



Collaborative Leadership for Development – Niger, Health
(P159590)

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I. Introduction

Context and rationale:

1. Despite years of development programming and high-level support, Niger is struggling with critical issues in reproductive health and nutrition.
2. On related problems observed around the world, especially in developing and fragile countries, various studies have shown that improvements in reproductive health and nutritional achievements require behavioral changes and mobilization of a diversity of actors from different parts of the health system, sectors and community with often weak capacities.
3. Such specific issues are generally of the type that the Collaborative Leadership for Development approach (CL4D) can help to resolve, coupled with technical actions and interventions.
4. The CL4D, as part of results-based change leadership approaches, is indeed especially useful to address implementation challenges that involve complex behavioral and social changes; situations of slow change due to the very low capacity actors and institutions; and multiple actors from services, communities and government.
5. Hence, the design of the POPULATION AND HEALTH SUPPORT PROJECT (P147638) includes a rapid results approach (RRI) - one of the CL4D approach tools - component in supporting the implementation of the project, especially for improving and accelerating results related to the disbursement linked indicators (DLI).
6. Nevertheless, in order to explore the scope of the application of CL4D in a broader way, complementary support through a TA (P159590) has been added. Its underlying goal was hence to identify any other specific adaptive constraints for implementation to then allow the selection and facilitate the test of other CL4D tools. What will later should be scaled up under the P147638, once considered as relevant.
7. This type of support is part of the overall approach promoted by the CL4D program (P155048) whose development objective is “to demonstrate the value of multi-stakeholder leadership approaches in strengthening client capacity to address complex development challenges under World Bank Group operations / activities. Value will be demonstrated through increased success and achievements in project implementation by clients supported by CL4D”. Application to the health sector in Niger is not therefore an isolated case.
8. This note provides a detailed description of how this approach through its methodology and tools has been set in motion in Niger for the health sector. And in order to get a more comprehensive analysis, its coverage goes beyond the period of activities funded by the technical assistance. Which should then make it possible to present in a single document a broader overview of the experience that is described – for the time being – in a rather succinct way in the existing official documents (ISR, and mid-term review, in particular).

Activity Development Goals:

9. The objective of the CL4D (P159590) in Niger is to improve the Ministry of Health and the Ministry of Population's implementation capacity for achieving reproductive health and nutritional service priority outcomes in Niger.
10. This is done in support to the implementation of the POPULATION AND HEALTH SUPPORT PROJECT (P147638) whose development objective (PDO) is to increase the utilization of reproductive health and nutrition services in Targeted Areas.
11. Five regions (05) out of a total of eight (08) are targeted by the P147638, which represent 75% of the country sanitary districts, 81% of the country health centers, and 89% of the country health huts (*cases de santé*).

NUMBER OF HEALTH CENTERS, HEALTH HUTS AND SANITARY DISTRICTS					
REGIONS	HC1	HC2	HC TOTAL	HH	SD
DOSSO	36	97	133	392	8
MARADI	61	102	163	471	9
TAHOUA	39	132	171	436	13
TILLABÉRY	68	137	205	415	13
ZINDER	51	113	164	499	10
5 regions TOTAL	255	581	836	2213	53
NIGER (NE) TOTAL	327	699	1026	2497	71
5 regions/NE (%)	78%	83%	81%	89%	75%

Source: Annuaire statistique sanitaire 2017

Results achieved:

12. The RRI approach has been deployed in supporting implementation of five (05) DLIs of the P147638. Except for assisted birth delivery, the figures on progress in the achievements of the four (04) other DLIs speak for themselves, far exceeding the target forecasts.

Observed DLIs	Baseline (2014)	Progress (as of 2019)
DLI1: Number of women (15-49 years) utilizing modern contraceptives	549,304	1,491,453
DLI2: Birth delivered by a trained health professional	317,748	251,103
DLI3: New acceptors (girls <20 years) using modern contraceptives	5,239	88,609
DLI4: Children <1 year of age having received nutritional counseling and an updated growth chart	1,389	360,679
DLI5: Children 0-11 months immunized with measles	730,410	811,193

