



# **Re-Imagining TA**

## Intent Workshop

### Recap

June 24-25, 2019  
Abuja

# About This Document

**This document aims to capture the raw conversations and ideas** generated during the first co-creation workshop June 24-25, 2019 to re-imagine technical assistance in Nigeria.

The content is not a verbatim representation of what was said, rather it captures the key points in the participants own words and writing. The purpose of this document is to preserve the voice of the participants and reflect their views and priorities.

The conversations and activities from this workshop will inform the next step in the design process: the framing of three priority areas that will be the focus of the co-creation team design phase.

# Project Background

# How might we **co-create new models of engagement** between in-country and international actors for **enhanced alignment and collaboration in health service delivery.**

The government of Nigeria has set the 2030 vision for national health outcomes in line with the Sustainable Development Goals (SDG). To achieve this vision, the SDGs also call for greater commitment to strong partnerships and cooperation. This provides the platform to explore new ways of partnering and collaborating among health system actors. Strongly aligned and collaborative partnerships can support health service delivery in various ways, for example, this can include strategic planning, monitoring, information platforms, facilities and equipment, medicines and commodities, skills training, knowledge sharing, administrative and financial support.

The global Child Health Task Force has received funding from the Bill and Melinda Gates Foundation to facilitate a participatory design process that engages stakeholders involved in the delivery of health services in Nigeria -- Ministry of Health employees, providers operational and clinical health care, as well as national and international support partners -- to co-create new methods of engagement that can enhance harmony and collaboration among health system actors.

The design process will be led by Sonder Collective using human centered design approaches (more about this approach below).

The Child Health Task Force (CH TF) is a multi-stakeholder network of global and country level child health stakeholders constituted to contribute to strong child health programs. Launched in November 2017, the CH TF aims to strengthen comprehensive child health programs by improving coordination of partners and implementation at global and country levels. The Maternal and Child Survival Program (MCSP) provides the secretariat function to the CH TF through John Snow Inc. (JSI) the technical lead for child health.

## How will we approach this project differently?

This project will follow a participatory and human-centred design approach. This means we will design *with* you, the experts operating in and experiencing the current models of engagement because you have the greatest expertise and insight to change them. Your input will provide a

deeper and richer understanding of the behaviours, motivations and barriers affecting people's capabilities for change in this space.

## Why do we want to approach this differently?

We want this change to be sustainable! By taking a participatory and human-centered design approach, we look to deeply understand the internal determinants (attitudes, expectations, past experiences, current knowledge, current behaviour, motivational intent) as well as social determinants (social learning, social norms and group identity).

This participatory process will be shaped by this rich understanding and your active involvement. With this approach, we hope to inspire participants, like yourself, to take ownership of the developed recommendations and concepts after the initial co-creation activities.

## What is the expected output of this project?

The anticipated output of this participatory design process is a set of recommendations and concepts for new models of partnering between in-country and international health actors for enhanced alignment and collaboration in health service delivery.

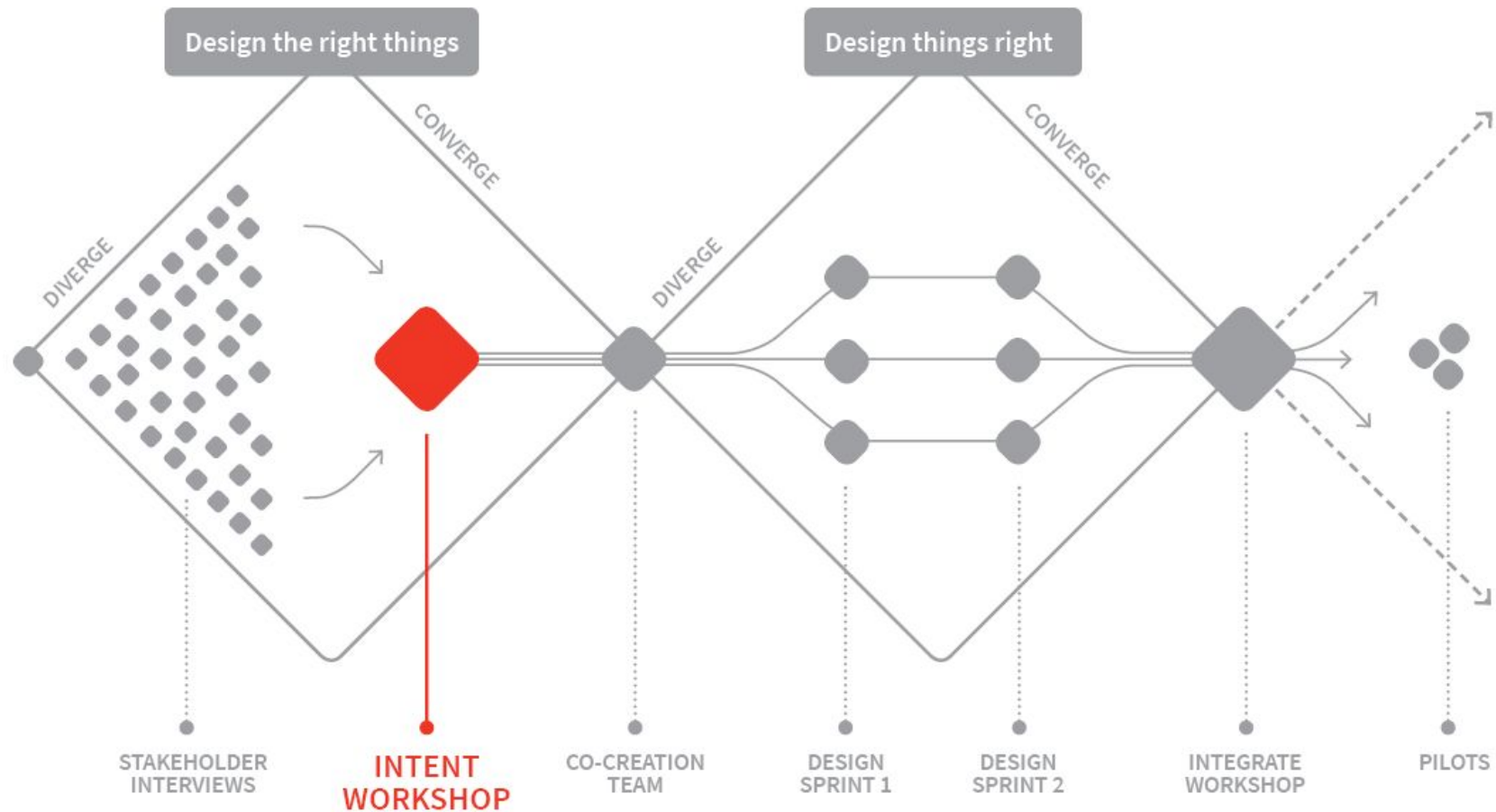
# How we will work together

## Thinking with a designerly mind



# Approach

Co-design follows an iterative process of inquiry and problem-solving represented by the double-diamond below.





# Workshop Overview

# Workshop Objectives

## **Purpose:**

This is the first of four co-design workshops using Human-Centered Design to support the Re-imagining of Technical Assistance in Nigeria. In this workshop, we will build a shared understanding of what it means to re-imagine technical assistance and identify opportunities for change.

## **Hypothesis:**

Better technical assistance models will sustainably improve countries' health systems performances through the strengthening of service delivery, human resources, financing, governance, information, and medical equipment for MNCH. This ultimately will accelerate the reduction in preventable, maternal, newborn and child deaths.

## **Objectives and outcomes:**

- Explore how TA is defined and what models of TA look like today
  - Understand the relationship of current models to the National health system with a case focus on MNCH+N
  - Understand the different approaches to TA
  - Understand the experience of TA from the perspective of different players in the ecosystem including recipients
- To locate opportunities for change
  - What are the most important TA issues in Nigeria?
  - If we could solve these problems what difference would it make?
  - What should we prioritize and why?

## **Participants:**

- Federal and State level Ministry of Health and allied parastatals
- Donors who fund public health sector programs
- Implementers of MNCH/HSS projects
- Professional Associations

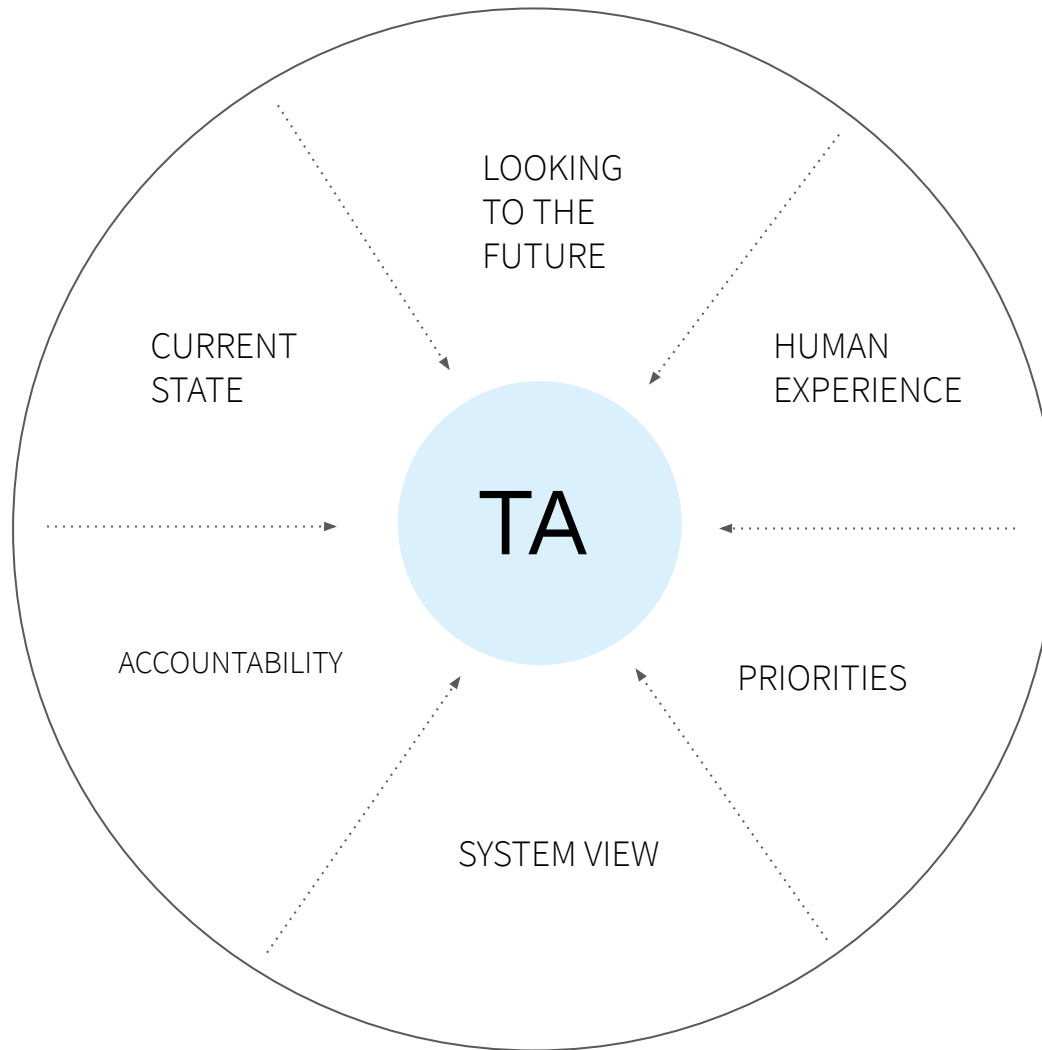
# Overview of the two days

## Day 1

Explore how TA is defined and what models of TA look like today

## Day 2

Identify priorities for change



# Agenda

## Day 1

Kick off and welcome  
How we will work together  
Break  
Approaches to TA  
Looking to the future  
Lunch  
Where are we now  
Experience pathways  
Project stories

## Day 2

Reflections on yesterday  
Identifying key challenges  
Break  
Defining the challenges  
Lunch  
What next  
Pitch  
Prioritisation  
Interest in co-creation teams

# Overview of Activities

## **Day 1:**

Explore how TA is defined and what models of TA look like today

# Opening Remarks

Dr. Adebimpe Olugbemi Adebisi  
*Director of Family Health*



# What is TA?

What types of activities does each group experience as Technical Assistance in Nigeria today?

