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 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.

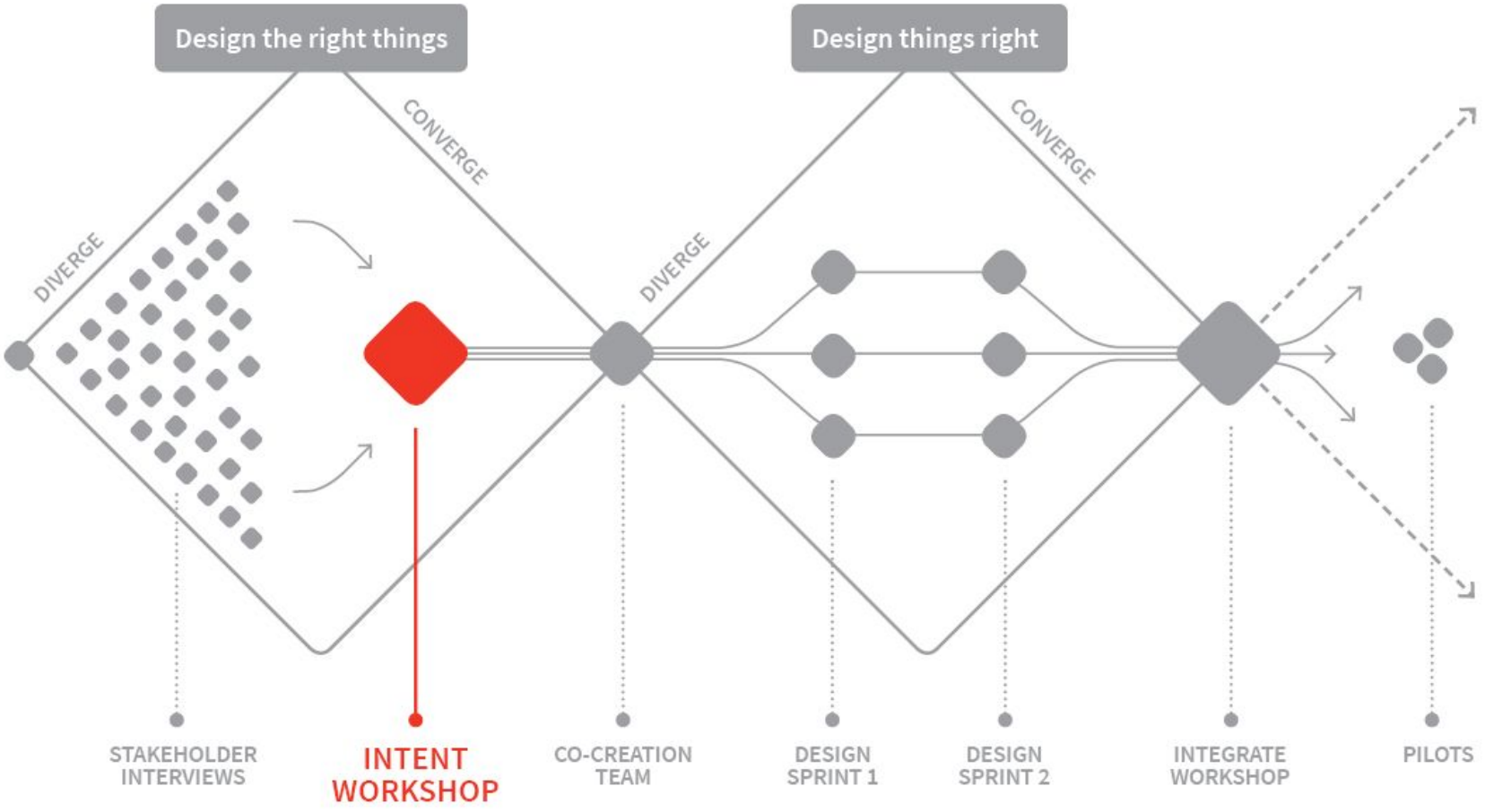
How we will work together

Thinking with a designerly mind

1. Embrace the pace The process works in fast iterative cycles Actively participate so the team can move together at pace
2. Trust the process Embrace uncertainty, creativity, intuition and critical thinking.
3. Be optimistic Look beyond today to the future of what Technical Assistance could be
4. Defer judgement Be receptive to alternative viewpoints and be willing to challenge your assumptions
5. Keep in mind the people we are striving to help Families, clients, health workers, facility managers, who are end recipients of technical assistance
6. Be willing to work 'tech-free' and avoid the distractions of phones and laptops during workshop sessions
7. Make to learn Design has a bias towards action. Understanding of diverse perspectives is built and tested through rapid prototyping
8. Contribute your own expertise and insights to support shared understanding

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?

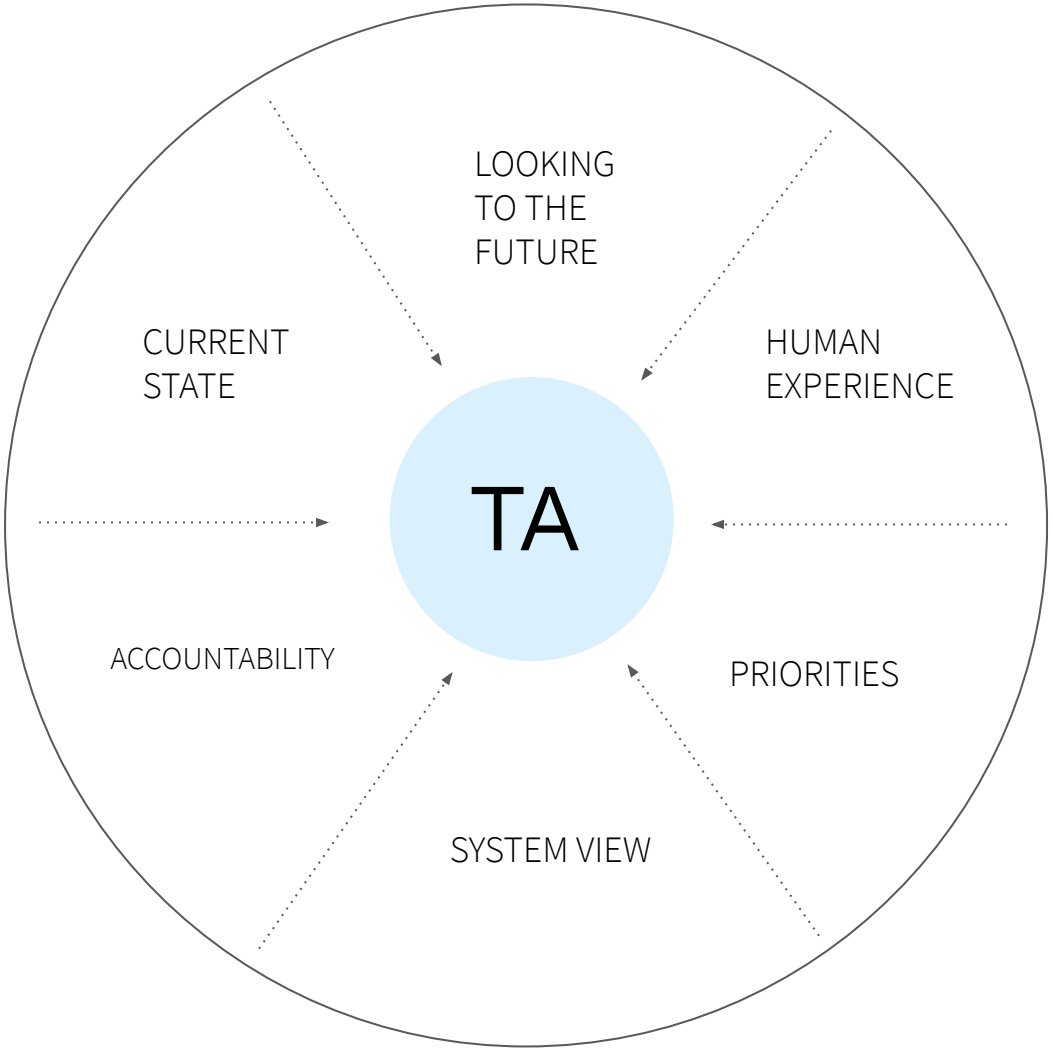
Participants:

- 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 Olugbeminiyi Adebiyi
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.*