13. It is worth to mention that in the P147638 ISR approved in April 2018, progress towards achievement of PDO is rated satisfactory. And in particular, the results achieved on two indicators supported by the CL4D/RRI – i.e “ Women 15-49 years using modern contraceptive methods” and “ Skilled birth attendance at delivery for women 15-49” – during the last two years - 2016 and 2017 - have exceeded the targets of the Project Appraisal Document, which were already ambitious.
14. In terms of direct value-added, the periods in which Rapid Results Initiative cycles were implemented (on average two cycles of 100 days per calendar year) resulted in much better achievement levels compared to the rest of the program year for several reasons: setting ambitious performance objectives at 100 days, personalized commitment of teams and leaders, close support brought by coaches at different levels, rigorous follow-up of the implementation process according to the rules of the RRI method throughout of the cycle, ...
15. Salient results from the RRI process have been achieved which have greatly contributed to improvements in DLIs. As an illustration of that, on average for the 3 regions of Maradi, Tahoua and Zinder in 2018:
- Delays in the routing of inputs (family planning, childbirth, infant feeding consultation) have been reduced, ie from 5 to 1 month from the central level to the regional level, from 3 months to 2 weeks from the regional level to the departmental level, and from 2 months to a week from the departmental level to the health centers level;
 - Reproductive health inputs and materials (Family Planning, Birth Deliveries, Infant Consultation) have been increased from 30% to 80% in health facilities;
 - Patient complaints of poor reception by health workers in health facilities have been reduced from 100% to 20%;
 - Areas of reluctance to family planning have been reduced from 80% to 20%. It should be mentioned that in the past, no initiative had been taken with regard to areas of reluctance.
16. The sequencing of the RRI process gave rise to the institutionalization of structure and organization which then increased the efficiency, in particular:
- Formation of a critical mass of previously reluctant and now positive couples and families in favor of maternal and child health in several villages;
 - Constitution of different groups (in particular women, religious, traditional healers) actively involved in awareness-raising activities in family planning, assisted deliveries and nutrition in several villages;
 - Establishment of anti-reluctance committees set up in each community of Village Chiefs, some religious leaders as well as influential actors with the role of ensuring that populations remain constantly sensitized and completely change their attitude. The committees against reluctance work directly with RRI teams at health centers level and with departmental authorities to report in case of persistence, while members of departmental teams were monitoring the management of these areas bi-weekly by phone call.
 - Establishment of communication and information sharing system - based on WhatsApp and mobile phones - by the teams at the regional level with those of the

departments and municipalities to quickly get back the news related to any breakdown of inputs and materials.

17. Another important spin-off from the application of the RRI approach was the change in behavior, especially from different actors taking responsibility by proactive decisions to provide concrete solutions to the problems they face. Example:
 - Census of all pregnant women and referencing them in health facilities for prenatal consultations and deliveries by village chiefs;
 - Provision of their carts or motorcycles by several village members for pregnant women ready to give birth;
 - Establishment of financial penalties of 5000 FCFA against women and traditional birth attendants who perpetrate home births;
 - Internment for seven (07) days in the health facility of every woman giving birth at home;
 - Instruction of the census of all the children of less than one year including the parents lost in sight in infant consultation by a certain number of chiefs of village;
 - Establishment of monitoring cards for pregnant women and children in health facilities that are made available to religious leaders, traditional and other influential community actors for their follow-up and actions;
 - Beyond the cost recovery system put in place with the support of the state, mobilization of financial contributions by local authorities, traditional and religious leaders, community relays and several souls of good will. Most of the time, this has been done through the sale of their field products to support input buying efforts in several health facilities;
 - On several occasions, voluntary contribution of health workers themselves and community members of RRI teams to the purchase of materials and inputs outside of the local cost recovery mechanism.
18. Adoption of new effective methods of work by teams is among the induced changes in the application of RRI, such as the following:
 - Improvement of the supply of services and the attendance of health facilities following the taking over of certain positions (reception of patients, counseling, participation in the establishment of calendars and hours of consultation ...) by trained community actors thus partially alleviating the deficit of health workers in health facilities and thereby contributing to the motivation of health workers.
 - Emergence of innovative practices in the implementation of the rapid-results approach in the health sector in Niger, such as the organization of mixed outpatient clinics integrating the community actors, which then increased significantly the number of people adhering to the new methods promoted in Reproductive Health.
19. Fostering collaboration among stakeholders has generated improved relationships and work functioning. And in particular, trust has been restored between community and health workers. This then allowed the latter to better understand the criticisms made to them by the community and as a result, to make specific efforts to improve the reception of patients.
20. Lastly, there was a spillover effect of the success of the CL4D/RRI through its adoption by other users such as in the following cases:

- The Secretary General of the Ministry of Public Health's report during the ANNUAL REVIEW OF THE YEAR 2017 of the National Health Committee (CNS) highlighted that because of the implementation of the Rapid Results Initiative improving the performance of health structures, the expansion of such innovative strategy is indicated as one of the ministry 2018 PRIORITIES.
- RRI will be one of the pillars of the new Human Capital project being prepared starting 2019.