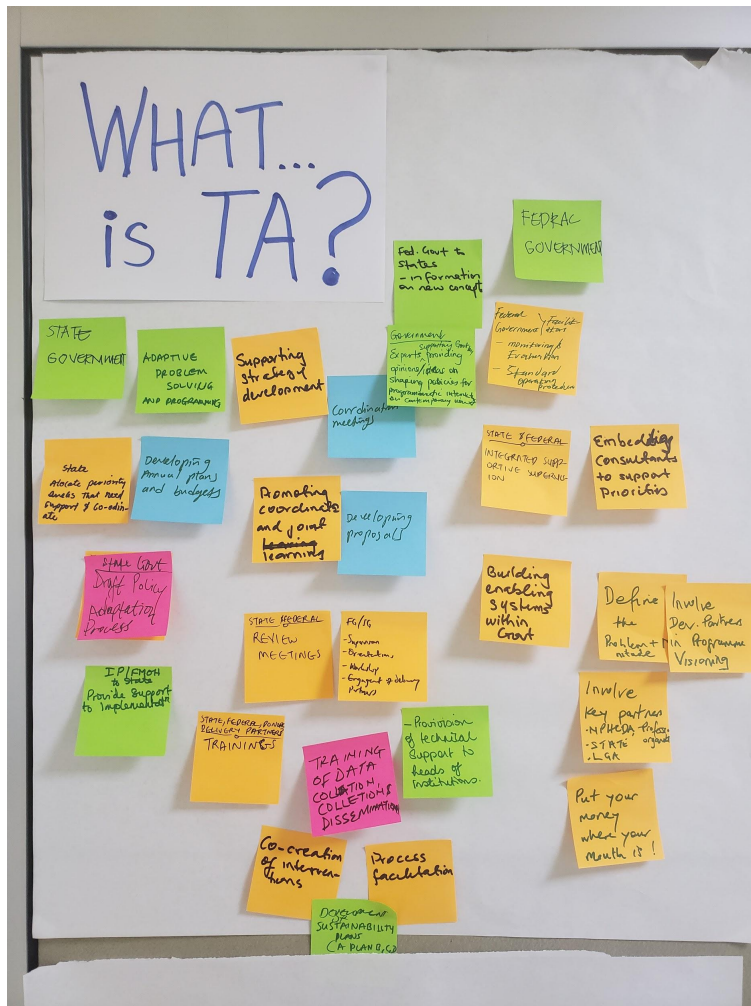




# What is TA? *cont.*



# What is TA? *cont.*



## Federal Government

- Support strategy development
- Support for implementation to state government
- Involve development partners in program visioning
- Define the problem and magnitude
- Involve key partners
- Embedding consultants to support priorities
- Building enabling systems with in government
- Training of state government in data collation, collection and dissemination

## State Government

- Supporting strategy development
- Identify and allocate priority areas that need support and coordination
- Draft policy adaptation process
- Adaptive problem solving and programming
- Developing annual plans and budgets
- Provide support to implementation
- Developing proposals
- Coordination meetings
- Review meetings
- Joint learning
- Provision of technical support to heads of institutions

# What is TA? *cont.*



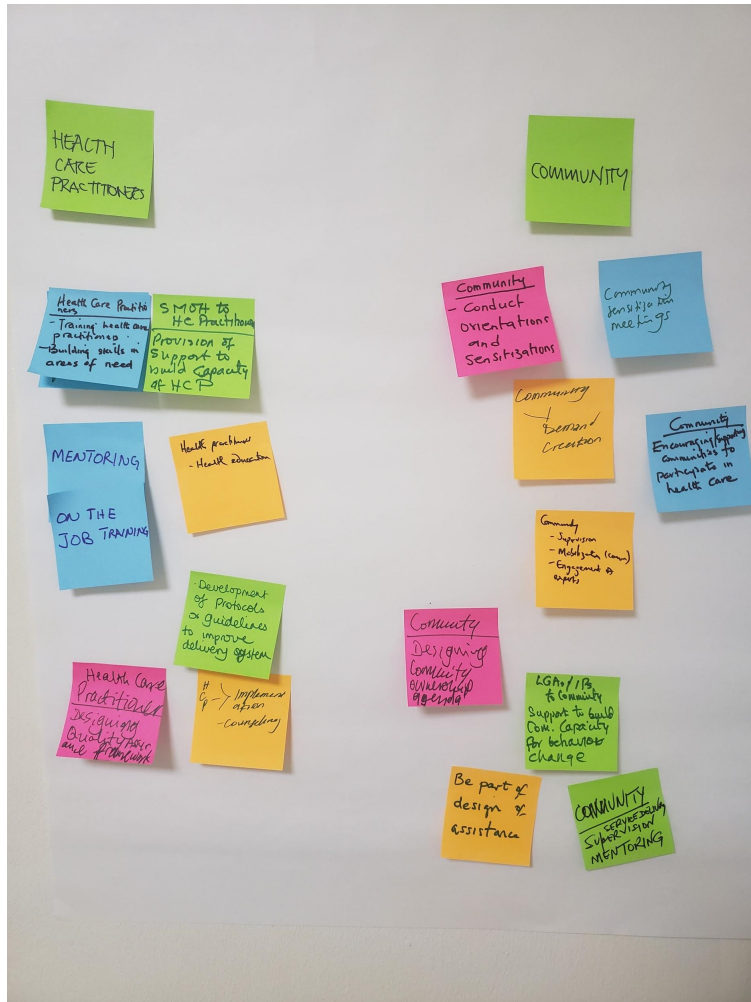
## Donors

- Funding
- Mentoring / Supervision
- Expertise in international best practice
- Co-design of projects
- Capacity strengthening
- Develop tools and guidance in their usage
- Human resource embedded support
- Provision of evidence base to influence policy
- Provision of infrastructure: Hospitals and equipment
- Strengthening the health system
- Improving community logistics
- Providing salary for key staff

## Delivery Partners

- Programme coordination
- Advocacy
- Development of frameworks
- Development of SOP's
- Use donor funds to implement activities that met donor objectives
- Program design
- Implementation support
- Assessment evaluation
- Provision of materials like publications and newsletters
- Convening meetings of key stakeholders
- Capacity strengthening

# What is TA? *cont.*



## Health Care Professionals

- Training health care practitioners
- Building skills in areas of need
- On the job training
- Mentoring
- Health education for practitioners
- Development of protocols and guidelines to improve delivery system

## Community

- Conduct orientations and sensitisation
- Community demand creation
- Encouraging communities to participate in health care
- Designing community ownership agendas
- Community service delivery supervision and monitoring
- Support to build community capacity for behaviour change

# Looking to the Future

This project can go beyond trying to fix what is broken. If we had a blank slate to totally re-imagine TA, what could we imagine?

## OUR VISION FOR TA... IMAGINE IF...

- HEALTH NEEDS NOT POLITICAL NEEDS DICTATE DECISION-MAKING OF TA
- INCREASED DOMESTIC FUNDING + COUNTRY OWNERSHIP
- IMPROVED COORDINATION & IMPLEMENTATION OF TA
- BETTER KNOWLEDGE SHARING & ENHANCED CAPACITY BUILDING
- COMMUNITIES ARE INVOLVED IN DECISION-MAKING IN SPHERE OF TA THAT BUILDS COMMUNITY OWNERSHIP
- TA MEETS THE NEEDS OF GOVERNANCE PARTICULARLY THE VULNERABLE
- IMPROVED DOCUMENTATION & ACCOUNTABILITY - SO AT END OF TERM WE SEE RESULTS
- TA COOPERATES SOLUTIONS THAT RELATE TO GOVERNMENT INSTITUTES
- GOVERNMENT DAVES THE TA AGENDA
- TA SUPPORTS INSTITUTIONAL STRENGTHENING

## IMAGINE IF...

- Collaboration Continuum**
- We had Better Collaboration between Stakeholders
- Better Knowledge & experience sharing
- BETTER COLLABORATION BETWEEN GOVERNMENT AND DONORS/PARTNERS
- Health Crisis Specialists
- Build capacity of people & Govt to do the work better
- Learn from behind the scenes
- Improved COORDINATION OF HEALTH PROGRAMS
- Knowledge
- Increased long/ Sustainability
- INNOVATIVE THE WAYS TO IMPLEMENT PROGRAMS
- More clear role for front row
- Imagine if people who are TA to lead do the work to support country
- Autonomy/empowerment - Sustainable program - well thought out policies
- Beneficiaries of TA involved in planning
- Context-specific TA - Community, State, Country
- Better Planning especially for Funding allocation
- Beneficiary-driven TA

## IMAGINE IF...

- Support institutional strengthening solutions that align with demand driven gov priorities
- technical assistance that helps gov identify strong planning solutions that align with demand driven gov priorities
- TA to support gov in increasing domestic resources and expenditure tracking
- Domestic funds fully support need for activities
- State Govt need F
- IMPROVED PROGRAM DESIGNS THAT WORK!
- SUPPORTS policy dialogue + advocacy to high impact outcomes
- Develop a transition plan for TA
- Capacity building and not trainings
- IMPLEMENTATION
- COORDINATION
- RESULTS
- TA that helps government focus on achieving its health related projects to measure EVALUATION
- Unrestricted funding for innovator
- TA about specifically helps address govt...
- EFFECTIVE PARTICIPATION OF ALL
- INNOVATIVE SOLUTIONS
- Health Facility could help provide feedback to manage supervisor
- DEVELOP POLICY/STRATEGY/IMPLEMENTATION
- 4 SERVICES REGULATORY SUPERVISION
- IMPLEMENTATION
- COORDINATION
- TA about specifically helps address govt...
- 2 CAPACITY BUILT
- Strategy driven TA

## IMAGINE IF...

- Improved resources built system to ensure that funds meant for TA are used properly
- DOCUMENT (1) MONEY (2) RESULTS
- BOTTOM-UP NOT TOP-DOWN
- BETTER COORDINATED DRIVEN BY GOVT
- DE-ADDED BEEN FINING TO CALL ABOUT A GAP LIKE THIS IDENTIFIED
- USAID CALL TO ASK HOW THEY WOULD HELP
- DE-ROUTINIZED LOCAL TA
- Health needs are political doesn't drive decision making about TA
- PROGRAM DESIGNERS ARE MORE PARTICIPATORY Govt & Partners & Donors & Community & women & vulnerable

## IMAGINE IF...

more than one model

- Health Facility could help provide feedback to manage supervisor
- TA can be more than one model Govt to support the country
- A new approach and model for TA to improve implementation
- we can not have one size fits all because of the complexity of the country and the world
- Policy shared at all level
- Policy can reach through for implementation
- Receipts of TA use part of the process of implementation
- Demand creation drive high
- Community uptake of services high
- Health indices improved

## IMAGINE IF...

- Govt could have more complete transparency for TA provided
- Govt Health System responsive to perceived needs of citizens
- Community/ household - live and at their perceived point of need
- Govt done - provide again with support the regions new appropriate for consumer beneficiaries
- Donors - provide again with support the regions new appropriate for consumer beneficiaries
- Equal evidence between TA being pushed support to recipient/ user
- Community Involvement
- Govt Commitment
- What if the donor is a member? Register or use their human CAPITAL?
- Performance Delivery - Quality, Cost, and appropriate support
- Building a culture that is not just a program
- Final insights!
- Govt driven TA agenda that meet the needs of the people beneficiaries
- IMAGINE IF TA USES STRUCTURE AND BEST PRACTICES TO HELP GOVT HEALTH CARE WORKERS

# Looking to the Future *cont.*

## Imagine if...

### TA is inclusive

- Decision making about the funding allocation of technical assistance is depoliticised: driven by health needs, not political needs.
- Setting the strategy/priorities for technical assistance is more bottom up: involves community participation and is responsive to each specific context requirements.

### TA is accountable

- Accountability is improved so at the end of each technical assistance initiative we see results.
- Technical assistance meets the real needs of beneficiaries, particularly for those most vulnerable.
- Documentation of technical assistance initiatives provides transparency relating to spending.

### TA is country-owned

- National/state government(s) drive the agenda and implementation for technical assistance, not international partners.
- Technical assistance has increased domestic funding and country commitment.
- The long-term sustainability / impact of technical assistance is planned and built in from the onset.

### TA is collaborative

- Technical assistance initiatives are co-created and diverse in nature: there is not a 'one size fits all' model.
- The implementation of technical assistance is more organised and efficiently coordinated among delivery partners.

### TA is empowering

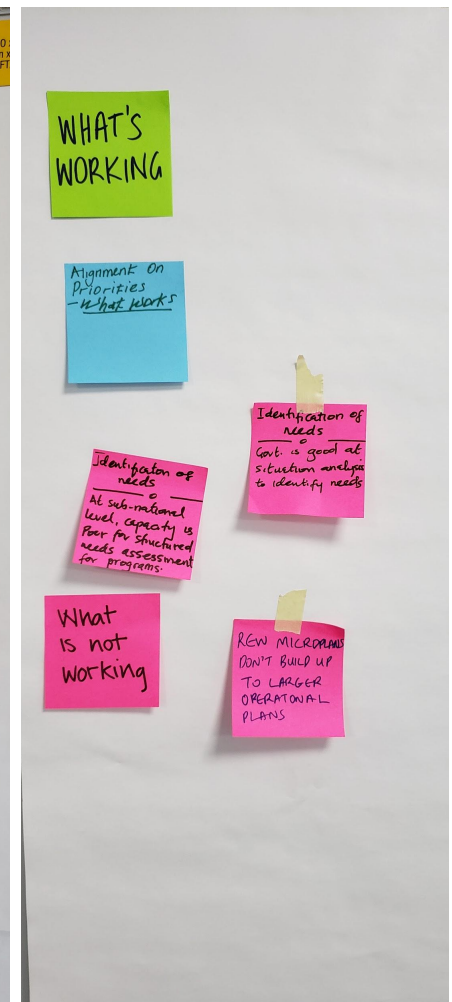
- Technical assistance that builds the capacities of people and not just runs trainings: What if health workers became so good, they don't need TA anymore?
- Technical assistance invests in knowledge exchange and experience sharing among various actors.
- Technical assistance initiatives/activities are guided by robust and reliable data.



# Where Are We Now?

Where are the strengths and limits of each approach?