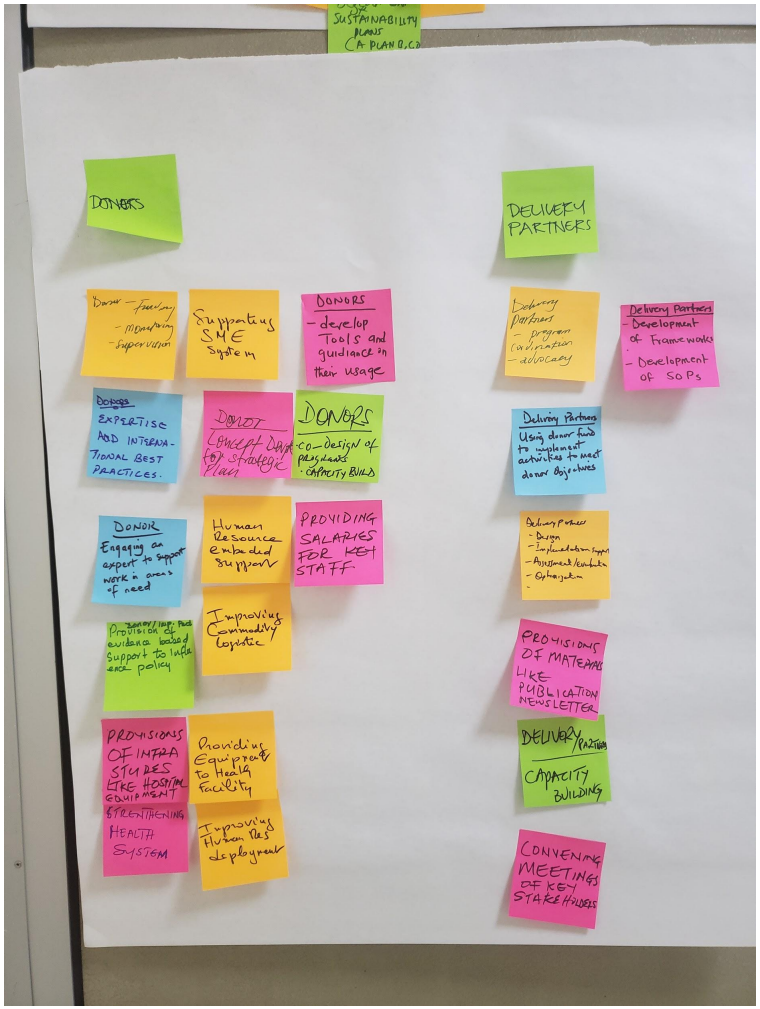
Federal Government

- 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.*



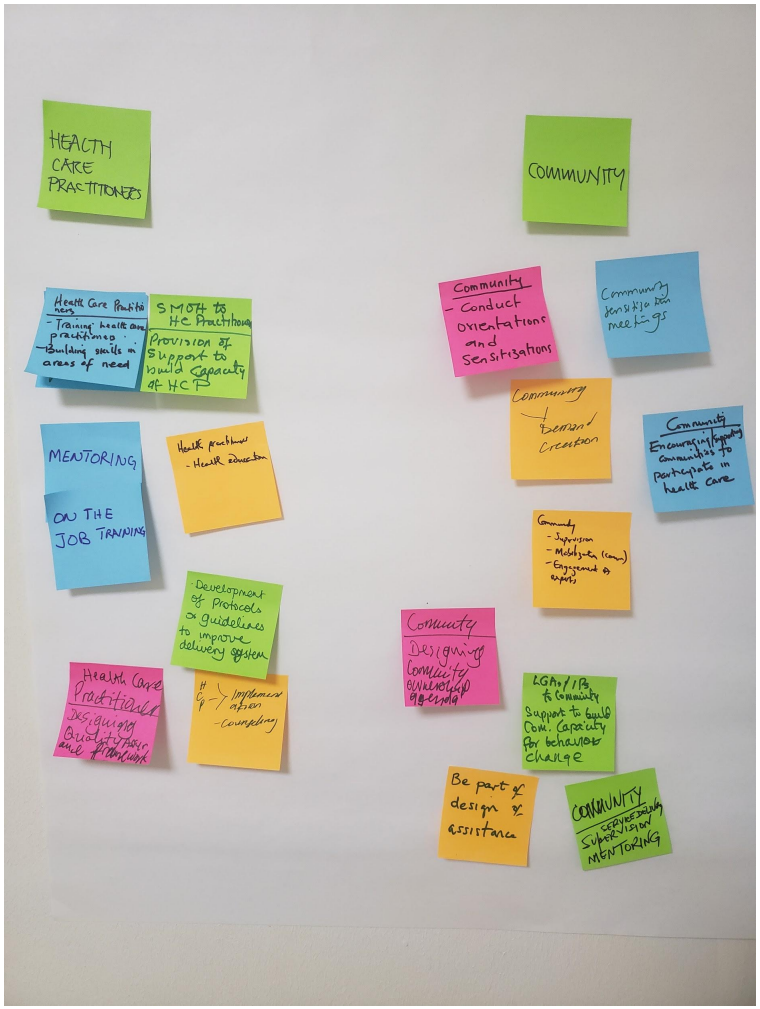
Donors

- 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

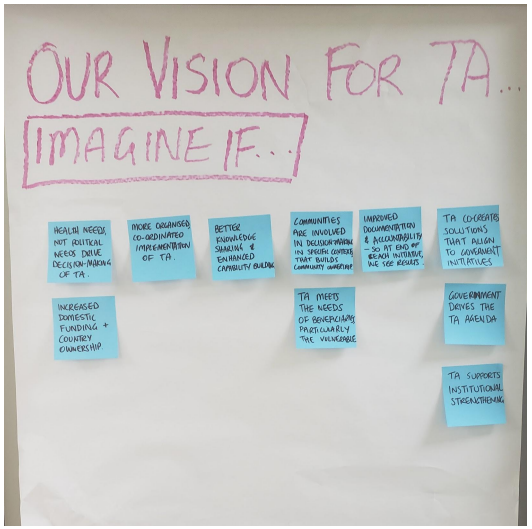
- Training health care practitioners
- Building skills in areas of need
- On the job training
- Mentoring
- Health education for practitioners
- Development of protocols and guidelines to improve delivery system

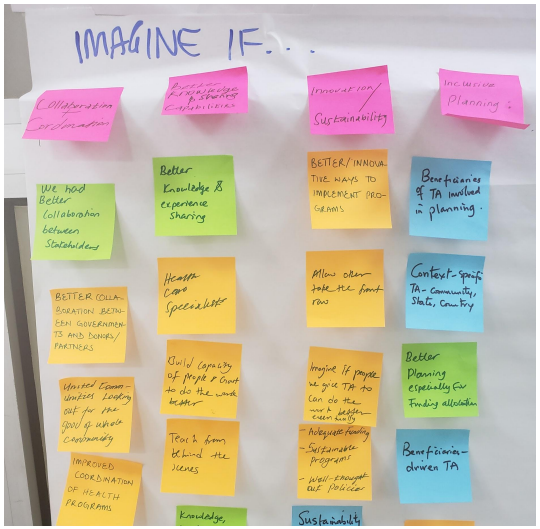
Community

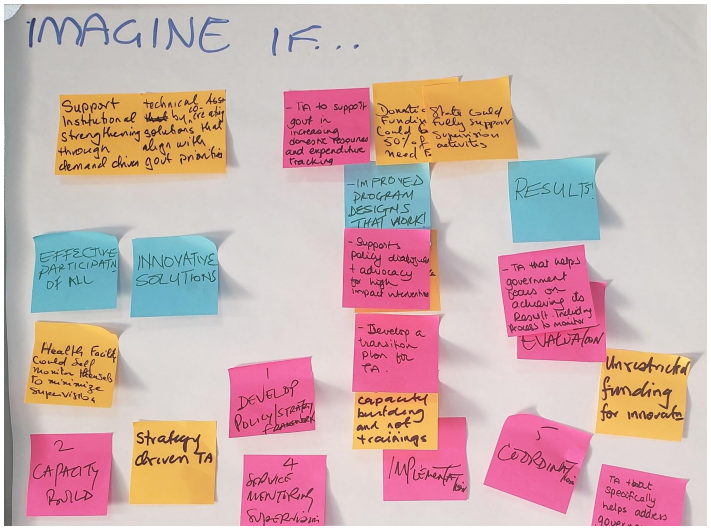
- Conduct orientations and sensitisation
- Community demand creation
- Encouraging communities to participate in health care
- Designing community ownership agendas
- Community service delivery supervision and monitoring
- Support to build community capacity for behaviour change

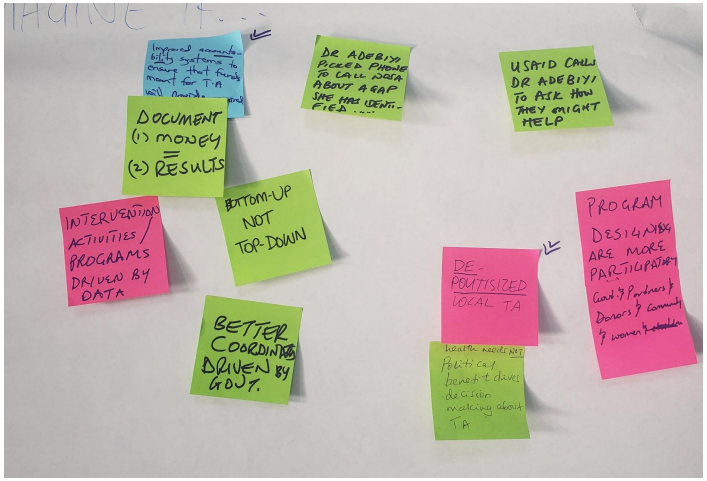
Looking to the Future

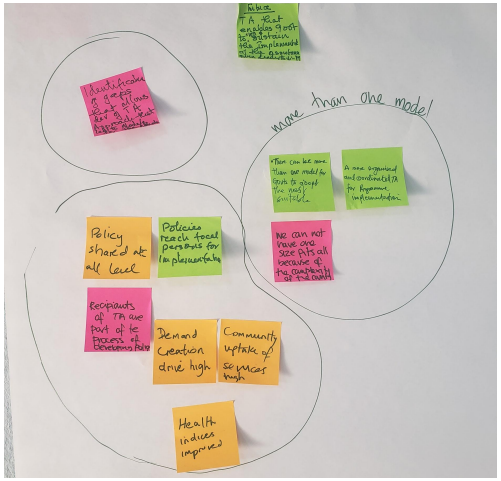
This project can go beyond trying to fix what is broken. If we had a blank slate to totally re-imagine TA, what could we imagine?

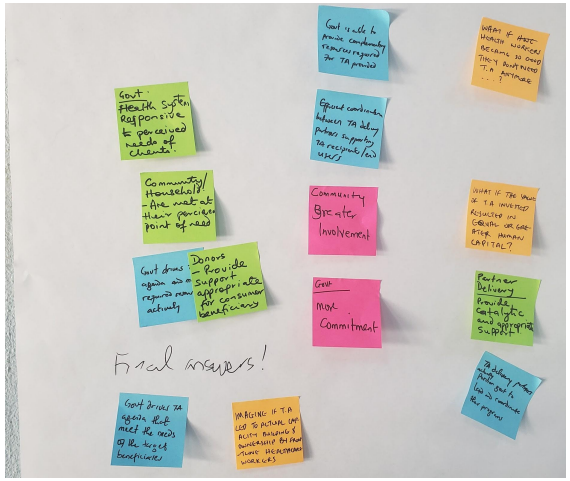












Looking to the Future *cont.*

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.

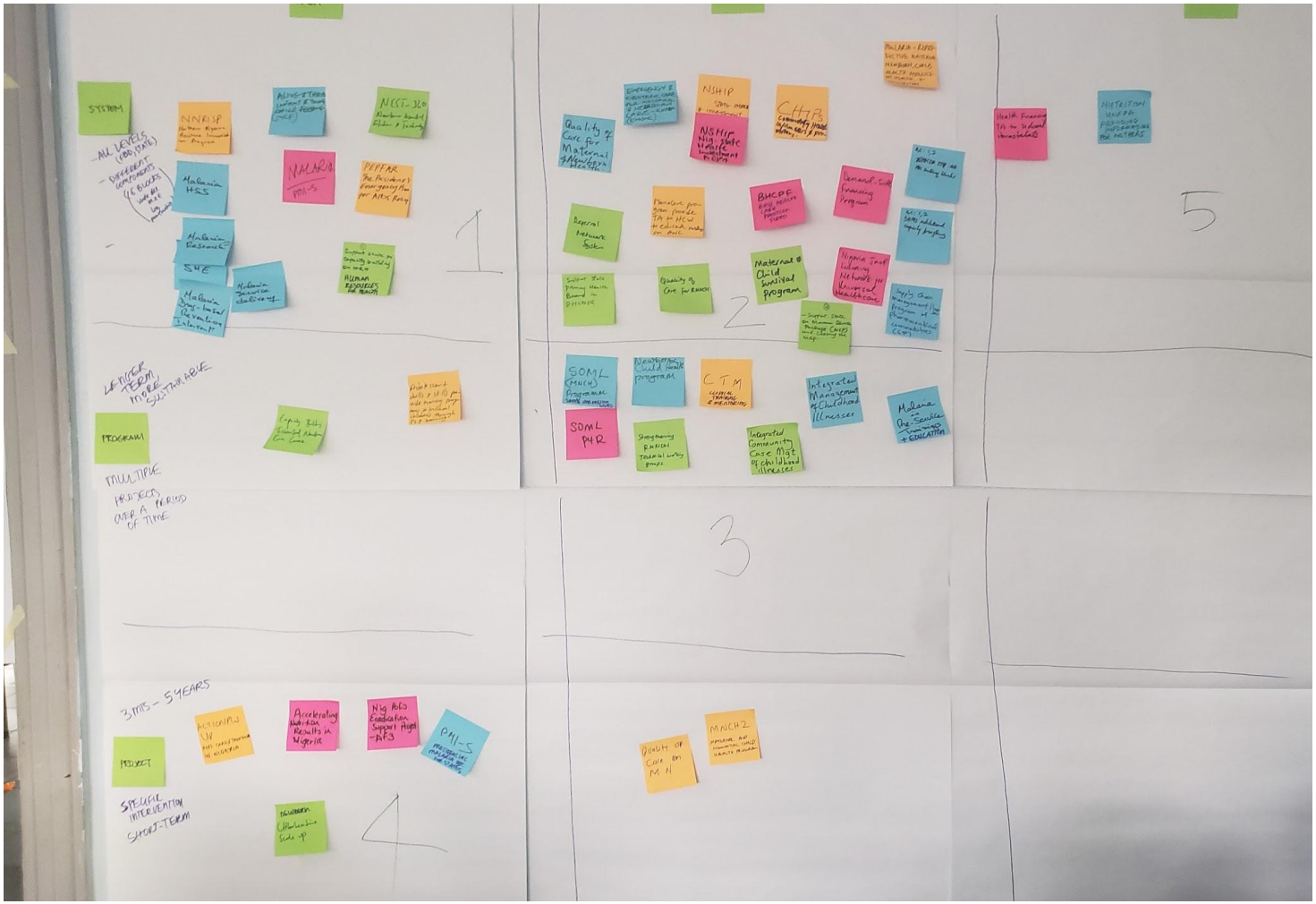
Approaches to TA

What is the current portfolio of TA activity of the participants in the room? Map them from short term to long term, proof of concept to large scale integrated programs.

