REVIEW MEETING FOR THE

WHO AYSRHR

TA Coordination Mechanism

9-10 JUNE 2021

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EXECUTIVE SUMMARY

The WHO Adolescent and Youth Sexual and Reproductive Health and Rights (AYSRHR) Technical Assistance (TA) Mechanism received its first request for TA in December 2019. Eighteen months later, the Mechanism is currently at various phases of responding to TA requests from 11 countries - a good time to take stock, to reflect on lessons learned from the experiences thus far, and to identify ways in which processes could be strengthened and refined.

The Review Meeting for the WHO AYSRHR TA Mechanism took place virtually over two days (9-10 June, 2021), with the following objectives:

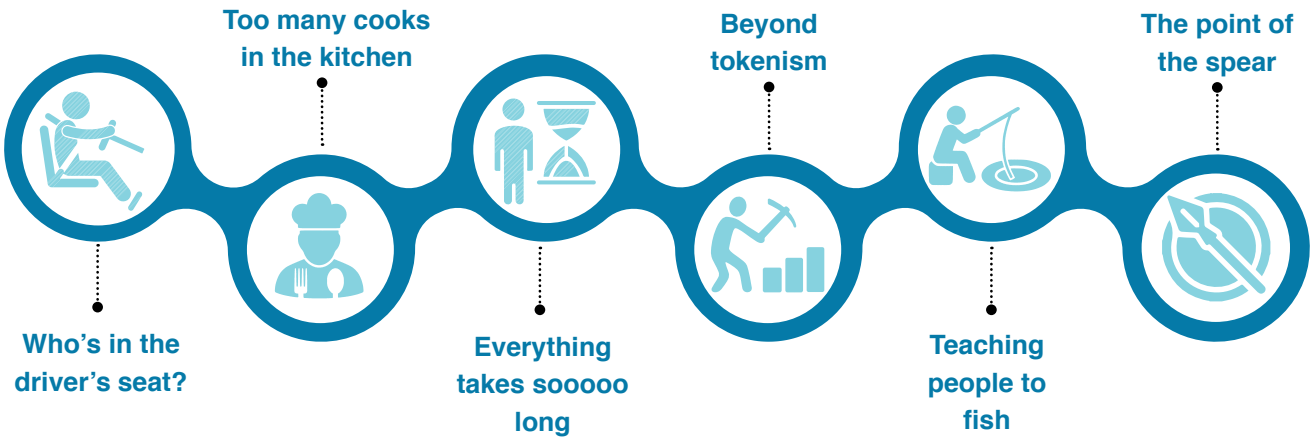
01 To provide an update of the Mechanism's status after 18 months;

02 To synthesize lessons learned from the perspectives of people requesting TA and people responding to the TA requests, and explore their implications for the future; and

03 To identify needs for strengthening the Mechanism and its Standard Operating Procedures (SOP), in order to ensure that the TA it provides is timely, effective, efficient and contributes to national capacity.

The first day of the meeting included an update of the Mechanism after 18 months of operation, followed by presentations from Ministries of Health who had requested TA and from partner organizations who had responded (or are responding) to the TA requests submitted. Presenters used a common structure that identified their positive and negative experiences with the processes and outputs of the TA that was provided, with a focus on both successes and problems, including proposed solutions.

The second day of the meeting included a synthesis of the presentations and discussions that took place during the first day, followed by a focused discussion on six issues arising from them:



For each of the topics, a brief presentation was made that included a problem statement, actions already taken by the Secretariat, and proposed solutions summarized from the first day's presentations, followed by more in-depth discussions and the identification of additional possible solutions.

The review meeting finished with an overview of next steps which, in addition to this meeting report, included: integrating key decision taken during the meeting into the Mechanism's SOP; ensuring that issues raised that could not be discussed during the meeting would be discussed on an ongoing basis during the monthly partners meetings; and preparing a journal paper to share the experiences of the Mechanism with a wider audience and contribute to the broader evidence-base on the provision of TA.