Governance and accountability	Coordination of resources and activities
Decision making	Development of plans
Identification of need	Implementation of activities
Prioritization of need	Ownership and sustainability
Alignment of priorities	Monitoring and reporting on activities
Allocation of contracts/ funds	Evaluation of outcomes/ performance





# Experience Journeys

## System / Single Health Area

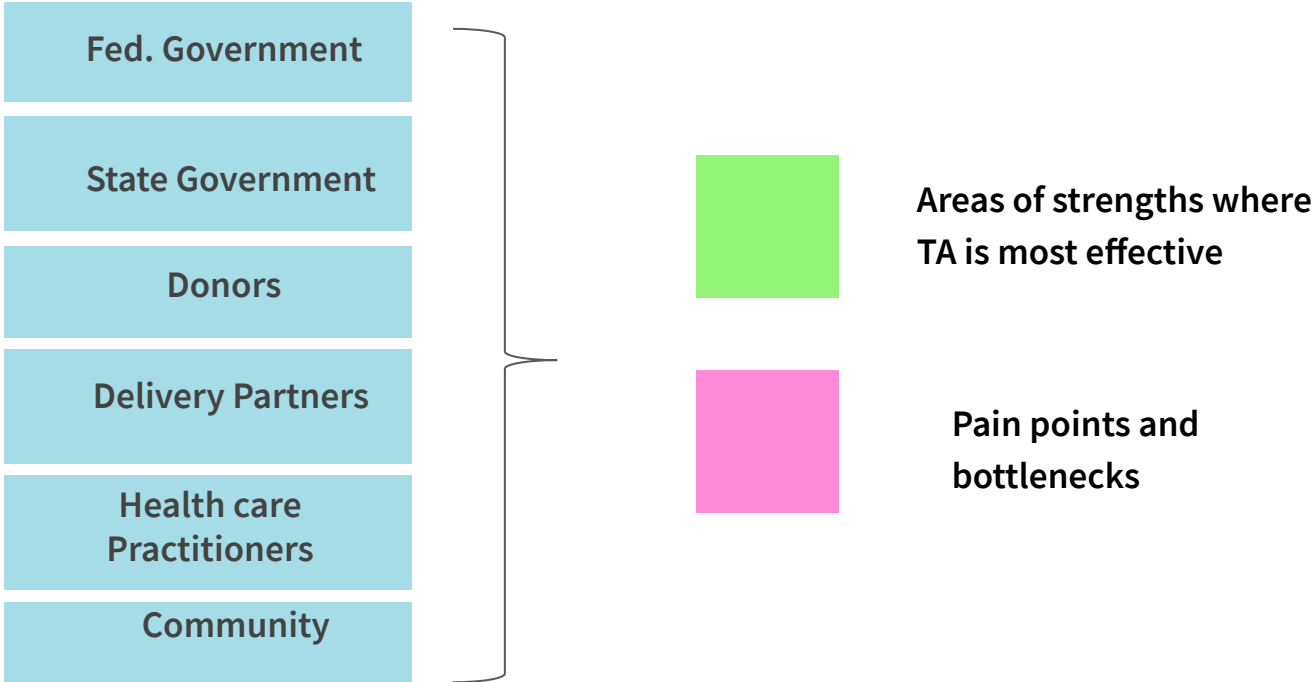


# Mapping Current State of TA

## 1. Map the key activities.

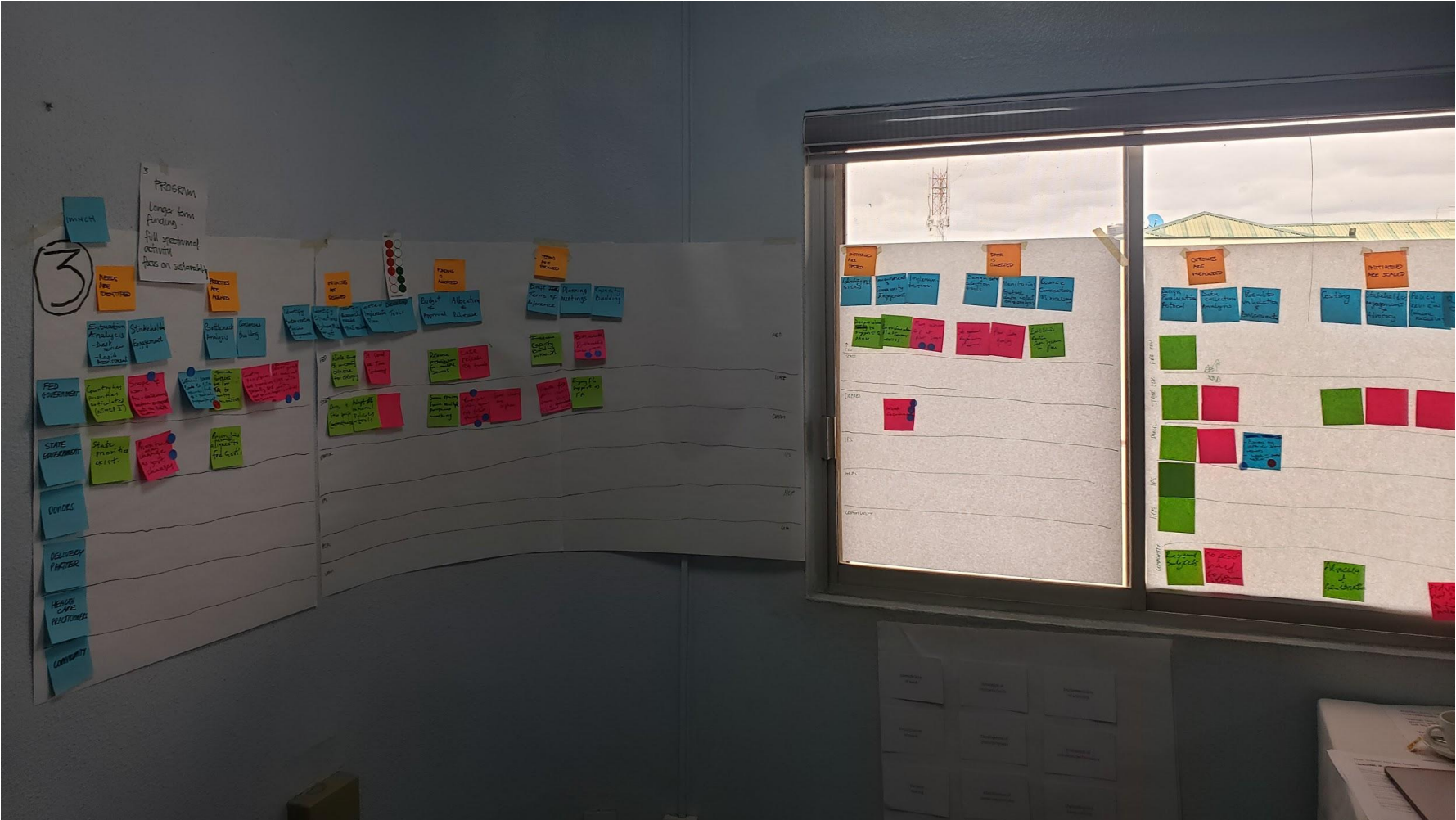


## 2. Map your experience

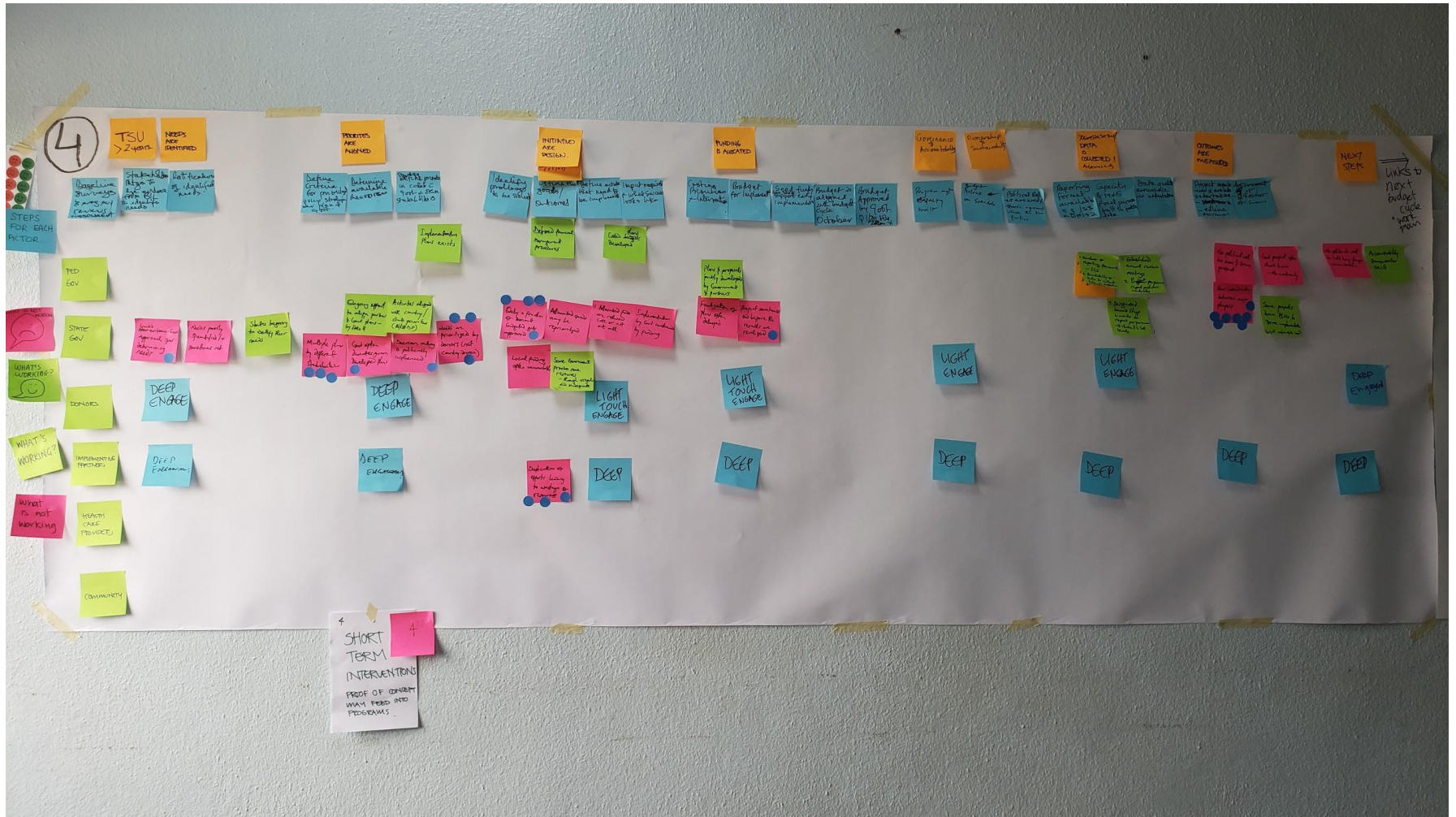




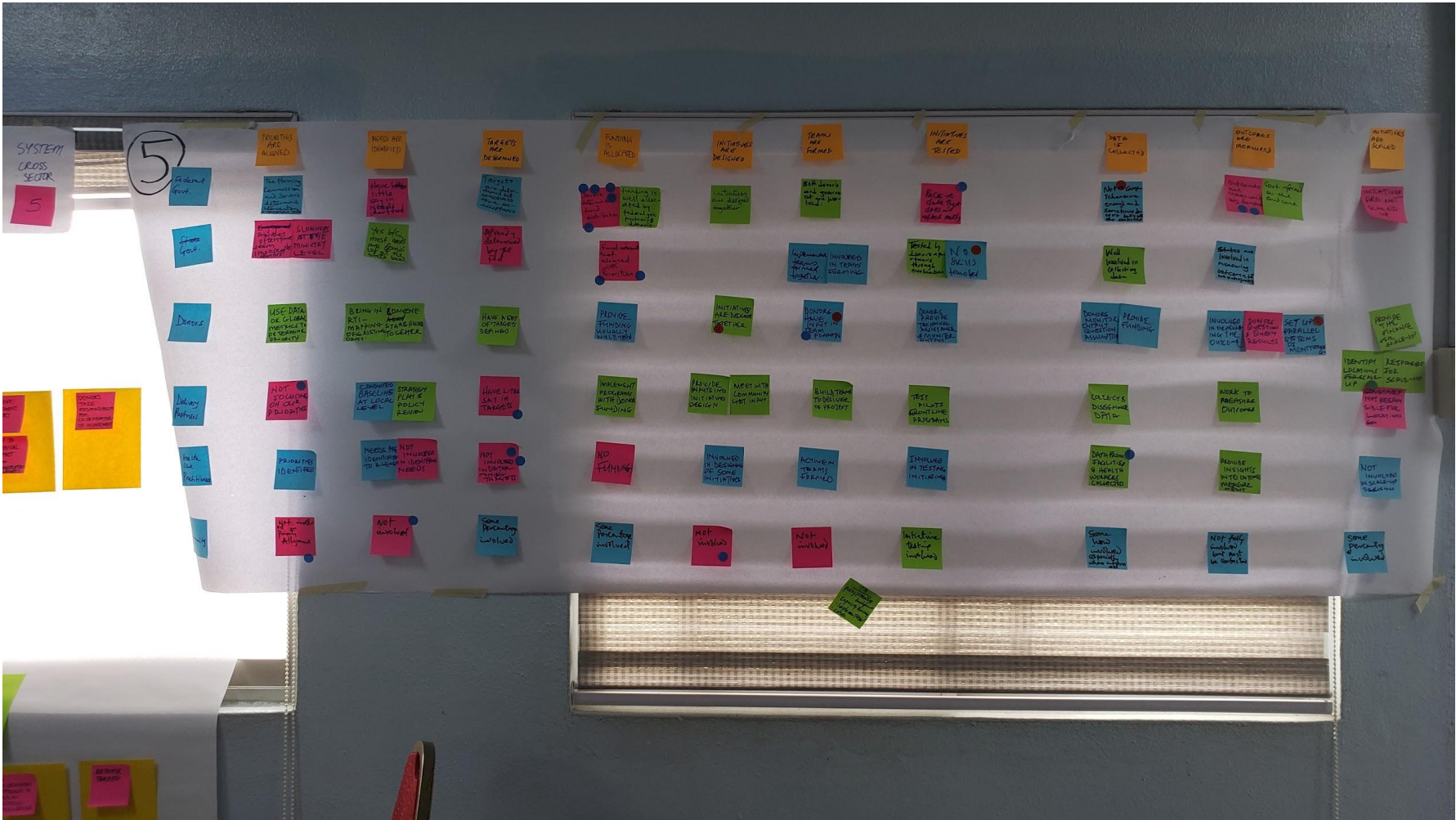
# Experience Journeys



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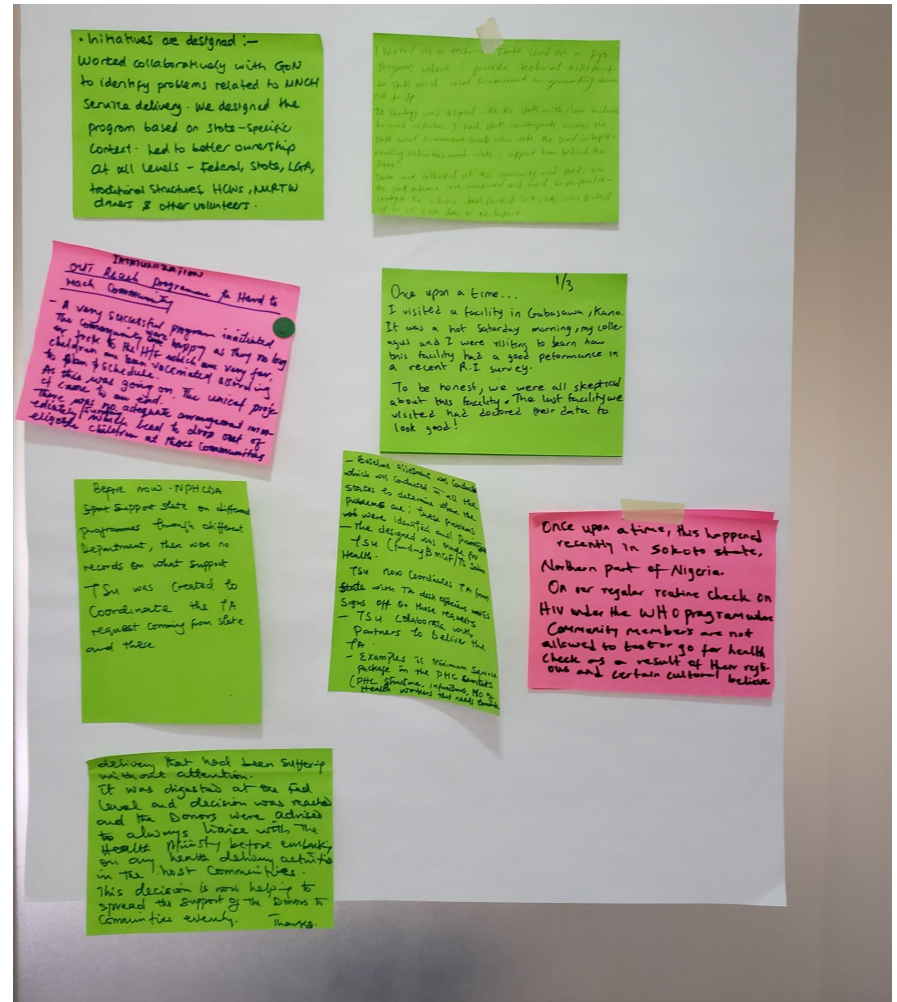
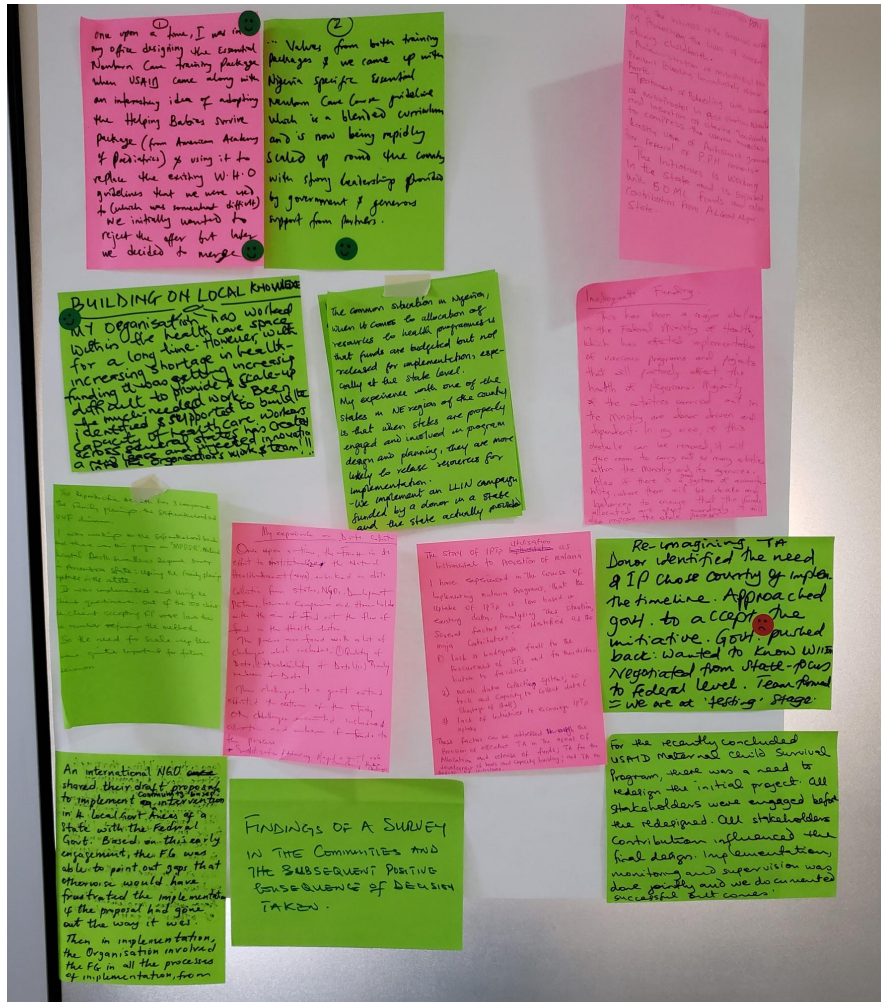


# Experience Journeys

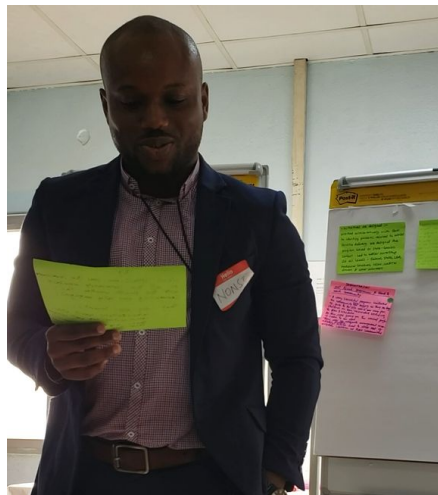
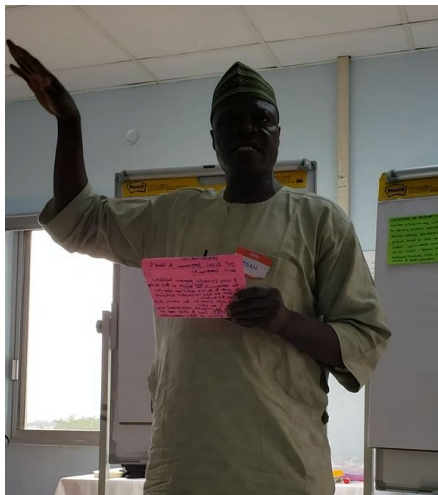
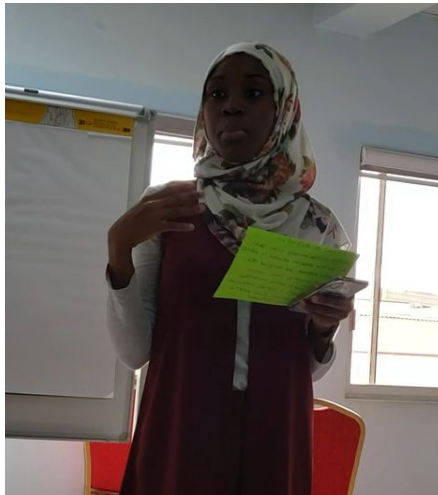


# Project Stories

Present stories that give examples of best and worst moments of providing or receiving technical assistance.



# Project Stories *cont.*





## **Day 2:**

Identify priorities  
for change

# Reflections

What do you think is the most important TA issue for us to focus on in Nigeria? What would you prioritize & why?



# Reflections *cont.*

**① IMPORTANT.**

- **HUMAN RESOURCES FOR HEALTH** (Lots of questions that need to be answered)
  - ↳ **NUMBERS & DISTRIBUTION** ← How does TA come in here? OF HCW
  - STRIKING CRITICAL BALANCE BTR TA/SUPPORT AND TO GOV & USING WHAT IS ALREADY THERE LOCALLY IN GOV
- **TRANSIT FROM TA TO IMPLEMENT SUPPORT TO TECHNICAL SUPPORT** (HOW TO MAXIMIZE EXISTING RESOURCES)
  - **PIBDA** → DO WE REALLY HAVE A SHORTAGE OF TECHNICAL EXPERTISE? (EX. HEALTH FINANCING)
  - ← AT WHAT LEVEL DO WE PROVIDE IMPLEMENT US. TECHNICAL SUPPORT?
- **CAPACITY BUILDING** ← CURRENTLY JOINING CAPACITY DOESN'T GET USED
- **AUGMENT OF PRIORITIES AT ALL LEVELS**
- **GOVERNANCE & ACCOUNTABILITY**
- **COORDINATION OF RESOURCES & ACTIVITIES** (GETTING TO UNDERSTAND HOW AND WHAT)