Single health initiative | **Integrated health initiative** | **Cross sector**

Longer term interventions

\+ 2 years



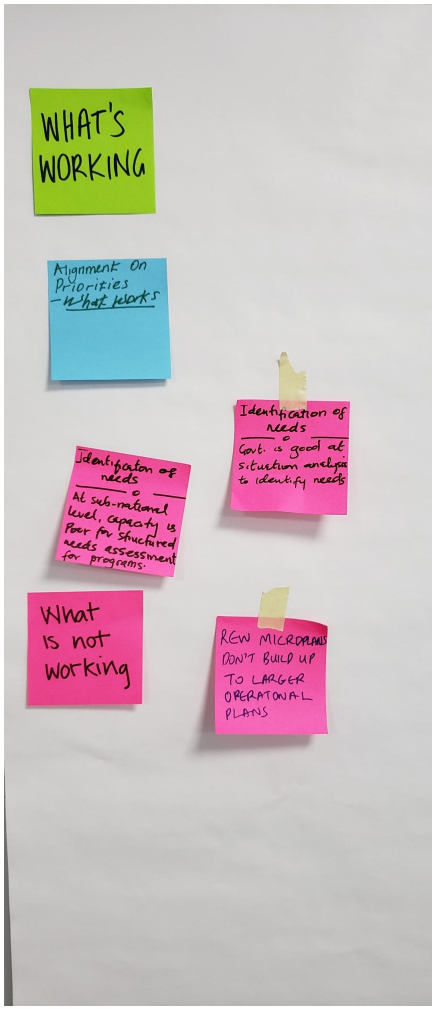
Short term interventions

Under 2 years
E.g. Pilots and proof of concept

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

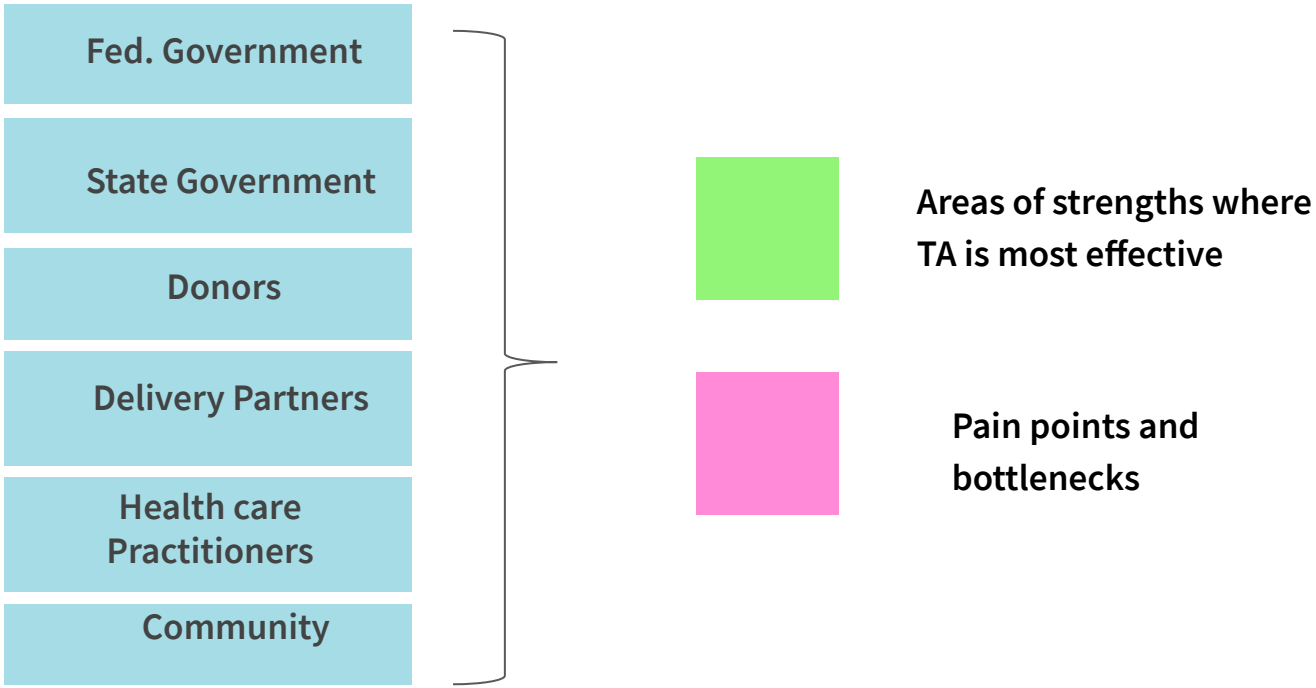
System / Single Health Area

Mapping Current State of TA

1. Map the key activities.

- How goals are set
- How funding is allocated
- How Activities Flow
- How Outputs are monitored and measured
- etc.

2. Map your experience



Experience Journeys

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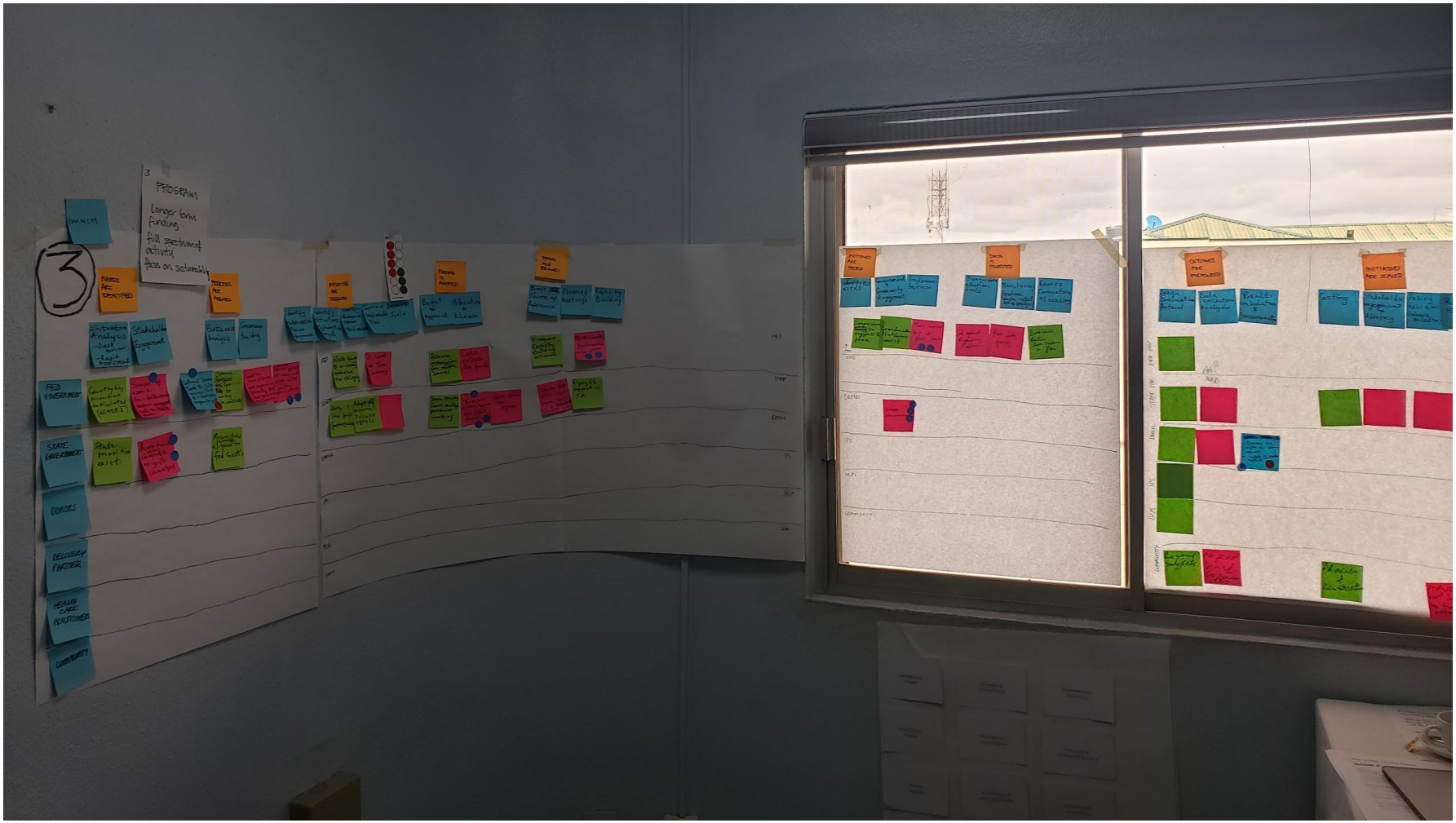

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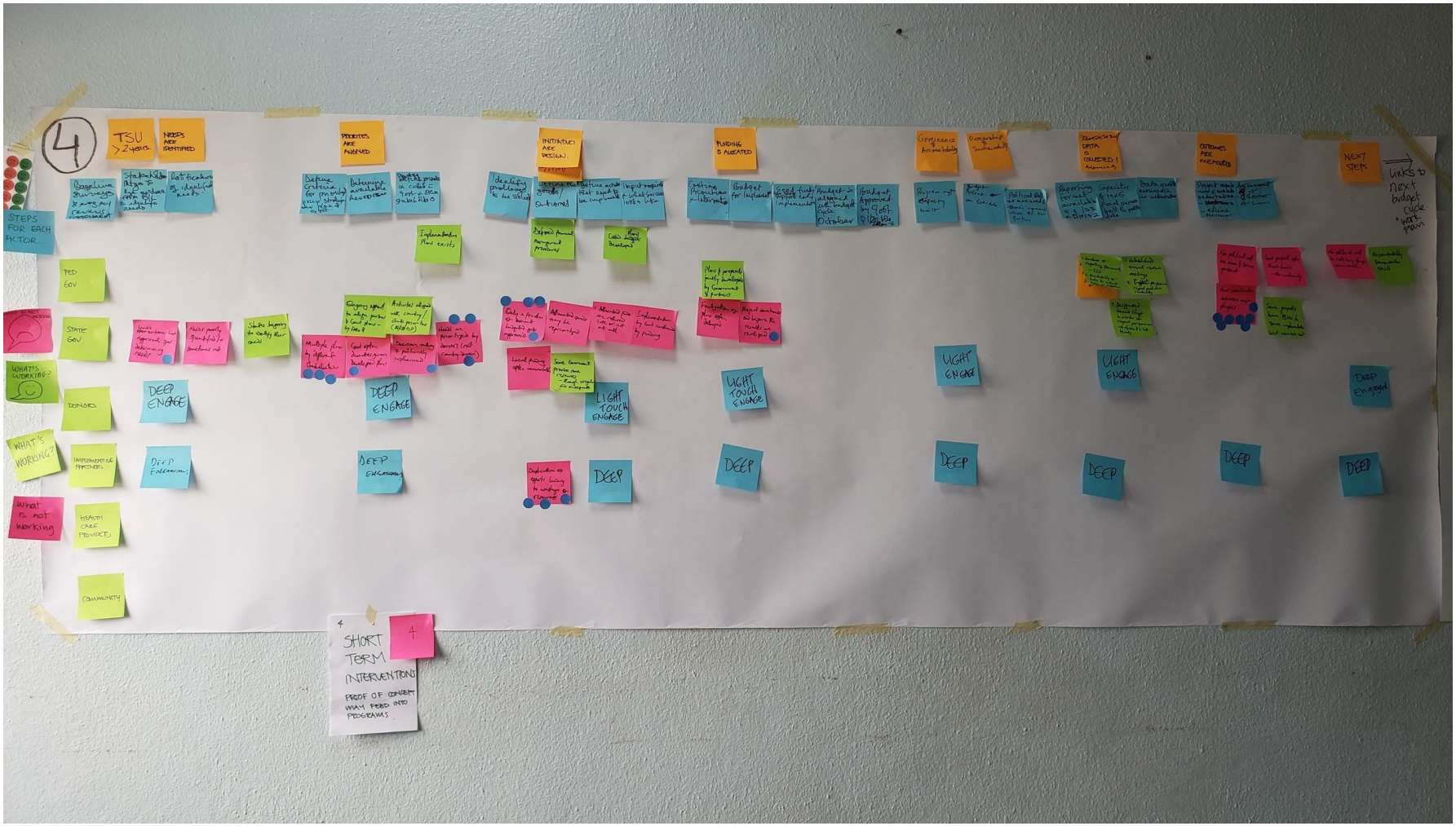

