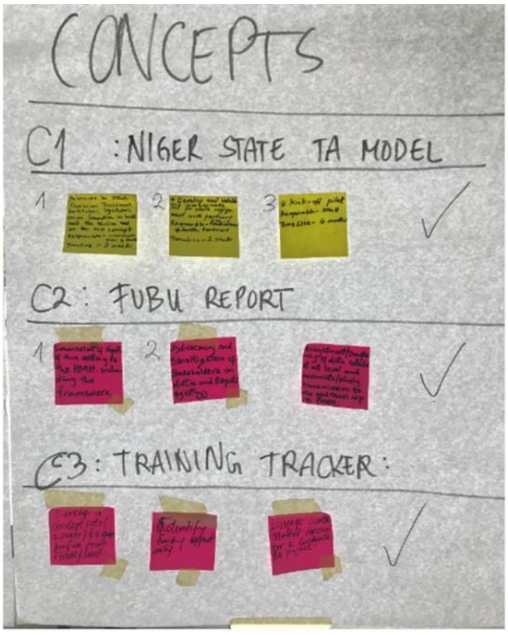


Table 2: Summary of Priority Outputs *(detailed worksheets for each concept are included in the Annex)*

Opportunity area	*Re-imagining interactions to build local ownership for greater sustainability*	*Re-imagining knowledge flow to support strategic decision-making*	*Re-imagining incentives to build greater workforce capacity and maximize impact*
Solutions developed under each opportunity area	For Us By Us (FUBU) – a comprehensive annual health report by the FMOH that identifies areas of need in different geographical areas of the country.	Niger State TA Model	The Training Tracker
Organizations represented	FMOH, JSI, Pharm Access, UNICEF, BHCPF, WRA	Niger State MOH, DAI, CHAI, BHCPF, JSI	Kaduna State MOH, IHP, PharmAccess, CHAI
List of next steps	Get feedback from FMOH if this is a viable concept for the co-creation team to develop further (implementation steps).	1. The Hon. Commissioner of Health for Niger State MOH committed to ensuring this idea is implemented in Niger because it is in line with existing state plans for aligning donor support with state priorities. 2. The State government will develop a step-by-step implementation plan for the next six months.	Get feedback from FMOH about the potential of this concept to rationalize training and to check if Kaduna State MOH can be pilot state for implementation.

Recommendations

1. Dissemination of the products and tools generated from the re-imagining TA process to the Minister of Health, other senior government officials like the Directors of the FMOH and the NPHCDA, the Core Technical Committee (CTC) for RMNCAH and development partners.
2. The FMOH should support Niger State MOH to test Concept 1 as the model state and use lessons learned to inform other states to align TA provided by external partners with priorities of the state.
3. The FMOH should commit to implementing the Training Tracker (Concept 3). Kaduna State can be the first State to use the tracker or develop it in conjunction with the FMOH.
4. The FMOH should involve partners to further explore the idea of the FUBU (Concept 2), creating a new way of prioritization (geographical or interventions or resource allocation) based on need and monitoring delivery of health services.
5. The FMOH should encourage co-creation team members, through the CTC, to continue using the HCD skills and tools they have acquired to co-create solutions to other challenges of TA.

Conclusion

Nigeria is a pathfinder country for re-imagining TA. Nigeria was selected due to several factors, including poor health indicators, slow annual rate of reduction of maternal, newborn and under-five mortality in light of the 2030 targets, and evolving government-led initiatives with development partners to improve service delivery (e.g. the Basic Health Care Provision Fund and Saving One Million Lives). The myriad of health projects and initiatives amounts to several millions of dollars spent on TA, which could be maximized to improve health outcomes for women and children. There is overwhelming agreement among actors (funders, providers, and recipients of TA interviewed and involved in the co-creation process) about the need to reimagine interactions and behaviors of all actors and shift the locus of decision-making from the global to the country level. The FMOH should encourage and support implementation of these ideas in order to test if the process of re-imagining TA and the tools generated can bear results.