**② COORDINATION HORIZONTALLY & VERTICALLY**

- NEED TO HARNESS STRENGTH OF THE PUBLIC SECTOR
- TA AROUND DEMAND CREATION
- **ABILITY OF PPL TO AFFORD THE HEALTH SERVICE** (SYSTEM CAN BE IN PLACE, BUT PPL CAN'T PAY)
- **OWNERSHIP SUSTAINABILITY**
  - STATE LEADERSHIP NEEDS TO SEE THE PROGRAMS AS THEIR OWN
  - OWN FROM BEGINNING
  - HAVE PLANS FOR AFTER PARTNERS TO KEEP PROGRAMS RUNNING
  - SPECIFIC POINT PERSON IN GOV.
- **PROGRAM CONTINUITY**
- NEED AN ORGANIZED APPROACH AT STATE LEVEL - STRUCTURE IN PLACE
- **ALLOCATION OF FUNDS** (GOV DOES NOT ONLY PROGRAMS / BASIC SUPPLIES NOT AVAILABLE THROUGH TA)

**③ FOCUS ON EVALUATION OF OUTCOMES & PERFORMANCE** (WE ARE NOT HITTING THE TARGETS)

- FOR GOV, IT ALLOW FOR IMPLEMENTATION INNOVATION
- FOR DONORS, NEGOTIATE FLEXIBLE FUNDING NEEDS TO BE NEGOTIATED
- ↑ IMPLEMENTING PARTNERS STUCK IMPLEMENT BASED ON FUNDING ALLOCATION NOT ACTUAL NEEDS
- **OWNERSHIP & CAPACITY BUILDING** → FOCUS ON AT COMMUNITY & HCW LEVEL
  - BRING THEM INTO THE PROCESS & SEE IT AS THEIR PROBLEM & FEEL OWNERSHIP
  - HCW - GET JOY OUT OF KNOW THEY ARE MAKING AN IMPACT.
- **ALIGNMENT OF PRIORITIES**
  - COUNTRY KNOWS WHAT THEY NEED, THEY JUST DON'T HAVE THE KNOW-HOW TO DELIVER
  - EX. NIGERIA, WE DON'T PUSH RESOURCES TO USE DATA TO PROPERLY MONITOR & EVALUATE.
- **MONITORING & EVALUATION/SUPERVISION IS KEY**
  - QUANTITY OF DATA NEEDS TO BE COLLECTED
  - DATA IS NOT USED AT POLICY LEVEL
- **COORDINATION OF PARTNERS IN FIVE FRAMEWORKS** AT ALL LEVELS
  - ↳ TO AVOID WASTING RESOURCES & MIS ALLOCATION
  - **NEED TO HARNESS BOTH PARTNER & GOV RESOURCES** ← USE RESOURCES GENERATED IN COUNTRY?
  - MIS ALLOCATION OF GOV FUNDS
  - CURRENTLY, "WE DO IT FOR THEM", NEED TO **RETHINK TRAINING**
    - SAME PPL ARE TRAINED TIME & AGAIN, THERE IS NOT A GOOD WAY TO TRACK.
  - **PLANNING** DOES NOT CURRENTLY INVOLVE LOCAL GOV TO UNDERSTAND EXISTING CAPACITY & STATE'S OWN PRIORITIES
  - **PLANNING** SHOULD GO THROUGH THE FED PLANNING DEP. → **PLANNING** SHOULD GO THROUGH THE FED PLANNING DEP. → **PLANNING** SHOULD GO THROUGH THE FED PLANNING DEP.