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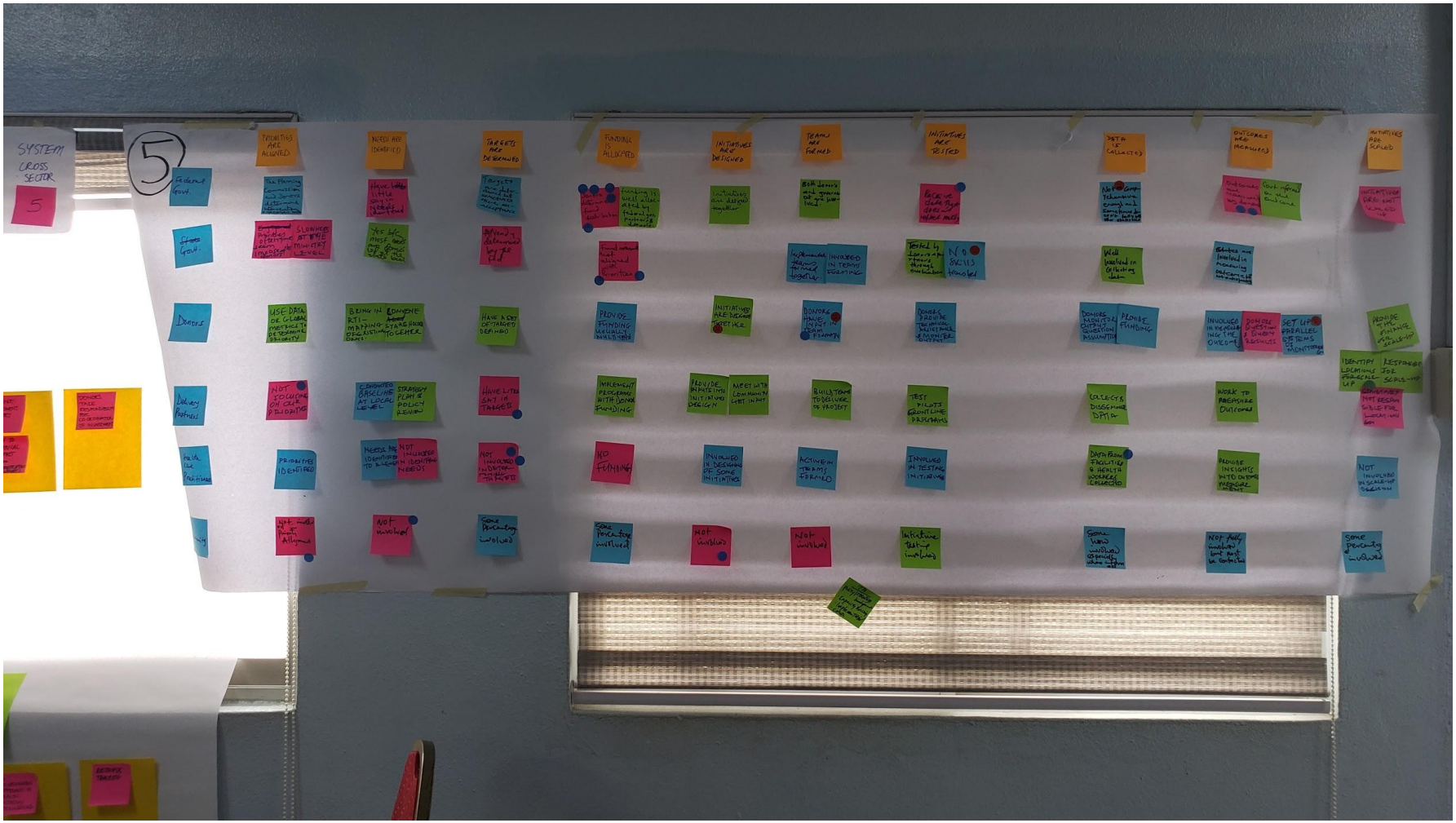
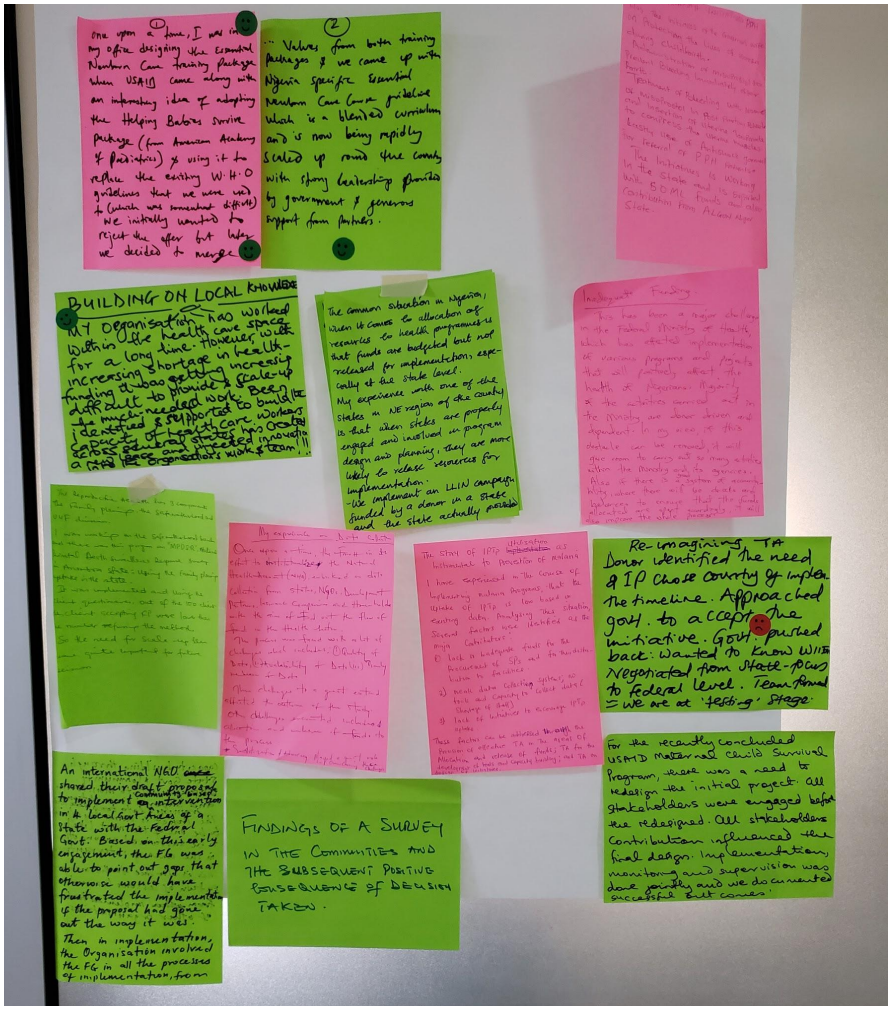
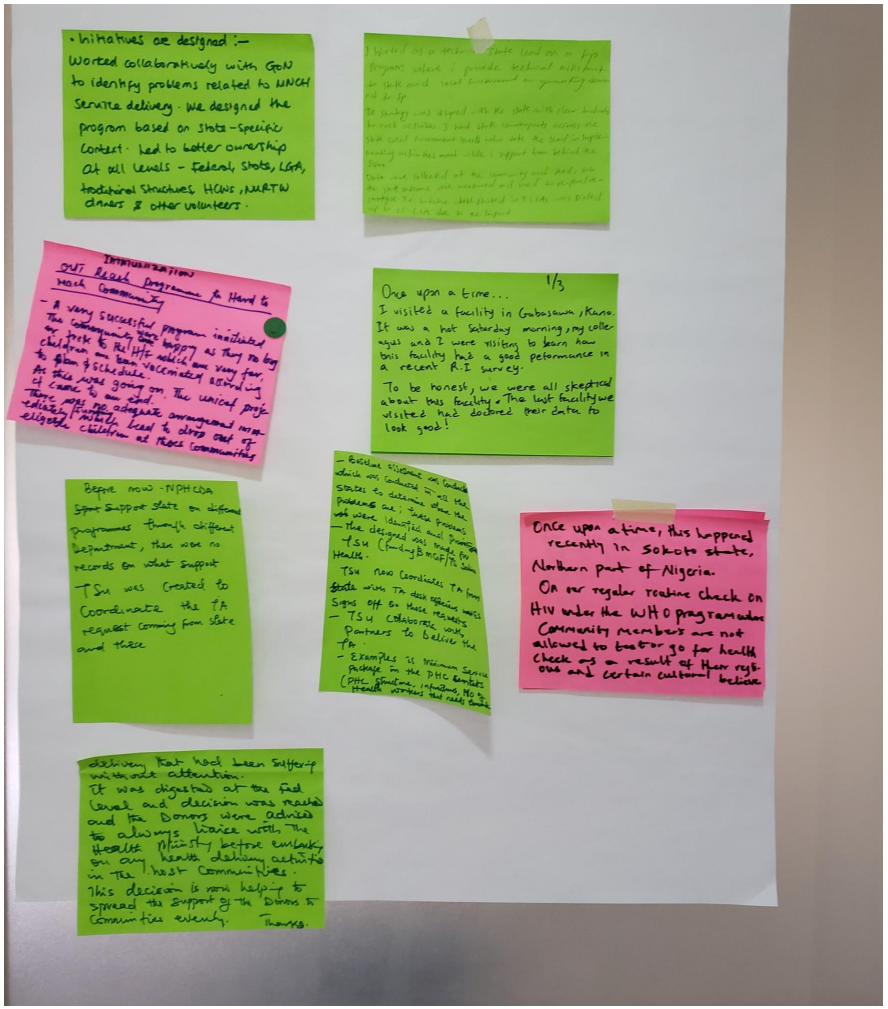