What the CL4D intervention was about:

21. In addition to usual technical work at the different levels, five approaches to solutions have been deployed for applying the CL4D approach, namely (i) the establishment of multidisciplinary teams; (ii) the deployment of Rapid Results Initiatives (RRI); (iii) the identification of areas of reluctance to family planning and the deployment of concerted strategies to mitigate them; (iv) the organization of joint missions of teams at the regional level; and (v) the development of partnership between health facilities and the community in implementing the cost recovery system.
22. **Establishment of multidisciplinary teams** (at regional, departmental and in each commune level):
 - Composition: made up of all community categories such as health workers, marabouts, traditional chiefs, community relays, midwives, women's and youth association representatives, community radio managers and NGO representatives.
 - Operation: Weekly meetings at District and Health Center level; Bi-monthly at the regional level
 - Actions: Higher level support for complex problem solving (From Regional to District; From District to Health Center); Social mobilization in the villages by the Health Center level teams to bring communities to change their behavior
23. **Deployment of Rapid Results Initiatives (RRI)** – 2 cycles of 100 days each per year – at Health Center level for the 5 targeted regions.

Objective: To provide a structured approach equipped with proven tools to multi-stakeholder teams set up to deliver short-term, ambitious results aligned with longer-term goals.

RRI process for each cycle: Setting performance objectives, detailing planning of activities to achieve them, implementing related work plans with weekly monitoring of progress, reviewing the degree of results achievement in the 50th and 100th days, and capitalizing on the achievements to sustaining effective practices and extending the dynamic of results.

Implementation of the process: Operationalized by multi-stakeholder teams at the level of health centers, facilitated and accompanied by coaches at different levels (health center, district, region, center), and supported by groups of leaders at different levels for the resolution of complex problems beyond the scope of teams' competences (in particular of political, institutional, interrelational, ... nature)
24. **Identification of areas of reluctance to family planning and the deployment of concerted strategies to mitigate them.**

Objective: Understand the root causes of reluctance and then consider concrete actions to undertake.

Process :

- Prior work of identifying zones by teams of the health center level under the departmental level teams' coordination.
- Relaying information on these areas to the regional level teams.
- Processing and mapping areas of reluctance based on these data.
- Multi-stakeholder multi-layer team making the trip to these areas of reluctance. Such team generally comprises administrative authorities of the governorate and prefectures, imams, canton chiefs, health workers, members of the departmental and regional teams in collaboration with the RRI teams at health center level.
- Repeated meetings with traditional leaders, religious leaders and influential actors in these areas until problems are resolved.

Findings: Many resistances were related to categorical refusal to attend the health facility for different reasons, including historical land-related or generational conflicts opposing either several villages or communities, or a community / village with the State of Niger.

25. **Organization of joint missions of teams at the regional level** in collaboration with departmental and health center level teams, administrative leaders and authorities as well as elected representatives of villages :
- Objective: to meet opinion leaders (religious, traditional, influential people ...) to discuss health issues, to understand their position and especially to show them the importance of changing attitudes towards sustainable mother and child health.
 - Approach:
 - (i) Develop advocacy messages that counter the prejudices of reluctant people;
 - (ii) Use the various existing media (community radios, meetings organized for this purpose by ensuring the presence in the team of people (women, men, parents) with poignant testimonials they could tell to highlight the negative consequences¹;
 - (iii) Deploy around the following arguments: recalling what the Qur'an² says (and does not say); reporting examples of other Muslim countries that allow modern methods of reproductive health (Pakistan, Bangla Desh, ...); providing scientifico-technical justifications³; telling stories of positive experiences in resolving the use of health services (including family planning, assisted delivery by skilled health personnel, and infant counseling); similarly on cases showing that the basis of success does not lie in money, that one can have enough money without succeeding, and that one may not have enough money and succeed.
26. **Development of partnership between health facilities and the community in implementing the cost recovery system** through community participation and the mobilization of local contributions to address problems of disruption and slowness in the delivery of health inputs and materials.

¹ Consequences of non-use of modern methods of contraception, or of birth deliveries at home, or of non-attendance of health facilities for infant consultation...