**④ M&E: IF FUNDS HAVE BEEN ALLOCATED & NOONE IS ASKING QUESTIONS ABOUT IF ITS BEING USED WELL.**

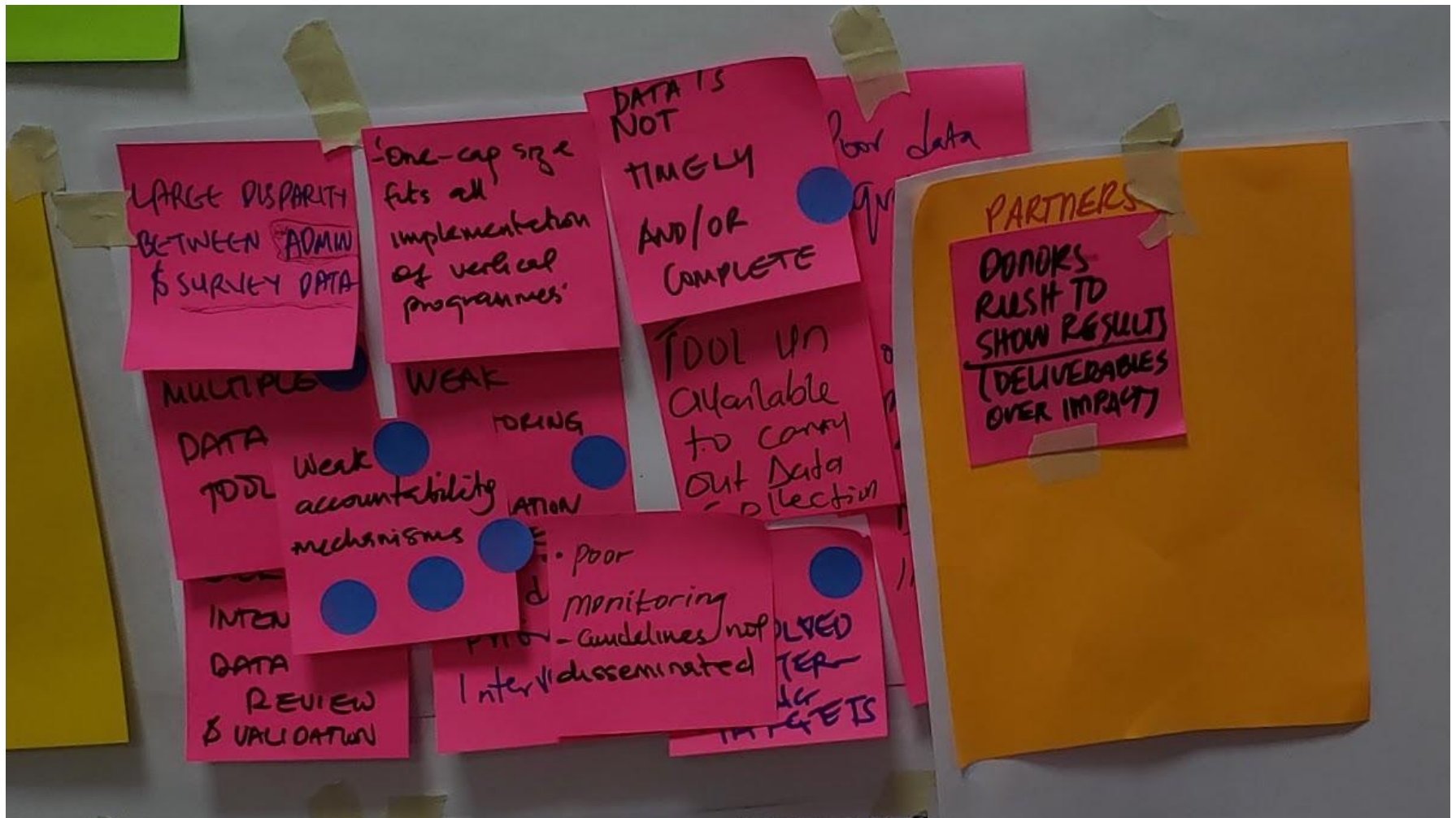
- ↳ **TA AS MEANS OF ACCOUNTABILITY FOR BOTH GOV & PARTNERS.**
- **IMPLEMENTATION OF ACTIVITIES:** PARTNERS SUPPORT STATE LEVEL PLANS, HARD TO IMPLEMENT WITHOUT TA SUPPORT
- **BURK SHOULD STOP WITH GOV, ONLY GOV CAN DRIVE TA**
  - ↳ HOW CAN PARTNERS HELP GOV DO THEIR JOB BETTER?
  - PLANNING SUPPORT.
- **PARTNER COORDINATION NEEDS TO BE DONE BY THE GOV** ← LIMIT LEAVE THIS TO PARTNERS
- **TRAINING HCWs:** PARTNERS NEED TO COORDINATE & TRACK
- **COORDINATION @ PLANNING STAGE, COMMUNITY LEVEL NEEDS TO BE INVOLVED.**
  - ↳ WHEN THE BACKGROUND INFO IS NOT THERE, PROGRAMS GET POLYUSED.

**⑤ HEALTH CARE SYSTEM IS THE ELEPHANT IN THE ROOM.**

- ↳ **MINIMUM REQUIREMENTS PER EVERY WARD** IN ORDER TO COVER THE WHOLE COUNTRY (MINIMUM HEALTHCARE PACKAGE AT WARD LEVEL)
- ↑ PARTNERS SHOULD COORDINATE TO ACCOMPLISH THIS
- **TA FOR ESTABLISHING MOELS FOR SHARED FUNDING**
- **COMMUNICATION**
  - ↳ ALL PROGRAMS COME TO GOV AT HIGH LEVEL. MOST OF US DON'T HAVE INFORMATION FROM DONORS ON WHAT'S HAPPENING.
  - WE SHOULD STAND OUR GROUND TO FILL THE MOST URGENT NEEDS, AS OPPOSED TO LETTING DONORS DO WHAT THEY WANT.
  - INVOLVE OTHER DEPS.
  - REVIEW PROCESS AT THE END.

# Identifying Key Challenges

Highlight priority challenge areas on the experience journeys created on day one.



# Identifying Key Challenges *cont.*

## Data is incomplete

- Large disparity between admin and survey data
- One cap fits all implementation of vertical programmes
- Data is not timely and/or complete •
- Poor data quality
- Sub-optimal reporting rates
- Tool unavailable to carry out data collection
- Weak accountability mechanisms ••••
- Multiple data tools •
- Lack of intentional data review & validation •
- Poor monitoring
- Guidelines not disseminated
- Weak monitoring and evaluation system ••
- Needs assessment not done prior to intervention
- Community not involved in determining the targets •

## Ownership and sustainability by state

- Lack of sustainability of initiatives due to funding.
- Funds not released •
- Decision on priority is most times donor-driven
- Poor use of data for prioritization process

## Decision-making is Politically Influenced

- Lack to coordination to enhance teams
- Evaluation not done
- Allocation of contracts/funds

## Donors take responsibility for coordination of investment

- Create parallel systems of data allocation due to requirements outside NHMS indicators •
- Donor-funded proposal development does not involve government at the design stage
- Priorities at times seem imposed by donors

## Human Resources Numbers & Distribution

- Healthcare providers are not carried along ••
- Weak human resource for health ••••
- Overworked healthcare workers

# Identifying Key Challenges *cont.*

## Ownership at Community & HCW Level / Involvement of Community in Planning Design of Programs

- Lack of the technical capacity to determine this
- Not involved most times in needs identification and the process leading to it.
- Not involved in initiatives design
- Overwhelmed, poorly motivated HWs/poor attitude to work
- Community resources are underutilized
- Community HWs yet to be fully operational
- Government and political agendas disrupt sustainability
- Initiatives are not always tested and deployed most times
- Gaps in understanding priority in federal/sub-level

## A Coordinated Approach to Health Systems Strengthening

- Poor community engagement in needs prioritization .....
  - Donor priorities sometimes do not align with government priorities ..
  - Some donor priorities may not align with country priorities ..
  - States not aligning with national priorities ...
  - Even tough needs are identified, donor funding leads to misalignment •
  - Needs are prioritized by donors (not-country-driven) .....
  - Lack of coordination and governance •
  - Multiple plans by different stakeholders ..

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# Identifying Key Challenges *cont.*

## Healthcare Finance Branch Capacity & Accountability

- Funding does not reach PHCs •
- Donors determine fund distribution •
- Funds not getting to end users •
- Fund amount is not aligned with priorities •
- Lack of adequate funding •

## Advocacy to Government

- No funding
- Funds distributed fall far below budgeted amount
- Some states are orphaned
- Poor funding of priorities by state governments •
- Counterpart funding agreements not followed through
- Evidence and findings not shared with government
- Weak coordination •••

## Advocacy to Government *cont.*

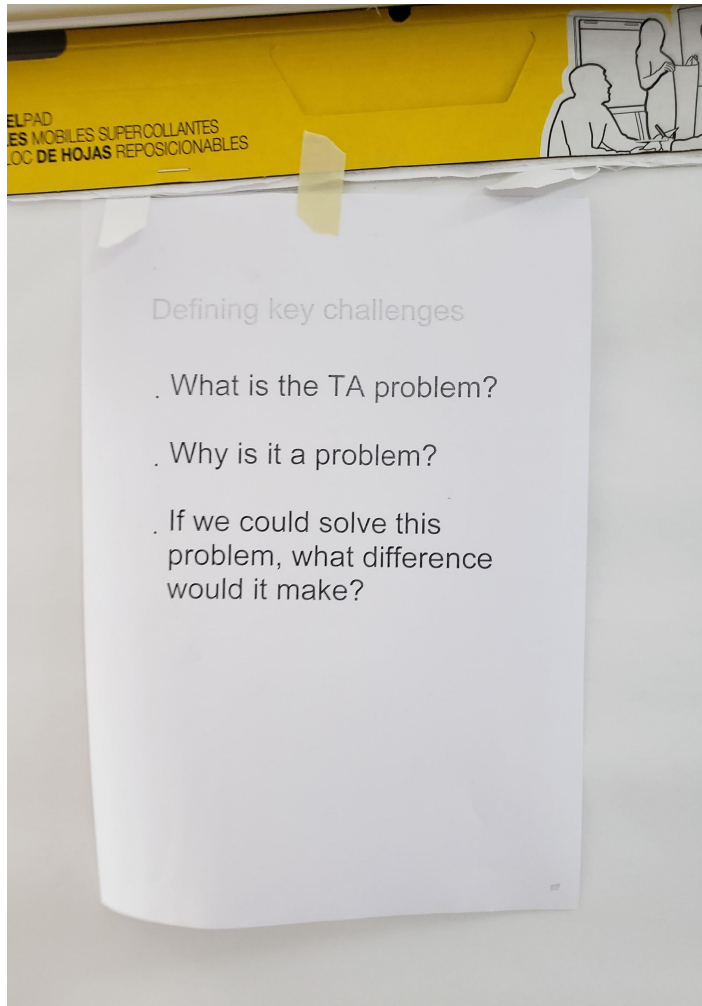
- Over-dependence on donors for programme planning and implantation •
- Late release of funds
- Scope of work pre-determined before engagement with the health sector
- Stakeholder engagement and advocacy
- No political will to own and drive project
- Have little say in needs identified
- Country priorities not trending globally are not prioritized by donor
- Priorities may change as government changes
- Advocacy not leading to fund allocation
- Policy misalignment between different government agencies and ministries

## Funding

- Not focusing on our priorities •
- Poor supervision of implementation
- Implementation by government is constrained by funding
- Allocated funds are released late or not at all.
- Needs poorly qualified or sometimes not
- Finalization of plans often delayed
- Poor data collection processed and practice
- Lack of the M&E technical capacity to determine targets
- Expertise to form robust teams thins out at subnational levels
- Duplication of efforts leading to wastage of resources

# Defining the Challenges

What is the TA problem? Why is it a problem? If we could solve this problem, what difference would it make?





# Defining the Challenges *cont.*



# Defining the Challenges cont.

**HUMAN RESOURCES NUMBERS + DISTRIBUTION**

- State ministry of Health and health agencies do not have dedicated Human Resource for Health (HRH) units and for Planning and management teams
- HRH tools are not readily and in some cases unknown to individuals involved in HRH management
- Lack of necessary HRH Policy and guidelines.

**Why it is a Problem:-**

- There is no realistic HRH data base that specify the Uptake and distribution of existing Health workers
- Available skill set and expertise are maldistributed.