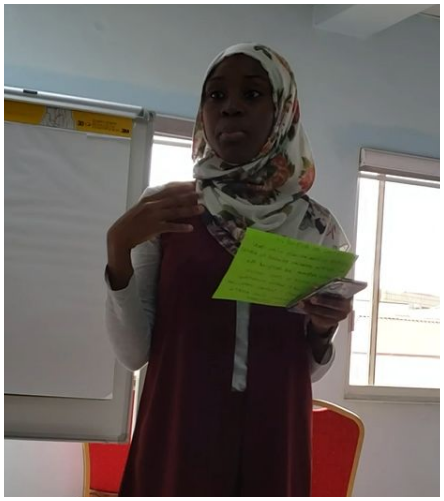
Project Stories

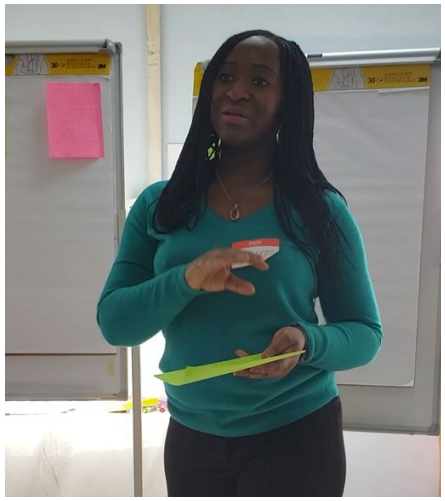
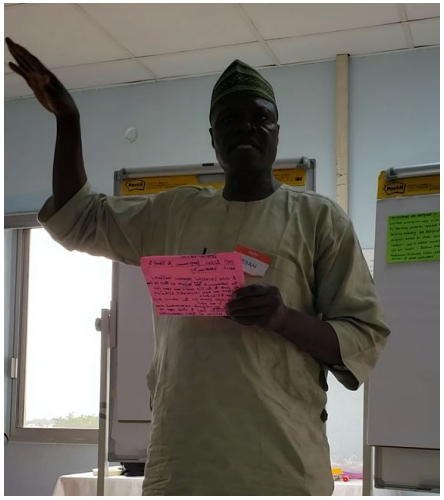
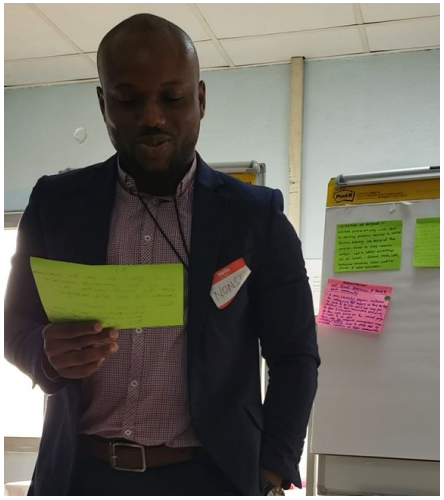
Present stories that give examples of best and worst moments of providing or receiving technical assistance.





Project Stories *cont.*



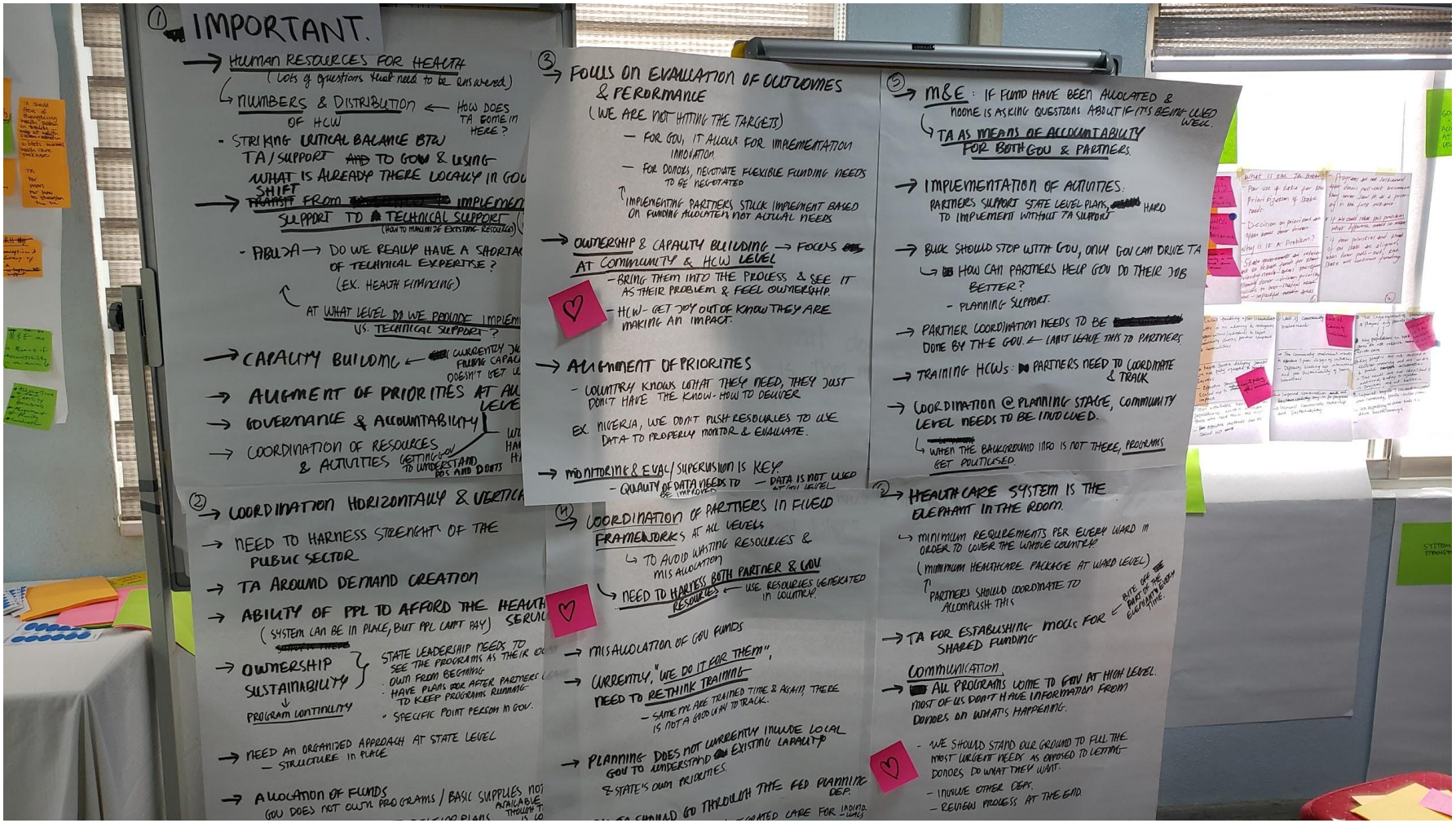





Day 2:
Identify priorities for change

Reflections

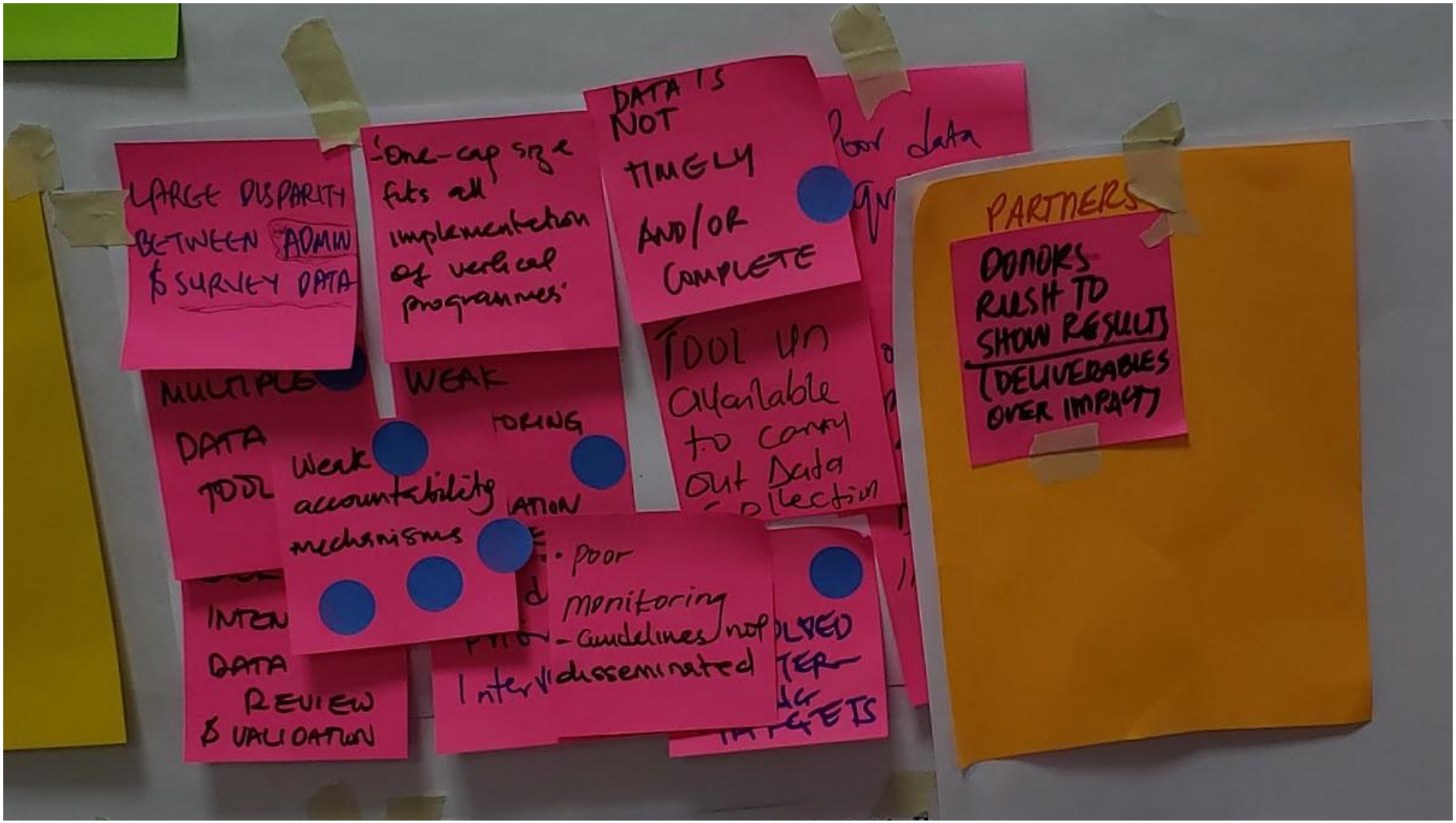
What do you think is the most important TA issue for us to focus on in Nigeria? What would you prioritize & why?