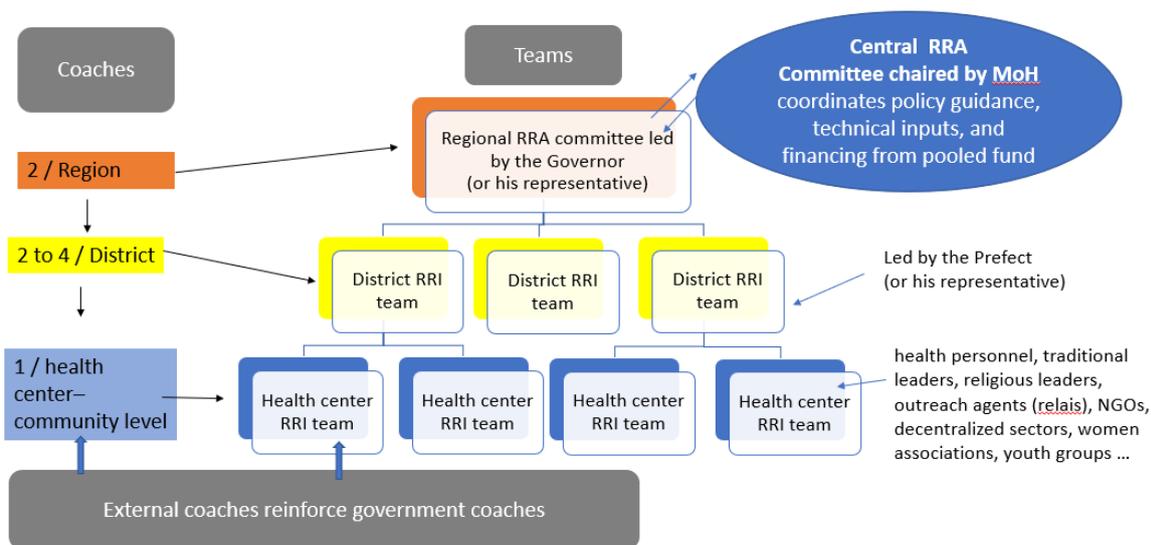
²In particular it does not prohibit family planning, it does not stipulate that the adolescent woman or girl who uses modern methods of contraception will go to hell,..

³ Family planning is helpful because it prevents the sexually active adolescent girl or woman from getting an unwanted pregnancy that would prevent her from doing her future projects

Who implemented the CL4D-supported activities:

- 27. In application of the RRI approach, CL4D has been implemented through temporary governance structures corresponding to the functions of piloting and institutional support (central level), strategic and coordination support (regional level) and operational implementing teams (district, health centers and health huts level), with respective roles clearly defined and disseminated to all.
- 28. These structures are composed by representatives of key stakeholders concerned by the selected challenges, who thus come from various horizons, be they political, administrative, traditional authorities, or community actors. They were identified in detail by using the findings from the different stakeholder mapping exercises (Net-Map), conducted in a representative sample of districts and communes throughout the 5 regions.
- 29. The whole process of change towards the results is then facilitated by coaches who had been trained in cascade according to the RRI approach, and who benefit from continuous methodological assistance provided by the coaching support set up all along this process.
- 30. In total, 1,022 persons have been trained and are playing the role of coaches to accompany RRI teams for implementing DLIs along the different levels.

A multi-actor platform, cascading DLIs to 836 health centers



When the CL4D process happened:

- 31. The year for which CL4D had covered its own expenses corresponds globally to 2017, the continuation of its specific interventions having been totally supported by P147638 from there. The table below then presents the sequence of related main interventions.