**Existing and**

- Entry and exist into work force is not properly accounted for, hence no strong data driven evidence for effective HRH Planning as well as advocacy to Political leaders for increased recruitment.

**Difference it will make**

- Reliable data base and Evidence for HRH Planning and Management.
- Problem of maldistribution will be minimised, if not eliminated.
- Enhanced quality and equity in Service provision because of better Health worker Motivation.

**What is the TA Problem? Why is it a problem? If we could solve the problem, what difference would it make?**

- States developing AOPs and not creating or implementing them
- States developing AOPs with gaps due to the lack of alignment with the ISSHP or the SHDP and other national documents
- States' SSPs/CPs not aligning on State priorities or targets
- The State not aligning with left leans on priorities/needs etc
- Donor pressure & priorities result in parallel prioritisation between TA partners and government plans.
- Multiple plans of agency workers, ministry workers etc
- Responsible donor - not accountable
- Donor approach govt with intent to work through the institutional heads who in turn often their own if implementation which sometimes does not give the way of the donor, leaving them to their options.
- Engage working parallel till no good outcome then for a good outcome.
- FINER Understanding that budget allocation has been done, should communicate to the other lower levels for better implementation.
- All planning toward execution of any program should have been carried out a month prior to its implementation, to avoid any delay in the scheduled date.
- Diversification of activities of program execution is key to good deliverables.
- Transparency, good, custom window, feedback
- Sharing of task among different units/ open door policy with other in the house.

**RETHINK TRAINING**

**Root Sustainability Plan:**

Traditional training methods do not allow for knowledge chain and cascaded skills.

Government does not take ownership of the process and is part of the bigger picture.

Improved funding allocation, prioritization of resources may budgeting

Improved approaches to knowledge transfer and skills improvement (pre-service & in-service) and improved knowledge management

Improved quality of care & service delivery to clients/patients

**Problems:**

- Ineffective training**
  - Trainings could be delivered in a more effective manner
  - Multiple partners various times, disrupting services
  - This could also result in prolonged repetitive trainings and a waste of resources
- Literature loss**
  - This could also result in prolonged repetitive trainings and a waste of resources
- Built capacity of Health workers with improved service delivery.**
  - Uniform knowledge across health workers and improved quality of care

**Problem: Poor Need Prioritization**

- Trainings are in target groups are a out, leading to & skills.
  - Efforts are duplicated and not tailored to suit Health needs
  - Results in inefficient use of limited resources
- Improved design of training programs which are properly tailored to fill knowledge gaps
  - A wider spread of Health workers capacity for specialized service delivery
  - Optimal targeting of resources to where they are most needed.

**Allocation & Timely Release of Resources**

- Programmes and Projects are not implemented as scheduled
- Priorities not met
- Inadequate Resources
- Weak Health System
- Difference It will make Programmes and Projects are implemented as scheduled
- Priorities are met
- Resources will be utilized wisely.
- Health system is strengthened

**BETTER COMMUNICATION WITH LOWER LEVELS OF FINER**

**WEAK HUMAN RESOURCES FOR HEALTH**

**OVERWORKED HEALTH CARE WORKERS**

**HEALTH CARE PROVIDERS do not continue along**

**WEAK HUMAN RESOURCES FOR HEALTH**

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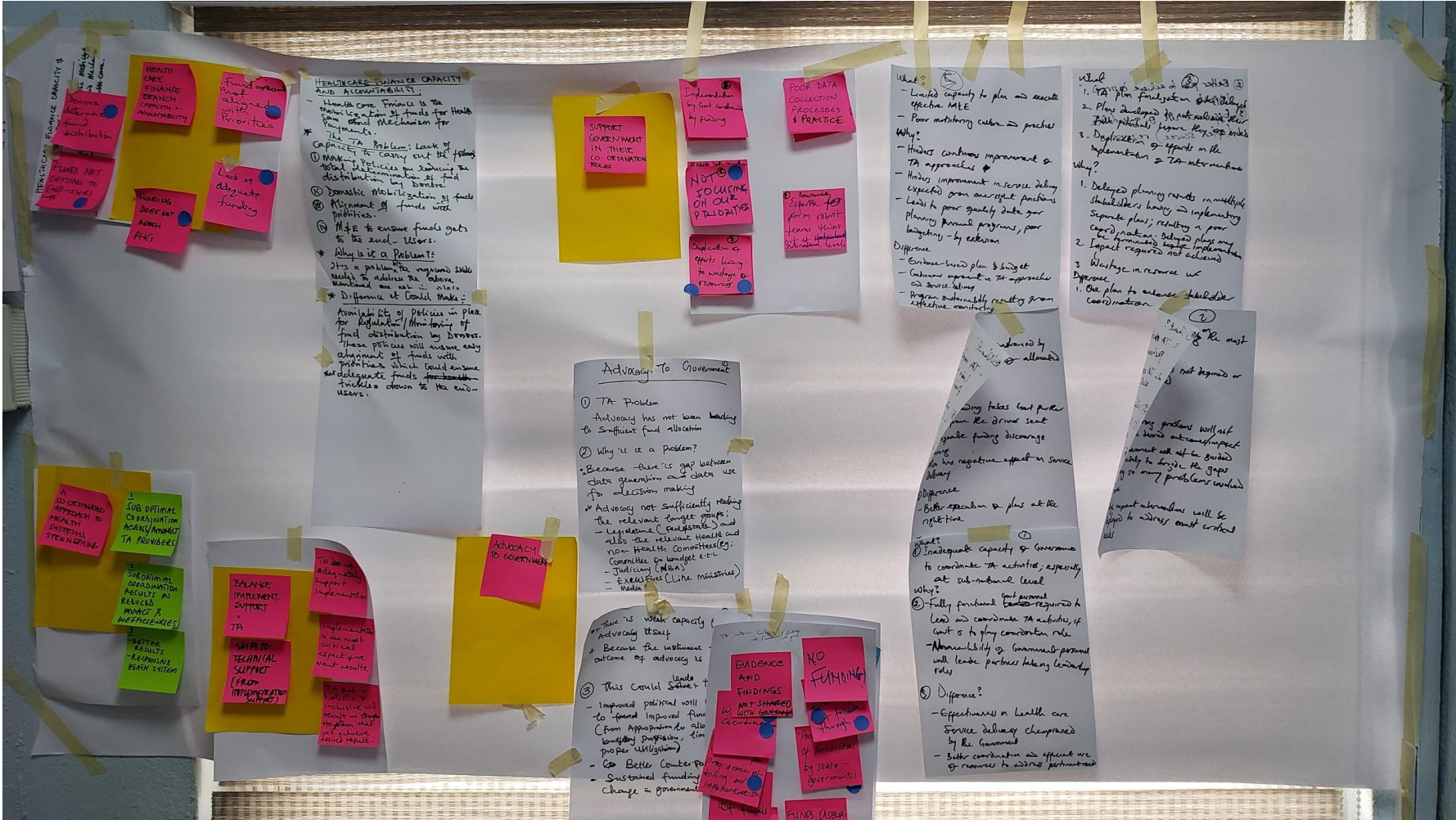
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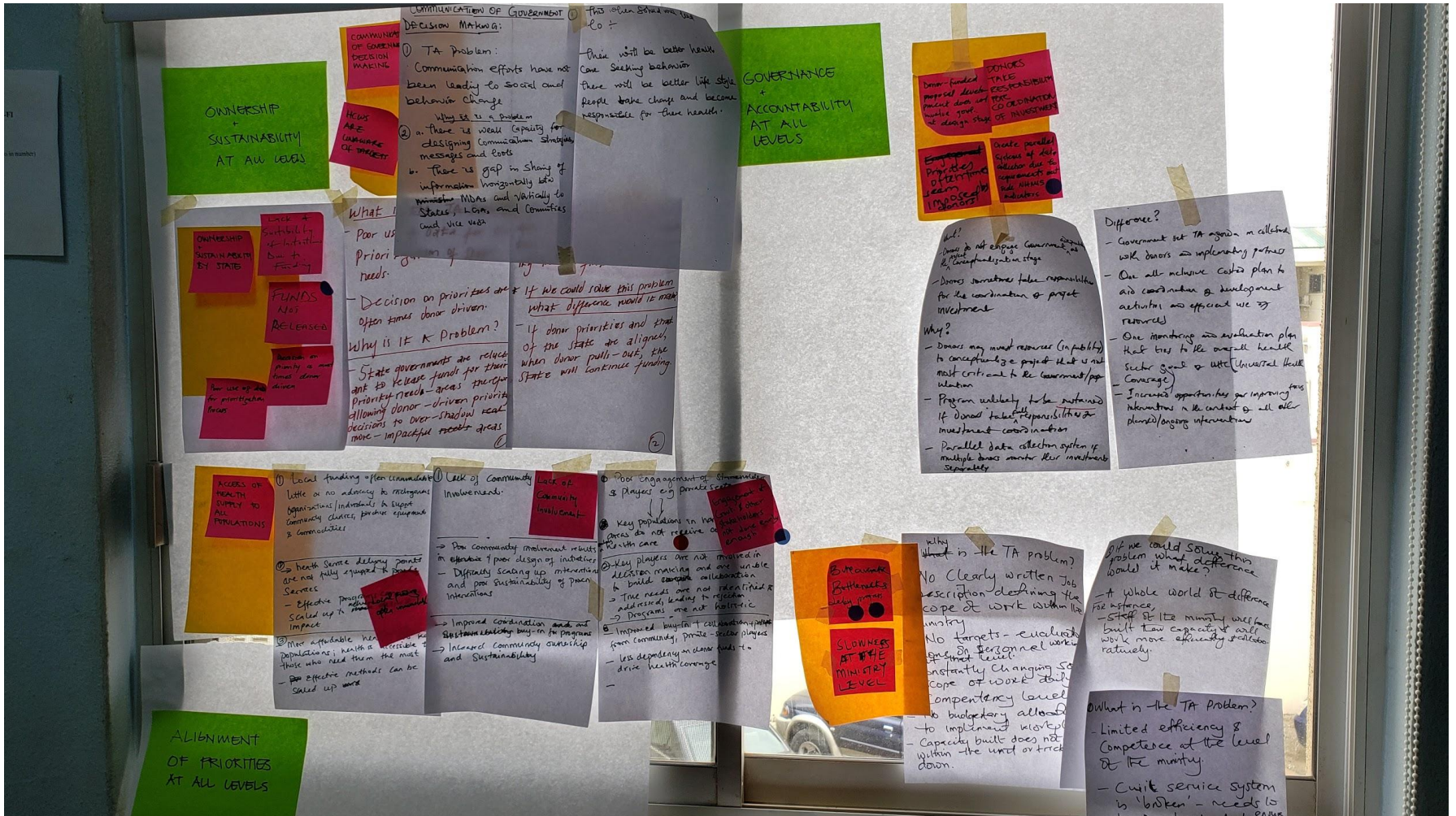
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**WEAK HUMAN RESOURCES FOR HEALTH**