Reflections *cont.*



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 ••

A Coordinated Approach to Health Systems Strengthening

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- Lack of coordination and governance •
- Multiple plans by different stakeholders ••

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.*

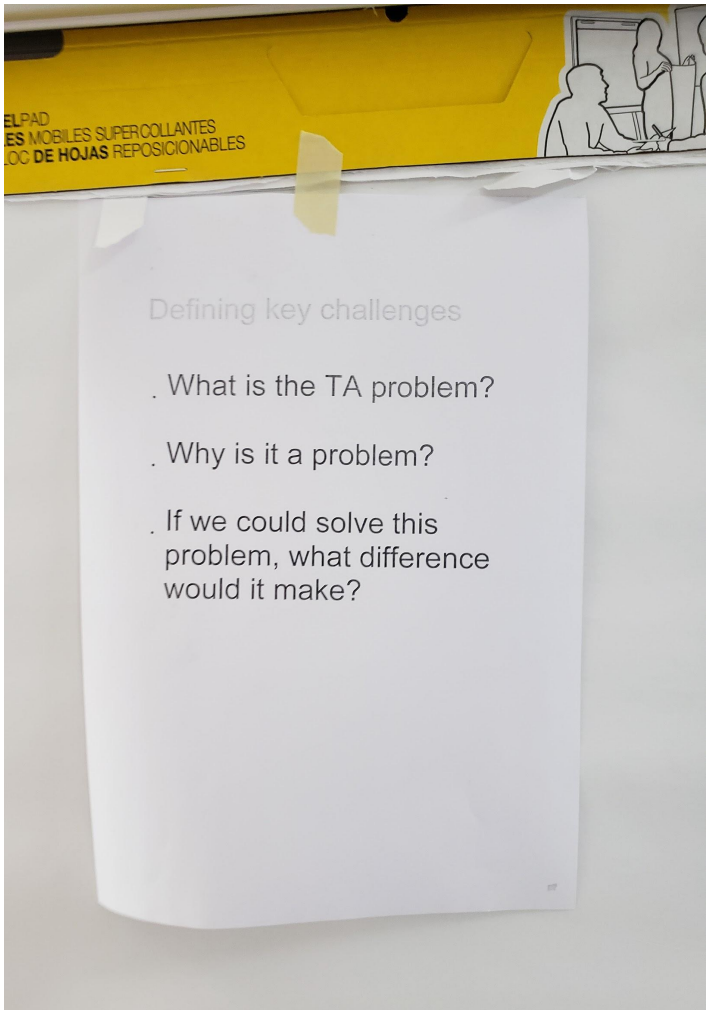
- Over-dependence on donors for programme planning and implantation •
- Late release of funds
- Scope of work pre-determined before engagement with the health sector
- Stakeholder engagement and advocacy
- No political will to own and drive project
- Have little say in needs identified
- Country priorities 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.*

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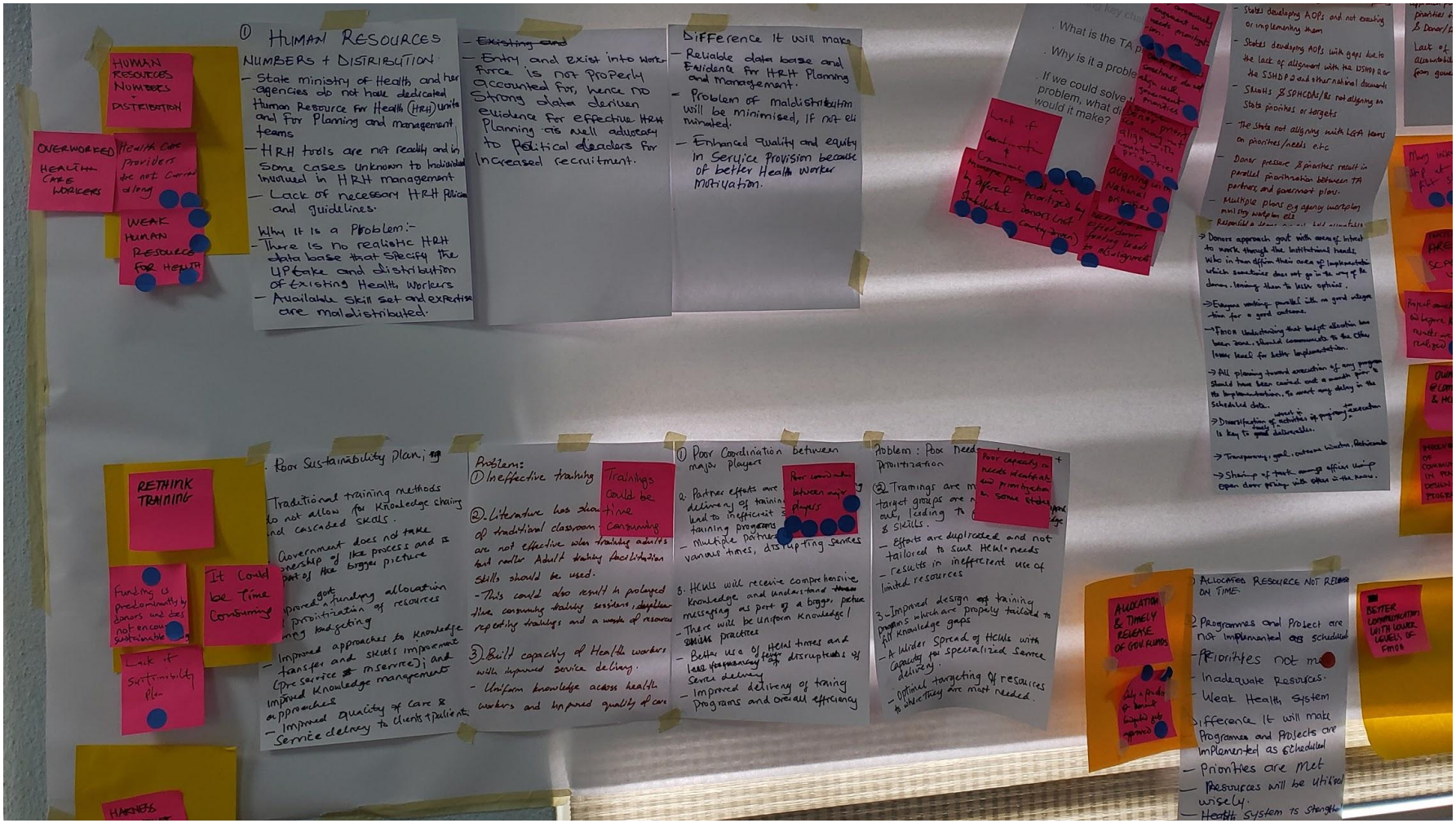
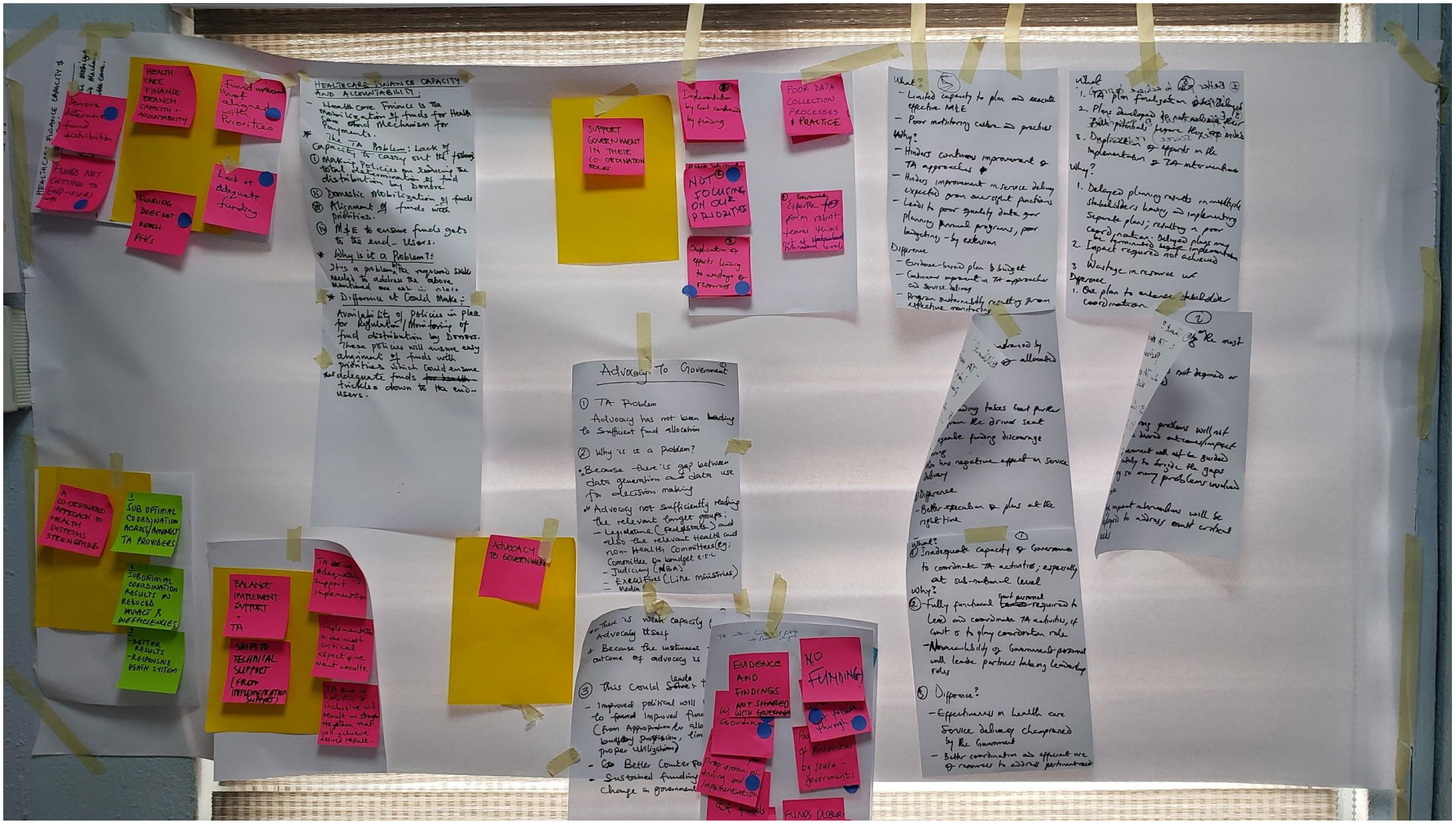
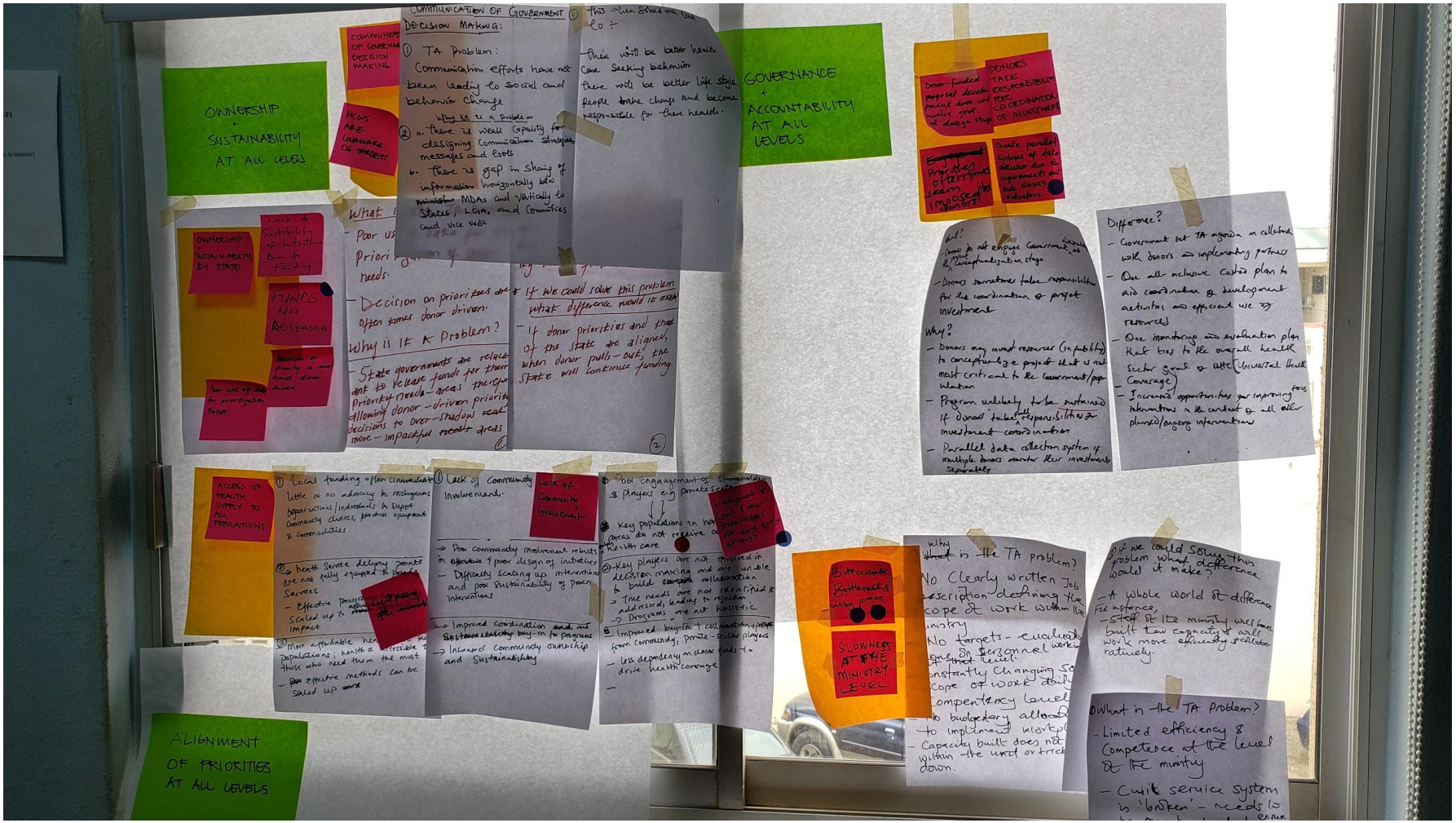