CL4D INTERVENTIONS ALONG THE IMPLEMENTATION OF THE POPULATION & HEALTH SUPPORT PROJECT IN NIGER

	2016	2017	2018	2019
CENTRAL LEVEL	<p>MAY: Organizing workshop on Introduction to COLLABORATIVE LEADERSHIP, RRI and NET-MAP</p> <p>MAY: Two (02) participants in RRI Coach regional workshop in Nairobi</p> <p>OCT: Hiring 2 part-time international RRI coaches (for Dosso and Tillabéry)</p>	<p>FEV: 1st draft of the GUIDE for applying RRI based on Dosso and Tillabéry pilot experiences</p>	<p>MARCH: Hiring 1 full-time international RRI coach (for Maradi, Tahoua and Zinder)</p> <p>MAY: Creating the CCIRR (RRI Steering Committee) by the MINISTER of Health</p> <p>SEPT: Organizing workshop on TRUST gathering the central level (3 ministries) and all targeted regions and districts representatives</p>	<p>APR: Organizing workshop on EXCHANGES ON BEST RRI-BASED PRACTICE gathering the central level (3 ministries) and the 5 regional directions, districts and CSI representatives</p>
2 PILOTS (DOSSO & TILLABÉRY)	<p>MAY: RRI Training for Coaches (#1)</p> <p>MAY: For each Region, two (02) participants in RRI Coach regional workshop in Nairobi</p> <p>MAY: Launching of 1st Cycle</p> <p>SEPT: Stakeholder Mapping</p> <p>SEPT: RRI Training for Coaches (#2)</p> <p>OCT: Launching of 2nd Cycle</p>	<p>JUNE: Launching of 3rd Cycle</p> <p>SEPT: Launching of 4th Cycle</p>	<p>APR: Launching of 5th Cycle</p> <p>AUG: Launching of 6th Cycle</p>	<p>APR: Participating in workshop on EXCHANGES ON BEST RRI-BASED PRACTICE</p> <p>MAY-JUNE: Launching of 7th Cycle</p>
MARADI	<i>RRI process not yet initiated</i>		<p>APR: Training on RRI for region & district level coaches</p> <p>MAY: Launching of 1st Cycle</p> <p>JULY: Stakeholder Mapping</p>	<p>APR: Participating in workshop on EXCHANGES ON BEST RRI-BASED PRACTICE</p> <p>MAY-JUNE: Launching of 2nd Cycle</p>
TAHOUA	<i>RRI process not yet initiated</i>		<p>APR: Training on RRI for region & district level coaches</p> <p>APR: Stakeholder Mapping</p> <p>APR: Launching of 1st Cycle</p> <p>SEPT: Launching of 2nd Cycle</p>	<p>APR: Participating in workshop on EXCHANGES ON BEST RRI-BASED PRACTICE</p> <p>MAY-JUNE: Launching of 3rd Cycle</p>
ZINDER	<i>RRI process not yet initiated</i>		<p>APR: Training on RRI for region & district level coaches</p> <p>JULY: Launching of 1st Cycle</p> <p>SEPT: Stakeholder Mapping</p>	<p>APR: Participating in workshop on EXCHANGES ON BEST RRI-BASED PRACTICE</p> <p>MAY-JUNE: Launching of 2nd Cycle</p>

32. Following a series of introductory and information workshops in RRI and CL4D at the central level and in the two regions selected to initiate the process, the first initiatives were launched in May 2016. However, the generalization to the 3 other regions could not finally start until 2018. Experience shows that at most, two RRI cycles can be launched per year.
33. Each cycle of RRI has roughly been able to apply the principles of the method and conduct key events as instructed by the RRA (launch, mid-term review, final review), except in some rare cases where it didn't comply with the RRA standard practice because of problems of lack of funds or insufficient funding of activities (especially for Maradi and Zinder in 2018).
34. The regional and district level coaches were trained by the WB CL4D staff before the international coaches recruited from October 2016 were able to take over. These latter were then tasked with strengthening the training and extend it to the health center level, according to a cascade approach involving the different levels. This then allowed to have a proximity coach for each IRR team, which represent a critical factor for such ambitious project involving so many actors quite throughout the extent of the country.
35. Other CL4D tools were deployed in support of RRI, including Net-Map, which identified stakeholders involved at different spatial levels according to each DLI. The quality and relevance of the data and information that ensued helped a lot in the composition of the teams and beyond the spheres directly concerned. Thus, the results obtained in Dosso, Tillabéry and Tahoua made it possible to frame and guide the composition of the teams in Maradi and Zinder, regions for which issues of difficulty in making the agendas of the actors concerned more coherent (regional teams, Net-Map consultant, MoH team) did not allow the Net-Map exercises to be conducted before the launching of RRIs.
36. In terms of selection of DLIs, six (06) out of the total of eight (08) have been implemented by RRI teams, with four (04) of them by all the five (05) regions in 2019. On the other side, two (02) DLIs seem less attractive since the beginning – namely the one on supervision and the other on modern contraceptives for girls (under 20 years old) – with 3 regions interested only beginning 2019.