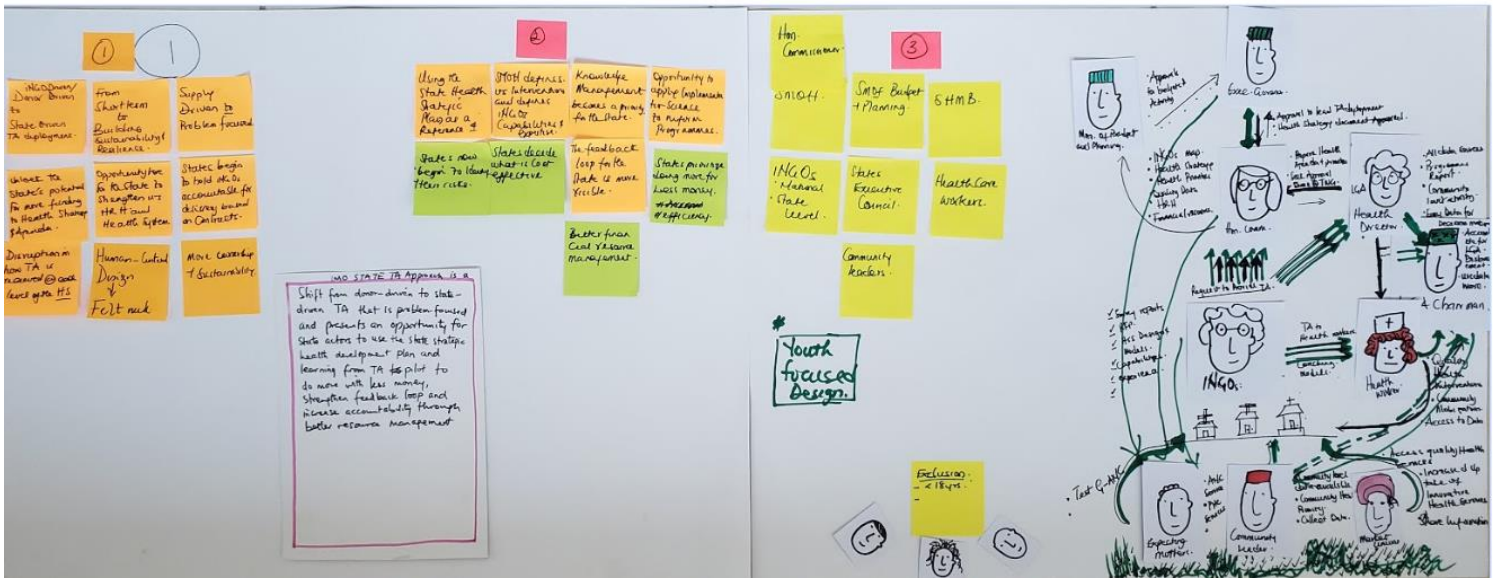
Acknowledgements

The workshop organizers would like to acknowledge the support from the Federal Ministry of Health of Nigeria who gave approval and participated in the Integration Workshop. Gratitude also goes to the members of the co-creation teams who have contributed and interrogated ideas put forward to improve TA.

Annex

CONCEPT 1

Reimagining Knowledge Flow to Support Decision Making: Case of IMO State

State-led approach to ensuring information flow, knowledge feedback loops for strategic decision making and stakeholder alignment	
Future state - IMO state approach 	
ELEVATOR PITCH ***(summary of refined idea)***	**HOW WILL IT BE DIFFERENT FROM STATUS QUO?**
• We propose a State-led TA model, with the State providing clear guidelines and rule of engagement with partners to ensure they align all interventions and TA to the needs of 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 after the end of the project.	• Increased ownership by the State • SOPs to guide all TA in the State • Harmonized incentives which ensure sustainability • Institutionalize a funding mechanism that taps into a variety of funding streams, i.e. counterpart funding, state basket funding, State Health Insurance Scheme.

<table>
<tr><th colspan="2">SELECT AT LEAST THREE DESIGN PRINCIPLES THIS IDEA ADDRESSES AND HOW?</th><th colspan="2">WHO NEEDS TO BE INVOLVED?</th></tr>
<tr><td colspan="2">• 1.1: Incorporate a detailed terms of engagement document that is signed by the designated authorities
• 2.1: The approach we model will use local expertise except if not available then IPs can use external experts
• 2.3: A consultative and collaborative process of developing the State Strategic Health Plan document</td><td>WHO OWNS IT
WHO MAKES DECISIONS
WHO FACILITATES
WHO COORDINATES
WHO BUILDS/DEVELOPS
WHO DELIVERS
WHO PROMOTES</td><td>State government
Join (State, partners, etc.)
State government
State government
Government, partners, end users
State, partners
State, partners, donors</td></tr>
<tr><th colspan="2">WHAT ARE THE TRADE OFFS AND RISKS?</th><th colspan="2">WHAT IS YOUR MVP AND HOW WILL YOU PROTOTYPE IT?</th></tr>
<tr><td>Who needs to make which trade off?</td><td>What are the potential risks or pitfalls along the way?</td><td>What is the smallest viable thing you can test to prove your idea is good?</td><td>How will you test and prototype your idea? How long will it take to produce and test?</td></tr>
<tr><td>• IPs need to trade off control and speed of planning and implementation
• Government should trade off “business as usual” Civil Service working style to become more prudent, result driven, and transparent</td><td>• Resistance to change on either side
• Reduce efficiency and longer timeline to achieve results</td><td>• The State will have a signed Terms of Engagement with partners
• A SOP document to guide engagement with partners for TA delivery</td><td>Develop and pilot the MVP in Niger State for 3 months