Defining the Challenges *cont.*



Defining the Challenges *cont.*



Prioritization of Opportunity Spaces

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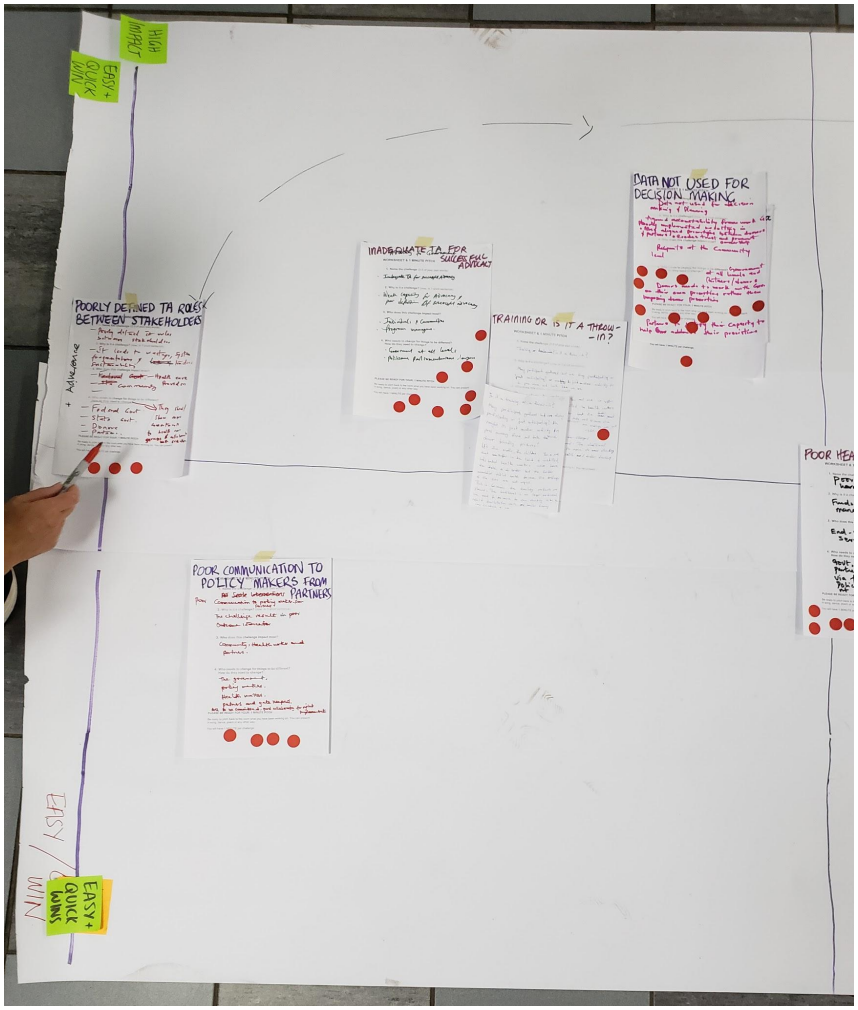
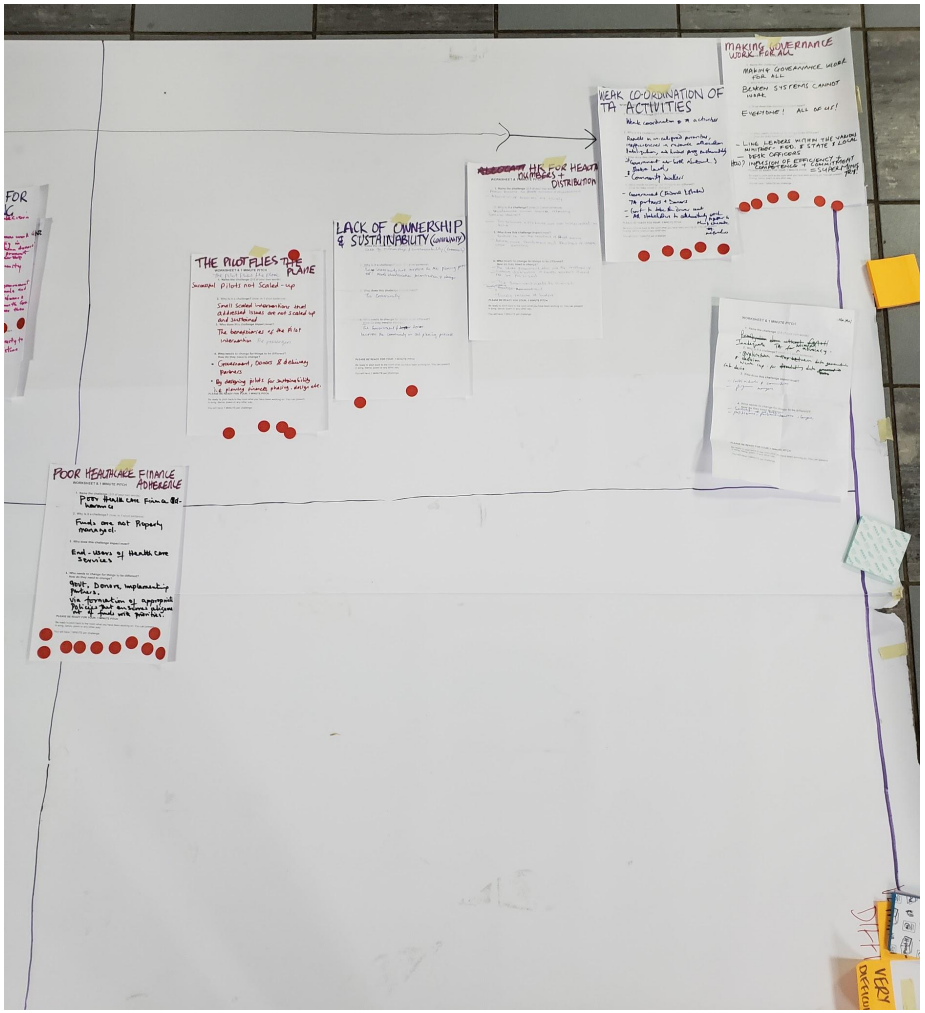
Prioritization of Opportunity Spaces

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?

- Piot 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-kepers.
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

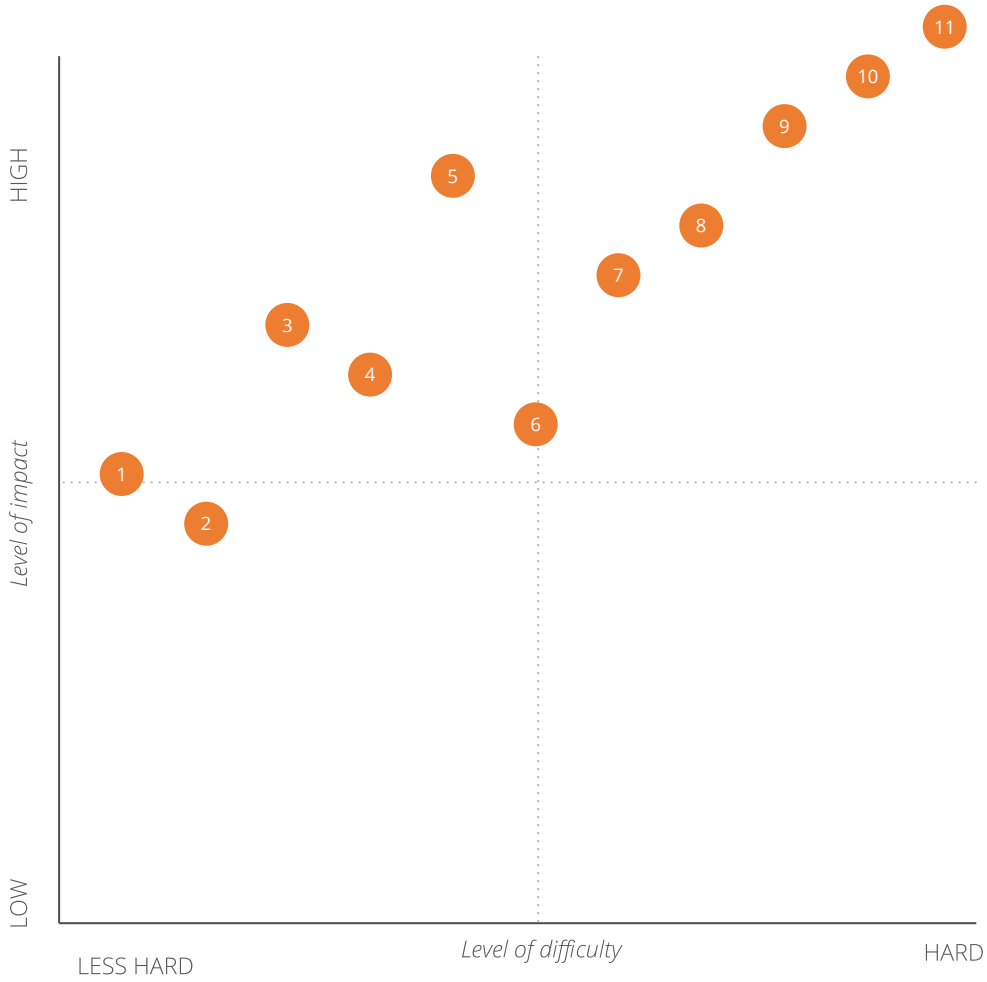
Why is this a challenge?
Accountability frameworks result in misaligned priorities between donors and governments. Erodes trust and ownership
Who does this challenge impact?
Recipients and the community level
Who needs to change for things to be different?
Governments at all levels, partners and Donors
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