DLI SELECTED FOR IMPLEMENTATION WITH RRI PER REGION								
DLI per REGION	2016		2017		2018		2019	
	#	Regions	#	Regions	#	Regions	#	Regions
DLI1 (modern contraception)	2	Dosso; Tillabéry	2	Dosso; Tillabéry	5	Dosso; Tillabéry; Tahoua; Maradi; Zinder	5	Dosso; Tillabéry; Tahoua; Maradi; Zinder
DLI2 (birth delivery by a trained health professional)	2	Dosso; Tillabéry	2	Dosso; Tillabéry	5	Dosso; Tillabéry; Tahoua; Maradi; Zinder	5	Dosso; Tillabéry; Tahoua; Maradi; Zinder
DLI3 (modern contraceptives for girls <20yrs)	-		1	Dosso	1	Dosso	3	Dosso; Tahoua; Zinder
DLI4 (nutritional counseling)	2	Dosso	2	Dosso; Tillabéry	4	Dosso; Tillabéry; Tahoua; Zinder	5	Dosso; Tillabéry; Tahoua; Maradi; Zinder
DLI5 (measles immunization)	-		2	Dosso; Tillabéry	2	Dosso; Tillabéry	5	Dosso; Tillabéry; Maradi; Zinder
DLI8 (supervision)	-		2	Dosso; Tillabéry	2	Dosso; Tillabéry	3	Tahoua; Maradi; Zinder

37. Two other CL4D tools were deployed, one in 2018 on the Tree of Trust and the other in 2019 on the inventory of efficient practices for the purpose of further capitalization and exchanges between regions, districts and health centers.

The workshop on Tree of Trust / Barometer of Trust held from 24 to 28 September 2018 aimed at improving the implementation of institutional and organizational reforms currently underway within the Ministry of Health in order to strengthen relationships of trust at different levels: between public representatives (policies and administration) and citizens; between political leaders and administration; and between central and territorial administration.

38. To enable concrete action to build trust, a modeling and description of the factors constituting trust and distrust were undertaken according to "The Tree of Trust" coupled with its measurement tool, the "Barometer of Trust". The seven factors of this model provide an excellent reading grid that will, in the long run, in discussions with communities, delve deeper into key questions that relate to the achievement of performance objectives.
39. The workshop held in April 2019 on developing the culture of sharing experiences on implementing RRI in the region showed that (i) many effective practices have occurred at different times in each region, but few have been documented; (ii) Many of the practices that were found to be effective focused on sensitization approaches varying by targets; (iii) Participants were keenly enthusiastic about continuing the process of exchanging knowledge on good practice.

II. Delivery Challenges for applying RRI approach

40. The level of candidates for RRI coaching was in general, quite low (with some cases of non-literate at the Health Center level) hence difficulties in assimilating concepts (logical framework, results chain, planning, monitoring, etc.). However, that was offset by good predispositions of most of them in group facilitation and their favorable perception by stakeholders.
41. Since every director wanted to cover all of his health centers with RRIs right from the first cycle, despite the cautious recommendation to start with tests on a few pilots, there were enormous challenges in the ability to accompany this multitude of initiatives by coaches who had just learned this new methodology. The workforce currently stands at more than a thousand trained coaches in the 5 targeted regions.
42. Short time for training: For reasons of budget and low availability of agents, the duration of training was relatively short. This was subsequently compensated with the direct accompaniments on the ground by top and international coaches, and some refresher sessions.
43. Inadequate coordination of RRIs conducted in Health Centers by district and regional teams: The cause of workload was frequently raised to justify the insufficient exit of district coaches to the Health Centers. In reality, there may be insufficient ownership of the participatory approach and team spirit.
44. Difficulties relating to the administrative, financial and planning aspects of the implementation of the RRI: Low estimate of budget for key RRI activities in several districts due to "insufficient support" of regions by the central level during the preparation of AWP (Annual Work Plan - PAAs)

III. Addressing Delivery Challenges

Chronological and descriptive narrative of the actions taken to address the delivery challenges:

45. Each member of the team (alone or in a group / sub-group) is mobilized / intervenes according to their predispositions, availability (diurnal vs. nocturnal) and their affinities with the targets (towards women by the groups). women, youth through youth associations, husbands through the Husbands' Schools, religious and traditional leaders as a whole.
46. The problem-solving process is very flexible and iterative (ex:), the only invariant being the course of the result to be obtained.
47. Coupling of coaching work with technical and administrative tasks: during their support visits to RRI teams in the field, departmental and regional coaches can provide purely technical advice with regard to their areas of specialization, or to inform on logistical aspects (ex: point of progress on printed matter, supplies, ...), or to carry out administrative tasks (ex: Internal control of data carried out by the Coaches of the Districts and region during the weekly monitoring missions, data clearance by the Sanitary District and the Regional Direction).
48. ... and conversely: during field visits as part of their duties within their respective structures, coaches take the opportunity to address issues specifically related to RRIs.
49. Motivation is at the base of everything. By way of example, the critical problem of the delay / lack of funding has often been solved by being taken in charge by one or the other stakeholder, such as (a) by the community for the relays of the community or those women and families visiting remote health facilities; (ii) use of their own resources (fuel, motorcycle, hikes) by community and health workers; (iii) fueling by some mayors for some RRI team.
50. Use of carrots and sticks to shift certain actors from a negative role to a positive role. Ex: For midwives, awareness, enlistment, training, and capacity building. And in parallel, setting fines by village chiefs against midwives who give birth and women and husbands who require their service for home birth delivery.

IV. Lessons learned on implementation

What we have learned:

51. Relevance and effectiveness of using the RRI approach to complement World Bank Operations: An innovative approach for the implementation of health reforms.

◊ It is possible to make people collaborate down to the level of villages and communities throughout the national territory to achieve results together;

◊ The RRI approach is powerful and quick to deploy when (i) there is a need for clearly articulated results to be achieved; (ii) there are many actors and stakeholders to mobilize and engage in a common effort to address the issue; (iii) the problems to be solved are not solely technical or financial in nature;

52. Committing Leadership throughout the process is crucial

◇ The commitment and determination of communities and leaders throughout the implementation of the initiatives is critical to their success and contribution to achieving ambitious and high impact results.

◇ The role of leaders is particularly required to create an enabling environment (e.g. providing means, advice, messages of encouragement, unlocking complex situations beyond the field of competence of the implementation teams, ...) allowing implementing teams to give the best of themselves to the achievement of ambitious results;

53. Engaging key stakeholders onboard matters

◇ Identifying the stakeholders to be part of the teams at one level or another is a critical step, ensuring the mobilization of those who are influential and concerned by the issues at stake;

◇ To be effective, the engagement process of these different actors should be dynamic, adjusted progressively, combining the formal (eg signed engagement note, administrative authorities) and informal (eg communication and fluid exchanges of information on all occasions, traditional and religious powers), accepting contributions of all kinds (financial, technical support, morale, presence, in-kind, networking, ...).

54. Coaching helps navigating the complex journey of change

◇ The process of change has greatly increased efficiency, self-confidence and credibility through the support of coaching equipped with methods, tools, and monitoring and communication strategies. This has helped enormously to facilitate the solving of problems and difficulties, the monitoring of indicators according to the targeted results, and the adoption of a structured, disciplined and flexible implementation methodology.

◇ Leadership coaching should be exercised at several levels, at all stages of the administrative and community chain, the most operational being those at the level of health center, and those at the higher level mainly playing a role of methodological support, of facilitation of knowledge exchange between the lower-level actors they support, of relays with the levels above them and their peers at the same level, and of consolidating data on the evolution of achievements.

55. Structured tools enable teams to be more productive and effective

◇ The RRI Practical Guide helped to consolidate RRI learning knowledge at a given point in time, and to provide those who had the reflex to use it a methodological reference. It should then be updated on a yearly basis, by including the use of effective practices, suggestions from the network, and proposals from the centralizing body for addressing issues that have come up to them over time.

◇ Result Culture Expansion: RRI's basic principle of formulating measurable goals has resulted in a whole cascade of outcome-oriented measures, such as the zoning of the health area and

the setting of the target rates by zone. Or on a completely different aspect, the signature of results-based performance contract between the Minister of Public Health and each DRSP for the implementation of the action plan, an improved approach compared to before by formulating more measurable indicators and increasing leadership accountability. Which all contribute to the improved achievement of results.

◊ The relevance of using the various tools of CL4D is to be analyzed as and when the problems occur. In the present case, it was soon realized that it was necessary to precede RRI by an in-depth analysis of the stakeholders concerned by the targeted DLIs with the use of the Net-Map tool with regard to their multitude, then after a few cycles, the lack of trust or even mistrust between several typologies of actors brought out the need to reinforce the dynamics of trust, hence the use of the concept of the Tree of Trust and its measurement tool, the Barometer of Trust. And just recently, with the completion of at least one (01) cycle for each of the five (05) targeted regions, which highlighted the proliferation of effective practices on shared issues within the network but scattered, the initiation of a capture process and exchange of knowledge on effective practices has emerge.