<u>Note:</u>
• Advocacy with stakeholders, State leadership and beneficiaries and developing terms of engagement and SOPs approx. 3 months
• Testing the MVP approx. 3 months
• Total time required to test idea approx. 6 months</td></tr>
<tr><th colspan="4">TA PRINCIPLES REFLECTED IN OUR IDEA</th></tr>
<tr><td colspan="4">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 five-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.</td></tr>
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2.1: Respect and build on local knowledge
Data can tell us which communities need TA, but it does not tell us exactly what the problem is or what the best solution is. Local TA resources are often overlooked 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.

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. Recognize local nuances and structures with a view to strengthening them.

CONCEPT 2

Reimagining Interactions for Ownership and Sustainability: The For Us By Us Report (FUBU)

Idea: For Us By Us Report (FUBU)	
	
REFINE YOUR IDEA	
What are the three good elements of this idea that work?	*What are three areas of concern/aspects for improvement?*
1. It is generated from the community and speaks to their needs 2. Local ownership 3. Comprehensive report	1. Timeliness 2. Institutionalizes who drives the process 3. Stakeholder alignment
ELEVATOR PITCH *(summary of refined idea)*	**HOW WILL IT BE DIFFERENT FROM STATUS QUO?**

To have a government coordinated comprehensive , timely and indigenous health report that speaks to the needs of the community and informs decision making and investment	Timely, compressive and indigenous

SELECT AT LEAST THRESS DESIGN PRINCIPLES THIS IDEA ADDRESSES AND HOW?	WHO NEEDS TO BE INVOLVED?	
• Build trust: ensures accountability • Cultivate collaboration; maximize outcomes • Foster strong governance: by implementing community led approaches guided by local priorities that follows clearly defined rules of engagement for all	WHO OWNS IT	All stakeholders
	WHO MAKES DECISIONS	All stakeholders
	WHO FACILITATES	Government
	WHO COORDINATES	Government
	WHO BUILDS/DEVELOPS	Technical Team
	WHO DELIVERS	Government
	WHO PROMOTES	All stakeholders

WHAT ARE THE TRADE OFFS AND RISKS?		WHAT IS YOU MVP AND HOW WILL YOU PROTOTYPE IT?	
Who needs to make which trade off?	*What are the potential risks or pitfalls along the way?*	*What is the smallest viable thing you can test to prove your idea is good?*	*How will you test and prototype your idea? How long will it take to produce and test?*
• All stakeholders will have to forego their individual report for the national comprehensive one • Partners aligning with government • Donors and IP will have to trade off their own interests in favor of government priorities.	Withdrawal of funds or support by donors	Quarterly reports from selected LGAs.	Develop an acceptable reporting tool to test the hypothesis over a one-year period in the selected LGAs.