# Defining the Challenges cont.



# Defining the Challenges *cont.*



# Prioritization of Opportunity Spaces



# Prioritization of Opportunity Spaces

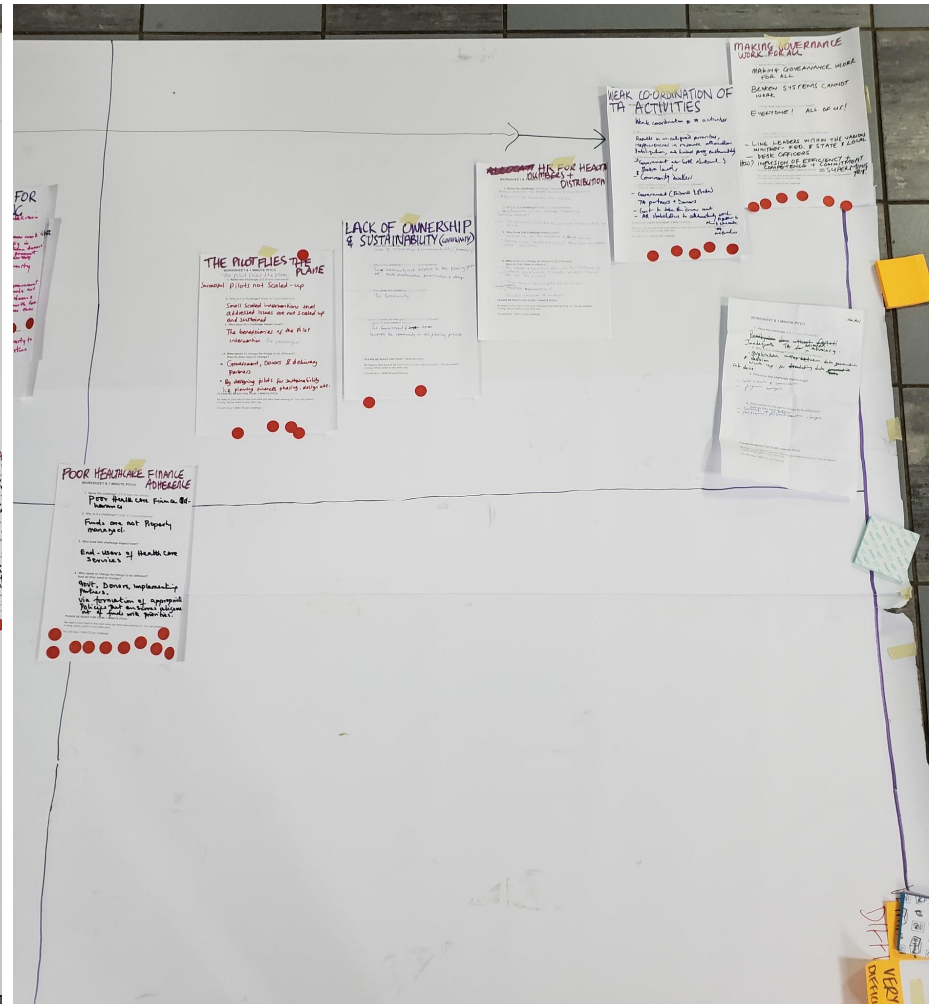
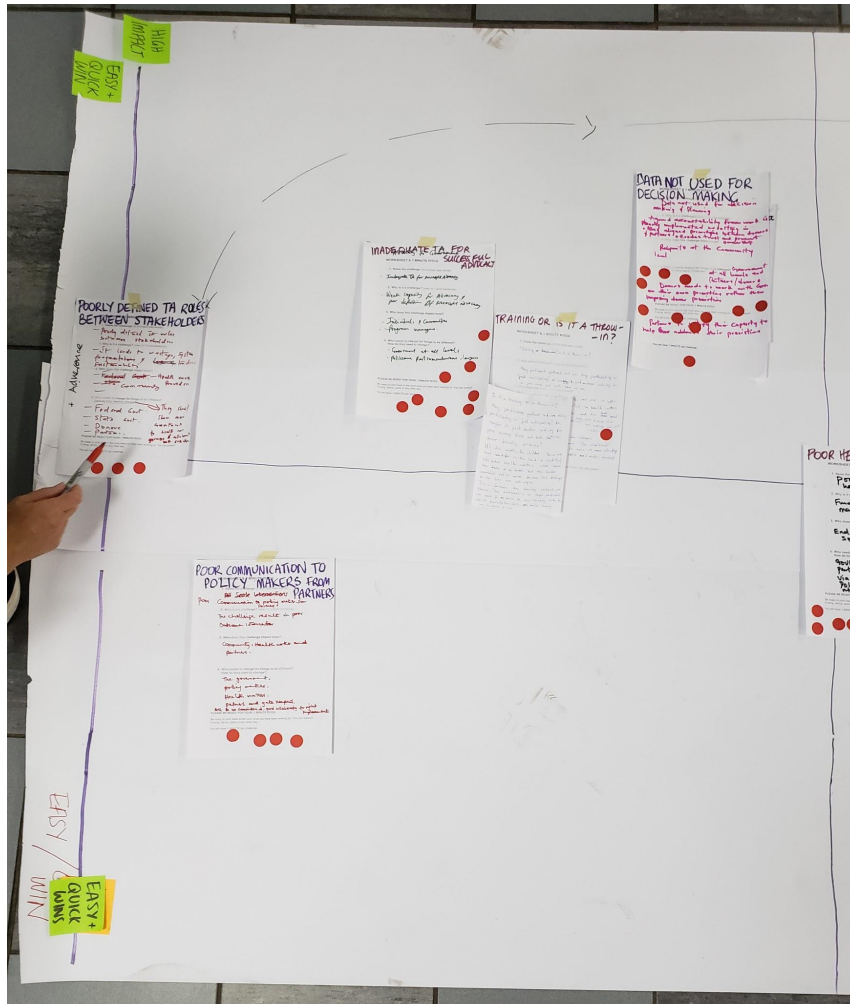


# Prioritization of Opportunity Spaces



# Prioritization of Opportunity Spaces

Impact vs. difficulty matrix





# Defining Key Challenges

# Key Challenge Areas

# Ownership, Accountability, and Sustainability At All Levels

## What is the TA problem?

- The roles and accountabilities of different stakeholders are not clearly defined.
- Communication between policy maker and partners is not effective.
- Donors and government priorities are not aligned.
- Donor-funded proposal development does not involve government at the design stage.
- Governments do not own programs because they do not commit funds.
- Partners rush to show results and prioritise deliverables over impact.
- Partners are accountable to donors and not to governments.
- States are not aligning with national priorities.
- Responsible teams are not held accountable.
- Communities are not involved in the planning process, in needs identification, prioritization, or design.

## Why is this a problem?

*“We have all these multiple meetings, plans are developed, there are all these knowledge banks but no implementation because there is a disconnect between the plans and the resources.”*

- There is weak capacity for designing communication strategies, messages and tools.
- There is a gap in sharing of information horizontally between MDAs and vertically to states. LGAs and communities and vice versa.
- Program unlikely to be sustained if donors take full responsibility for investment coordination.
- Decisions on priorities are often times donor-driven.
- State governments are reluctant to release funds for their priority-need areas, allowing donor-driven priority decisions to overshadow more impactful areas.

# Ownership, Accountability, and Sustainability At All Levels *cont.*

Why is this a problem? *cont.*

*“As an implementing partner, we discover we have designed programs that do not respond to needs and because the donor does not have flexibility we are forced to implement the activity without change.”*

- There is a wrong assumption that those at the community level lack technical capacity to be involved in planning. Therefore, community human & natural resources are under-utilized.
- Programs are not sustained after donors pull out because state governments never saw it as a priority in the first instance.
- If we solve the problem, what difference would it make?
- Improved coordination and buy-in for programs.
- Continuity of funding from Donor to state.
- Community human and natural resources are adequately harnessed to encourage ownership, accountability and sustainability.

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# Making Governance Work For All

## What is the TA problem?

- Inadequate capacity of government to coordinate TA activities, especially at sub-national level.
- Bureaucratic bottlenecks, delays, and slowness at the ministry level.
- Limited efficiency and competence at the level of the ministry.
- Allocated resources do not get released on time.
- Civil service system is broken – needs to be overhauled to ensure efficient and effective performance.

## Why is this a problem?

- Fully functional government personnel required to lead and coordinate TA activities, if government is to play coordination role.
- Non-availability of government personnel will leave partners taking leadership roles.
- No clearly written job description defining the scope of work within the ministry.
- No targets – evaluations done on personnel working at that level.
- Constantly changing SOW scope of work daily.
- No budgetary allocation to implement work plan.
- Capacity built does not stay within the unit or trickle down.

# Making Governance Work For All *cont.*

If we solve the problem, what difference would it make?

- Staff of the ministry will have built their capacity and will to work more efficiently and collaboratively.
- Effectiveness in health care service delivery championed by the government.
- Better coordination and efficient use of resources to address pertinent needs.

# Better Use of Data to Inform Decisions At All Levels

What is the TA problem?

- Data not used for planning (prioritization of needs, alignment of programs, implementation and monitoring, evaluation).
- There are Parallel data collection systems when multiple donors monitor their investments separately.
- Decisions on priorities are often times donor-driven
- Decision making is politically influenced
- There is inadequate TA for successful advocacy

*In Nigeria we don't use our data to plan, often the data is collected is not of good quality and when it get to the federal level it doesn't make sense*

Why is this a problem?

- Communities and HWs are empowered through better understanding of TA which they can then contribute to support various initiatives.
- The accountability framework is poorly implemented at all levels, it results in misaligned priorities between donors and government and erodes trust and ownership at all levels (government, partners, communities)

If we solve the problem, what difference would it make?

Appropriate use of data for planning and management:

- Builds trust and ownership at all levels (Government, partners and communities)
- Drives resource allocation by government and donors
- Ensures sustainability of programs

# Successful Advocacy

What is the TA problem?

- Advocacy has not been leading to sufficient fund allocation.

Why is this a problem?

- Because there is a gap between data generation and data use for decision making.
- Advocacy not sufficiently reaching the relevant target groups:
  - Legislature (fed and state) and also the relevant health committee (committee on budget etc.)
  - Judiciary (NBA)
  - Executives (Line ministries)
  - Media
- There is weak capacity for advocacy itself.
- Because the investment to measure outcome of advocacy is lacking.

If we solve the problem, what difference would it make?

- Improved political will leading to improved funding (from approval to allocation, budgetary provision, timely release, proper utilization).
- Better counterpart funding.
- Sustained funding despite change in government.



# From Pilot to Scale And Impact

What is the TA problem?

*There is difficulty scaling up interventions and poor sustainability of proven interventions.*

- State, LGA and communities are not involved in the pilot design and planning phase.
- Federal and state government unaware of pilot interventions being implemented by some partners.
- National and delivery partners not aligned on priorities for the pilot, sometimes even at design.
- Lack of stakeholder involvement leads to lack of ownership and lack of sustainability.

Why is this a problem?

- Pilot is not a priority area for the government.
- Ownership is a problem.
- Pilots are short-term.
- Poor design of pilots from inception (no context).
- Budgetary constraints not forecasting for scale-ups.
- No room/plan for iterative & adaptive changes.
- All stakeholders not involved in project design.
- Government not involved in planning and design.
- Government not involved in monitoring & evaluation.
- No appropriate debriefing to government on the outcome of the pilots.
- Policy restrictions not allowing scale-up.
- Donor interests and focus.

# From Pilot to Scale

## And Impact *cont.*

If we solve the problem, what difference would it make?

- Pilots will be designed with scale in mind.
- A shift in mindset from project ownership to problem ownership.
- Improved alignment at all levels will mean we are working towards solving the same problems from FMOH, state agencies, LGA & HF and community levels.
- The TA will be able to provide avenues for effective stakeholder engagements and platforms from the multiple layers to work together in the alignment process and achieve set goals. Fostering collaboration, inclusion etc and in the end will lead to improved ownership and accountability. Since everyone was involved.

# Strengthening The Human System (Numbers & Distribution)

What is the TA problem?

- Numbers and distribution of human resources
- State ministry of Health and agencies do not have dedicated Human Resources for Health (HRH) units and for planning and management teams.
- HRH tools are not readily available and in some cases unknown to individuals in HRH management.
- Lack of necessary HRH policies and guidelines.

Why is this a problem?

- There is no realistic HRH database that specify the uptake and distribution of existing health workers.
- Available skill set and expertise are maldistributed.
- Entry and exit into the workforce is not properly accounted for, hence no strong data driven evidence for effective HRH planning as well as advocacy to political leaders for increased recruitment.

If we solve the problem, what difference would it make?

- Reliable database and evidence for HRH planning and management.
- Problem of maldistribution will be minimized, if not eliminated.
- Enhanced quality and equity in service provision because of better health worker motivation.

# Training Needs, Prioritization & Approach

What is the TA problem?

- Poor needs identification and prioritization.
- Training, teaching methods, keeping record of who has been trained.

Why is this a problem?

- Trainings are misplaced and target groups are not properly mapped out, leading to gaps in knowledge and skills.
- Efforts are duplicated and not tailored to suit health needs.
- Results in inefficient use of limited resources.

If we solve the problem, what difference would it make?

- Improved design of training programs which are properly tailored to fill knowledge gaps.
- A wider spread of HCWs with capacity for specialized service delivery.
- Optimal targeting of resources to where they are most needed.

# Presentations

# Team Presentations

A one minute pitch of the technical assistance challenge. Participants vote for the challenge they believe is the highest priority. Criteria identified for prioritization include: Impact, root cause that will affect/enable many other things, what is possible to change



## Making Governance Work for All

### Why is this a challenge?

A broken system cannot work

### Who does this challenge impact?

Everyone! All of us!

### Who needs to change for things to be different?

Line leaders within the various ministries; fed, state and local Desk officers

### How do they need to change?

Infusion of efficiency competence and commitment.



## Training or is it a throw in?

### Why is this a challenge?

Many participants gathered but are they participating or just anticipating. Or maybe it's just another activity to pass the time

### Who does this challenge impact?

The mothers the children you and me we suffer in the hands of unskilled and half skilled health workers

### How do we need to change?

The teaching methods are flawed, the traditional is no longer medical. We need to move to now thinking like adult facilitation skills and better training.



## Poor healthcare finance adherence

### Why is this a challenge?

Funds are not properly managed

### Who does this challenge impact?

End users of health care services

### Who needs to change for things to be different?

Government, Donors, implementing partners

### How do they need to change?

Formation of policy that ensures alignment of funds with policy.

# Team Presentations *cont.*



## HR for Health (Numbers & Distribution)

### Why is this a challenge?

Affects service delivery and programs and projects are not implemented on time

### Who does this challenge impact?

Health care practitioner and recipients of health care services

### Who needs to change for things to be different?

The state government who are the employer of labour distribution of health workers and should not be politicised

### How do they need to change?

The government -- timely release of budget



## Inadequate TA for successful advocacy

### Why is this a challenge?

Weak capacity for advocacy and poor definition of successful advocacy

### Who does this challenge impact?

Individuals and communities  
Program managers

### Who needs to change for things to be different?

Governments at all levels  
Politicians, Parliamentarians, Lawyers



## Poor communication to policy makers from partners

### Why is this a challenge?

Results in poor outcome indicators

### Who does this challenge impact?

Community health workers and partners

### Who needs to change for things to be different?

The government, Policy makers, Health workers, Partners and gate-keepers.

### How do they need to change?

Commitment, goal consolidation for right implementation.