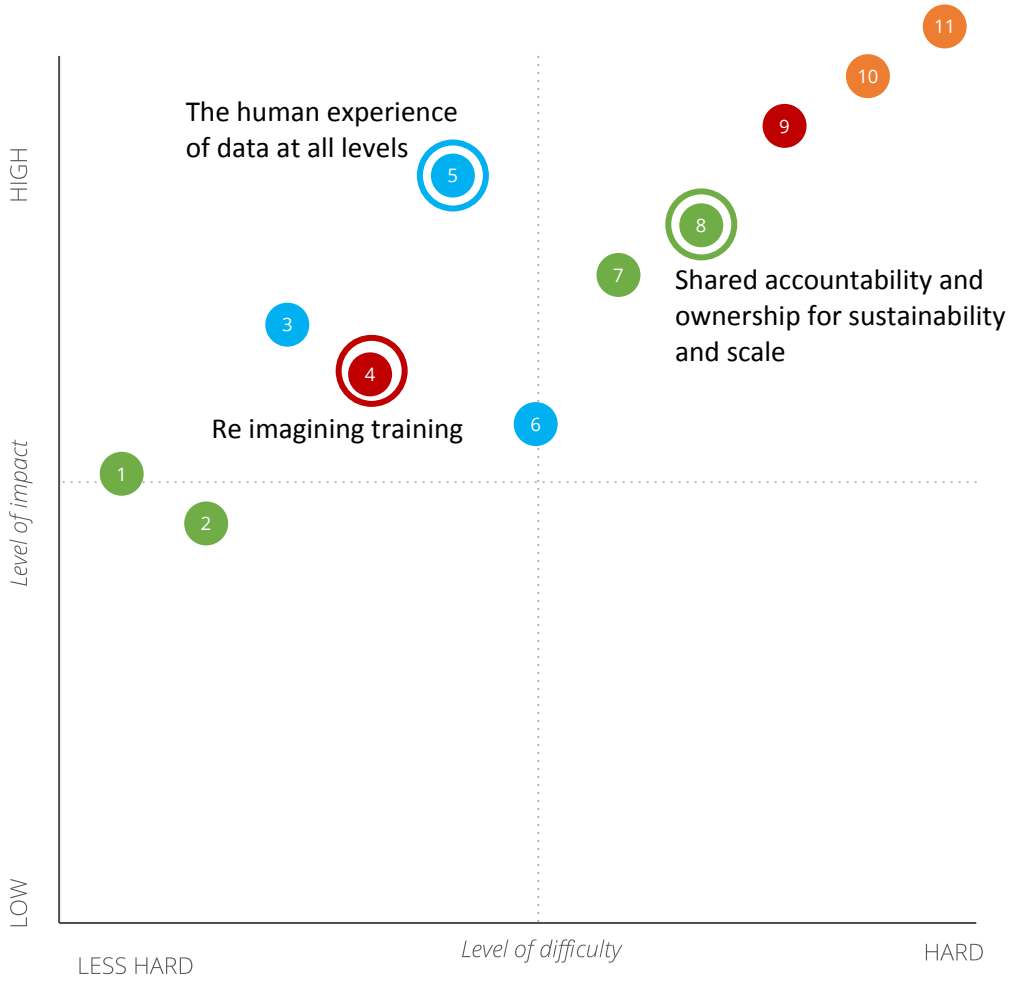
Prioritized Challenges



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



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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

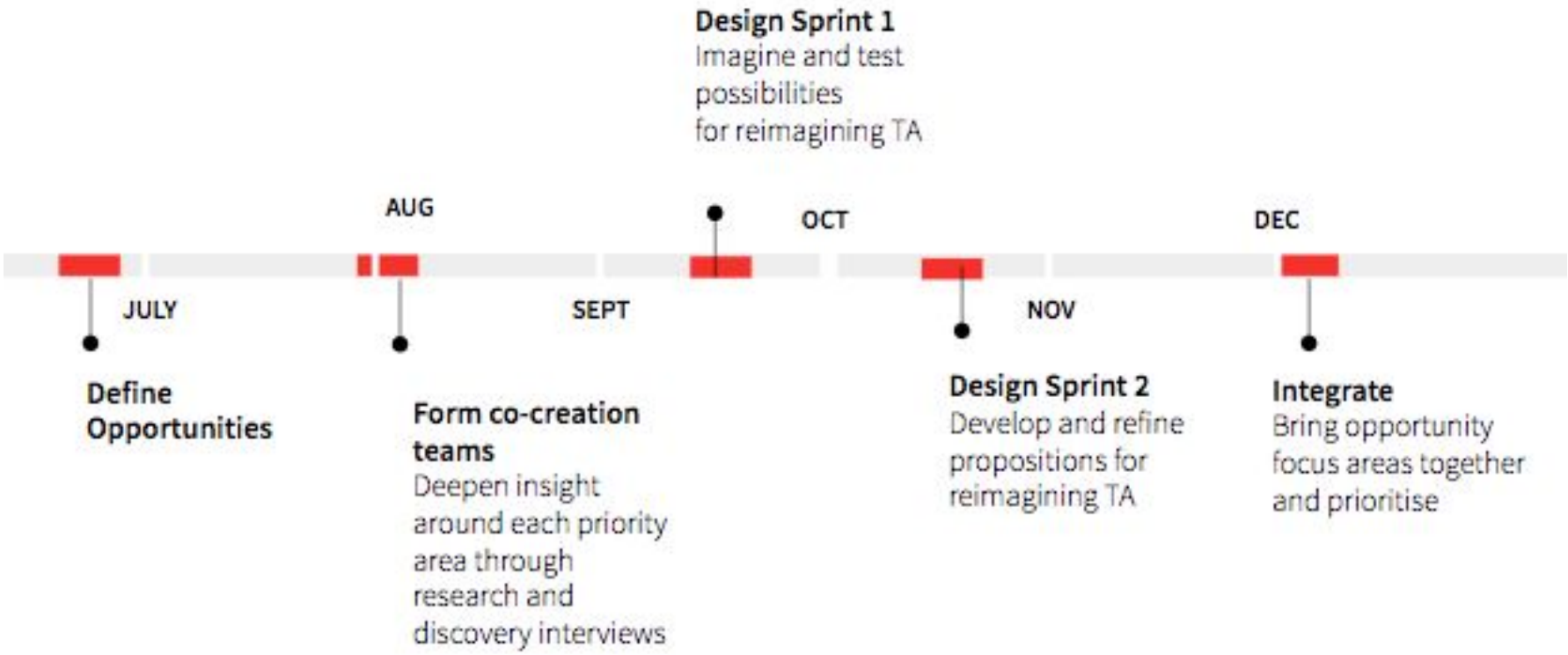
The next step will be the design phase of re-imagining technical assistance in Nigeria. Participants from the intent workshop will be invited to join the co-creation team who will divide into groups of 8-10 people to focus on the three opportunity areas.

The role for the co-creation team includes

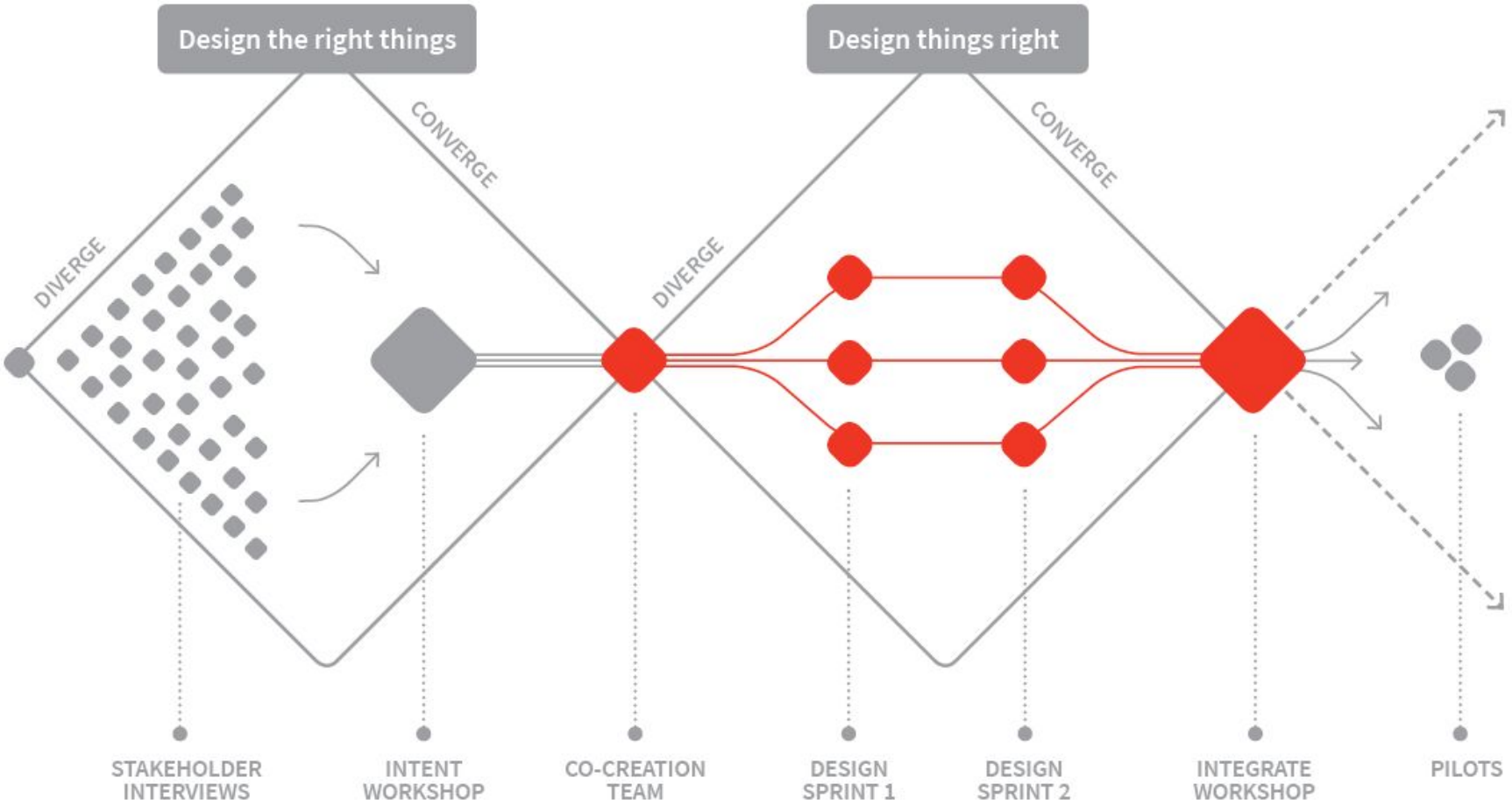
1. Attend one team forming session where we build out the problem definitions and questions for design and identify a wider network of contributors who can provide design input through discovery interviews, participating in workshops and testing prototypes
2. Participate in two design sprints that will 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


Design the right things
Design things right
DIVERGE
CONVERGE
DIVERGE
CONVERGE
STAKEHOLDER INTERVIEWS
INTENT WORKSHOP
CO-CREATION TEAM
DESIGN SPRINT 1
DESIGN SPRINT 2
INTEGRATE WORKSHOP
PILOTS