TA PRINCIPLES REFLECTED IN OUR IDEA

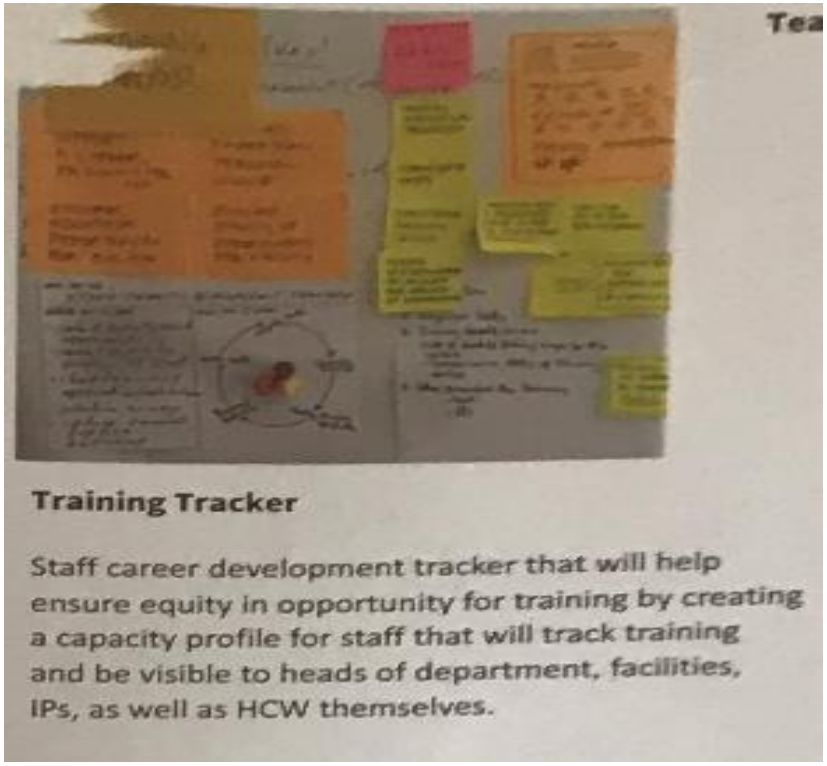
4.1 Build mechanisms of accountability

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.

Cultivate collaboration to maximize outcomes **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.

CONCEPT 3

Reimagining Incentives to Improve Workforce Capacity: The Training Tracker

Training Tracker


REFINE YOUR IDEA	
What are the three good elements of this idea that work?	*What are three areas of concern/aspects for improvement?*

1. Training based on needs and strategic objective of the government 2. It will be real time and results shared with relevant parties 3. Equity in training opportunities	1. Dashboard reporting for aggregate data 2. Individual reporting for staff 3. Need for training regulation and approval (for accountability)
ELEVATOR PITCH *(summary of refined idea)*	**HOW WILL IT BE DIFFERENT FROM STATUS QUO?**

• Digital solution that connects to the State MOH/FMOH Human Resource System
• Its functions include:
  ○ Staff training status at the aggregate and at individual level
  ○ Is an equity implementing training opportunity based on strategic opportunity of the SMOH/FMOH
  ○ It will advise policy makers on cost effective approach
  ○ It ensures accountability and transparency in training process
	• Training will be based on needs assessment
	• It ensures equity in training
	• Policy makers will be well informed about training needs of staff
	• Training decisions are approved at the central level

SELECT AT LEAST THRESS DESIGN PRINCIPLES THIS IDEA ADDRESSES AND HOW?	**WHO NEEDS TO BE INVOLVED?**
• **1.2.** Balance individual gain with collective good • **4.1.** Build mechanisms of accountability • **4.2.** Make data accessible	WHO OWNS IT: Collective ownership- DPRS/FMOH. Appoint project manager WHO MAKES DECISIONS: Training working group of HRH WHO FACILITATES: Project Manager with IP WHO COORDINATES: Same as facilitator WHO BUILDS/DEVELOPS: Designer/programmer WHO DELIVERS: Business System Analyst WHO PROMOTES: Technical Team (Gov/donor)

WHAT ARE THE TRADE OFFS AND RISKS?		**WHAT IS YOUR MVP AND HOW WILL YOU PROTOTYPE IT?**	
Who needs to make which trade off?	*What are the potential risks or pitfalls along the way?*	*What is the smallest viable thing you can test to prove your idea is good?*	*How will you test and prototype your idea? How long will it take to produce and test?*
Equitable and transparent system versus favoritism	• Lack of political will • Delayed contracting and disbursement • Availability of key actors for interviews and solutions, design	• Upload key information of employee of health MDAs • Track staff training status • Provide basic reporting such as; aggregate data on numbers of staff	• Driven by feasibility and usability study • Clickable prototype will be tested with a group of user development panel

	• Lack of effective IT support services	trained; percentage of business management training versus clinical training	• Total 24 months: ○ 1 year development ○ 6 months to 1 year implementation

TA PRINCIPLES REFLECTED IN OUR IDEA

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 incentives that create a fair playing field for all. When possible, invest in infrastructure that can be reused (think refurbishing a meeting space over renting a venue).

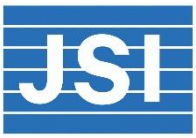
4.1 Build mechanisms of accountability

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.

1.2 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.

Federal Ministry of Health



sonder collective