◊ Make the tools as effective as possible by adapting the indications of the RRI Guide according to the specificities of the contexts:

- o Multiplying examples of illustration, case studies, and exercises from the multiple cases encountered with the thousand teams squaring the 5 targeted regions

- o Using the language of health practitioners and demand, translating into the vernacular

- o Developing lightweight (in terms of the number of pages) and visual documentaries as far as possible

- o Refreshing quickly in light of changing needs (yearly update, especially based on new cases)

- o Accompanying the use (including widely disseminating), checking the degree of use during RRI events (especially at launch) and during visits, ...

◊ Strengthen the efforts to document experiences, which are favored by the practice of the approach, and which were further structured after the workshop on effective practices, and identify stories of what effective operational support can do, and particularly the champions behind it

◊ Give sufficient importance to the quality of data management throughout the chain (from collection to archiving) as numbers allow for hearing each other quickly in case of disagreement and this is the main reference source for the external third-party auditor.

56. RRI as a full-fledged approach in the organization

◊ **Embed RRI practices into the usual routine of the organization:** To foster the sustainability of practices and changes induced by RRI, aligning and integrating RRI practices into the usual routine of the organization sounds determinant for the sustainability of effective practices induced by the RRI experiments. in particular during the annual planning of activities, and in the organization of activities in the field so as to save resource. ◊ **RRI cycles and calendar of**

activity: Calibrate RRI cycles with quarters (90-day cycle instead of 100-day cycle), ensuring a minimum of 3 cycles per year.

◊ **Expand the practice to the lowest operational level:** In the example of the Health project, cascading work to the level of health huts, with the role of coaching played by the community relays whose mandate naturally allows frequent visits of both the Health Center (In general, such role is coupled with the one of a coach) and Health Hut (in addition to sensitization).

◊ **Carry out an RRI when that is justified:** Focus the scope and activities of new RRIs on unresolved issues, and then inject into existing system (rules, procedures, organizational chart, communication plan, ...) the effective practices that were highlighted during each final review.

◊ **Stay in the logic of an integrated information system:** To be able to contribute to the existing system and avoid duplication / redundancy / surplus of work, periodic information coming from the monitoring of the RRIs should be kept consistent with that produced by the overall existing information system (DHIS2 in the case of the Ministry of Health).

◊ **Put into practice the added value:** In order to take the best advantage of effective practices from final reviews and capitalization workshops, a practical approach is to be taken to capture these lessons periodically, translating them into general-purpose practical measures for the whole organization and ensure their wide dissemination and application in practice.

V. Persistent challenges

57. There is a significant challenge at the central government level that has initiated the rapid results approach at the regional and local level, but has not been able to keep pace with these implementing teams in the regions and structures infra thereafter. A centralization structure has been officially set up and central coaches have been appointed, but the delays in responding to requests from the region are almost always behind schedule, and the quality of methodological support remains unsatisfactory, forcing the regions to run short. Circulate this structure and apply directly for international coaching. And even the benefits on the usual functions remain mediocre, in particular in the long delays of contracting of consultants (systematically exceeding 8 months) or the setting up of the financing of the activities (not before April for each calendar year).
58. Another challenge concerns the operational aspect, since RRI will have an almost zero impact if the basic conditions of availability are not met, as for inputs (drugs, ...), materials (health book, growth curve , ...) as well as the staff (a large number of the health centers have a good majority of contract employees, who have not been paid for several months).
59. The delays in adopting RRI practices as reflexes in usual working methods without external coaching intervention is a critical measure of the degree of ownership of the approach and all that underlies it. For example, the signing of performance targets between the Minister and each Regional Director in 2019 is a notable public management innovation, for which each of these directors could have significant achievements using the RRI approach and tools, for all outcome indicators and not just DLIs.

60. The desire to develop partnerships to generate leverage at the national level for the practice of RRI manifested itself on the part of CAPEG⁴ which has the ambition to constitute a national anchoring structure of the RRI approach in Niger. But for the moment it has remained at the level of symbolic exchanges, whereas the Ministry of Health team could boost such an approach with the potential that it can bring to it (Experiences and Anteriority; Presence on the whole territory; Coaches to accompany the process towards the results; RRI Guide, ...), whether at the central level or especially in support of service delivery at the decentralized level.

⁴ Cellule d'Analyse des Politiques publiques et d'Évaluation de l'action Gouvernementale (Public Policy Analysis and Evaluation of Government Action Unit), attached to the Prime Minister's Office