# Team Presentations *cont.*



## Weak coordination of activities

### Why is this a challenge?

Results in misaligned priorities, inefficiencies in resource allocation, and hinders program sustainability

### Who does this challenge impact?

Government and National and State level and community

### Who needs to change for things to be different?

Government Federal and state, TA partners and Donors

### How do they need to change?

Government to take the driver's seat  
All stakeholders work together



## Lack of ownership and sustainability

### Why is this a challenge?

The community is not involved in the planning process, needs identification, prioritization and design

### Who does this challenge impact?

The community

### Who needs to change for things to be different?

The government and Donors.

### How do they need to change?

Involve the community in the planning process.



## Poorly defined TA roles between stakeholders

### Why is this a challenge?

It leads to wastage, systems fragmentation, hinders sustainability

### Who does this challenge impact?

Health care providers and the community

### Who needs to change for things to be different?

Federal government, state government, Donors and partners

### How do they need to change?

Show more commitment to health care services and collaboration with each other.



# Team Presentations *cont.*



## The pilot flies the plane

### Why is this a challenge?

Small scale interventions are not scaled up and sustained

### Who does this challenge impact?

The beneficiaries of pilot interventions

### Who needs to change for things to be different?

Governments, Donors and delivery partners

### How do they need to change?

By designing pilots for sustainability. Planning finance, phasing, design.



## Data is not used for decision-making

### Why is this a challenge?

Accountability frameworks result in misaligned priorities between donors and governments. Erodes trust and ownership

### Who does this challenge impact?

Recipients and the community level

### Who needs to change for things to be different?

Governments at all levels, partners and Donors

### How do they need to change?

Donors need to work with governments on their priorities rather than imposing their own priorities.

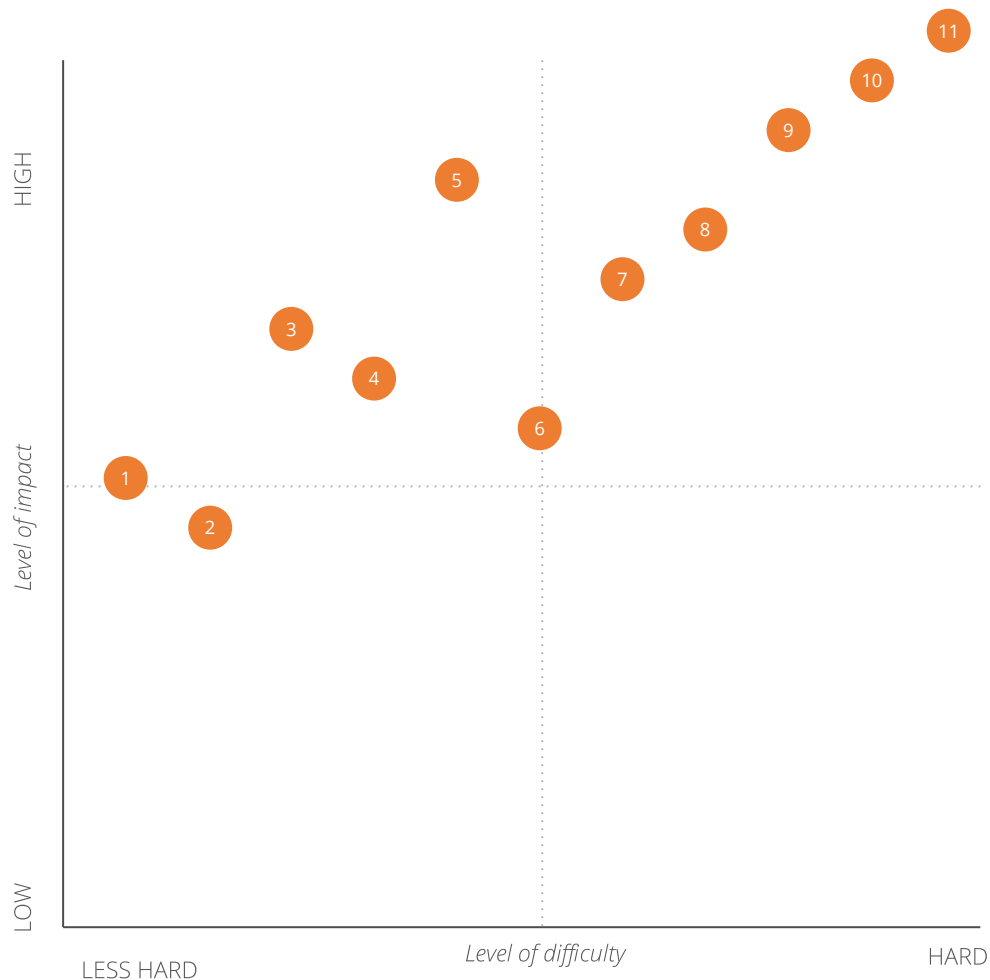
# 3 Opportunity Spaces

**These opportunity spaces were derived from the challenges surfaced during the workshop.** The challenge areas, which participants rated in terms of impact and difficulty, were combined into three main opportunity spaces.

**Principles/criteria:**

- Initial criteria for the focus of opportunity spaces to be taken forward to the next stage
- Ownership at all levels
- Piggy back with what is already happening- find the gaps
- Clearly TA not the health system
- Ensure that state and community level is involved
- Human experience lense

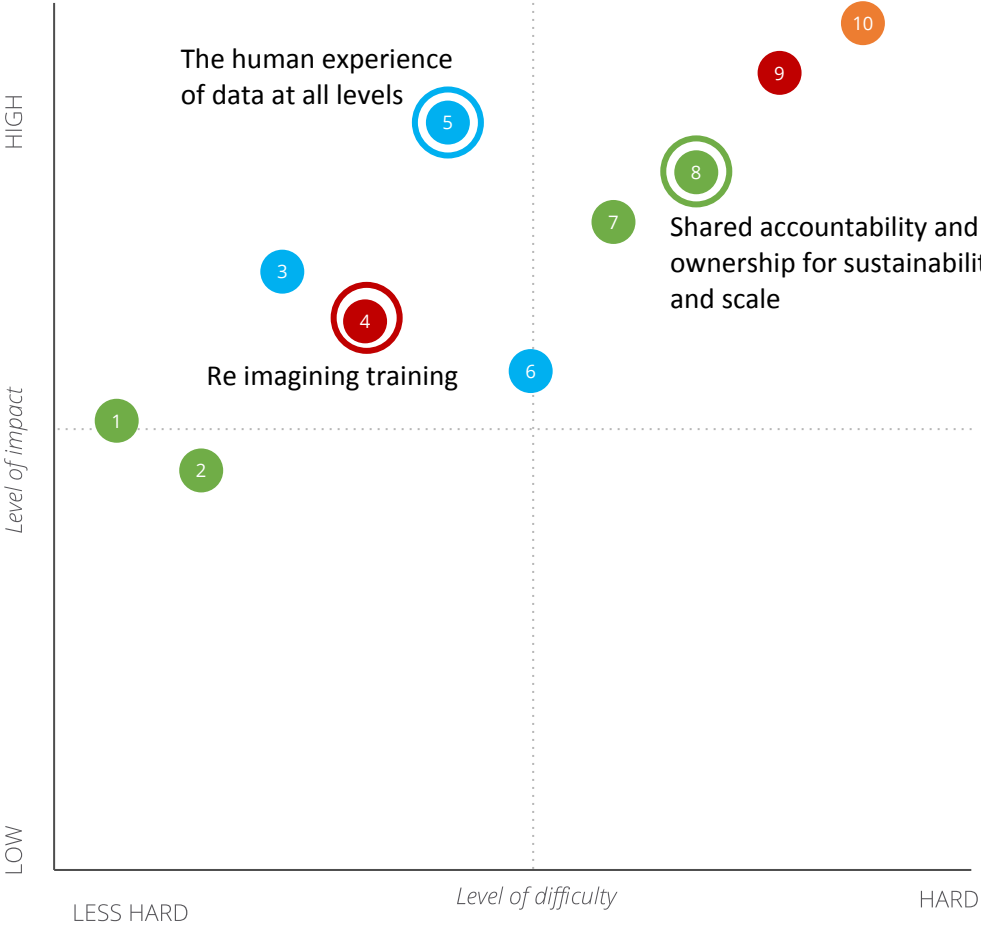
# Prioritized Challenges



## Prioritized Challenges

- 1 Poorly defined TA roles between stakeholders
- 2 Poor communication from policy makers to partners
- 3 Inadequate TA for successful advocacy
- 4 Training? or is it a throw in?
- 5 Data is not used for decision making
- 6 Poor health care financial adherence
- 7 The Pilot flies the plane
- 8 Lack of ownership and sustainability
- 9 HR for health numbers and distribution
- 10 Lack of coordination of activities
- 11 Making governance work for all

# Emerging opportunity areas



### Prioritized Challenges

- 1 Poorly defined TA roles between stakeholders
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# Emerging opportunity areas *cont.*

## Coordination as an overarching theme

Coordination is an overarching theme that cuts across all three of our opportunity spaces.

### Strengthening the human system

HR for health (numbers and distribution) ●●●  
Re-imagining training

### Ownership for sustainability

Ownership at all levels and transfer of ownership  
Poorly defined TA roles between stakeholders ●  
Poor communication from policy makers to partners ●●  
Poor Health care finance adherence ●●●●●  
The pilot flies the plane ●●●●●  
    Designing pilots with scale in mind  
    From project ownership to problem ownership

### Better use of data for decision making

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

# Next Steps

# Co-creation Teams

The next step will be the design phase of re-imagining technical assistance in Nigeria. Participants from the intent workshop will be invited to join the co-creation team who will divide into groups of 8-10 people to focus on the three opportunity areas.

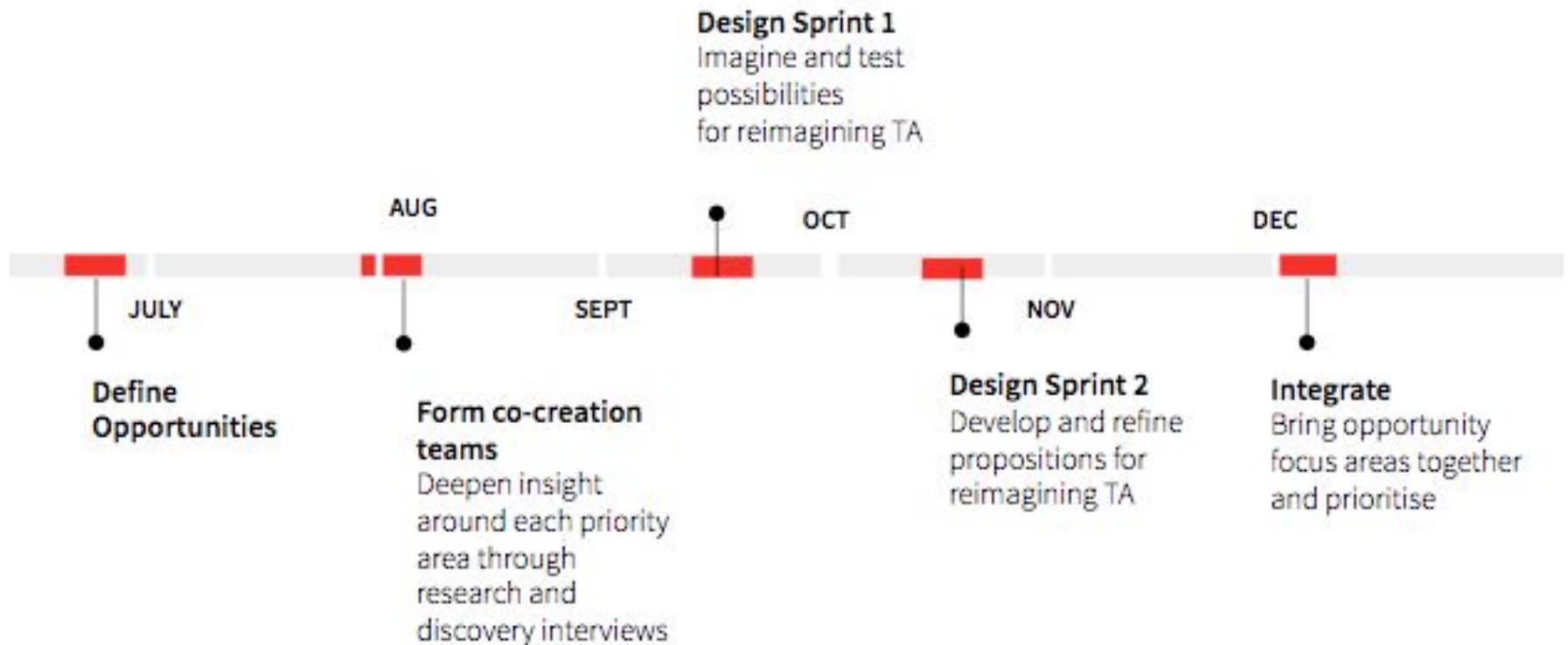
## **The role for the co-creation team includes**

1. Attend one team forming session where we build out the problem definitions and questions for design and identify a wider network of contributors who can provide design input through discovery interviews, participating in workshops and testing prototypes
2. Participate in two design sprints that will generate and test propositions for re-imagining technical assistance
3. Participate in one integration workshop that brings together the portfolio of propositions from the three working groups to understand: intersections, impact, desirability and viability of propositions

Participants in this design process will gain experience in a human centered design process including: problem definition, idea generation, prototyping, testing and prioritisation. At the end of the project you will receive a certificate that acknowledges your contribution and participation.



# Timeline for moving forward



# Process