ACKNOWLEDGEMENTS

This report was prepared by M Plesons, B Dick, and V Chandra-Mouli. An initial draft was reviewed by the participants of the meeting.

INTRODUCTION

This report summarizes the proceedings of the 'Review meeting for the WHO Adolescent and Youth Sexual and Reproductive Health and Rights (AYSRHR) Technical Assistance (TA) Mechanism,' organized by the World Health Organization's (WHO) Department of Sexual and Reproductive Health and Research (SRH) and the Human Reproduction Programme (HRP) in June 2021.

BACKGROUND

In 2019, WHO SRH/HRP established the AYSRHR TA Mechanism, as part of the FP Accelerator Project (see Annex 1 – Overview of the AYSRHR TA Mechanism). The objective of this Mechanism is to deliver the TA that countries need for designing, implementing, monitoring, reviewing and documenting their AYSRHR programmes, in ways that are timely (through a mechanism that can respond in a punctual manner); effective (from individuals with the right technical and practical experience in a similar context, with back-up from evidence-based programme-support tools); efficient (from experts located as close to the respective country as possible, using methods that are effective and take into consideration available resources); and contribute to national capacity development. After 18 months of operation, there is a need to take stock of the Mechanism's status and reflect on lessons learned from its experiences thus far, to refine it for the future and to contribute to the broader evidence base on TA.

Objectives

01 To provide an update of the AYSRHR TA Mechanism's status after 18 months;

02 To synthesize lessons learned from the perspectives of people requesting TA and people responding to the TA requests, and explore their implications for the future; and

03 To identify needs for strengthening the TA Mechanism and its SOP, in order to ensure that the TA it provides is timely, effective, efficient and contributes to national capacity.

Introductions & overview of the meeting

V Chandra-Mouli opened the meeting by welcoming the participants and thanking them for making time in their busy schedules for this two-day meeting to review the lessons learned from 18 months of experience with the AYSRHR TA Mechanism (see Annex 2 – List of participants).

M Plesons then gave an overview of the meeting (see Annex 3 – Agenda). As background, she noted that in April 2019, the partner organizations convened in Geneva to design the AYSRHR TA Mechanism. During that meeting, they jointly established its objectives, guiding principles, and standard operating procedures. The first TA request was received in September 2019, and in the 18 months since then, much has been learned about the provision of TA and the strengths and weaknesses of this Mechanism. She noted that the time was ripe to take stock and reflect on these lessons learned, in order to refine the Mechanism for the future and contribute to the broader evidence base on TA.

Update on the Mechanism's status after 18 months

M Plesons then provided an update on the Mechanism's status after 18 months of operation, outlining what the Mechanism set out to do and where it is now.

With regard to the rationale for the Mechanism (why did we think the Mechanism was needed?), she noted the following positive developments in AYSRHR in recent years, as well as ongoing challenges:

	Positive developments		Ongoing challenges	
1	Increasing attention, resources and commitments to ASRHR by governments and external funders		The evidence base is much stronger about what needs to be done than it is about how to do it	4
2	A stronger evidence-base and growing consensus about priorities for action		Insufficient capacity in resource-limited settings to achieve the good intentions/ commitments that have been made	5
3	Growing capacity and experiences of doing what needs to be done to improve ASRHR		MOHs are not always in the driver's seat for decisions about TA to help them move from words to action	6

With regard to the design and operationalization of the Mechanism (how did we design and operationalize the Mechanism?), she noted the following steps. Firstly, the TA Mechanism Secretariat reviewed experiences and lessons learned about the provision of TA. Secondly, they listened to people who are providing and receiving TA. Thirdly, they identified partner organizations with the following qualifications:

- Experience in planning, implementing, monitoring, evaluating, reviewing, and/or documenting efforts to address AYSRHR
- Experience in collaborating with a variety of stakeholders, especially government, other non-governmental organizations, and youth-led organizations on AYSRHR

- Experience providing technical support for AYSRHR within and outside their own organization
- Experience in fostering meaningful youth engagement
- Organizational presence in low- and middle-income countries, particularly in the African, Eastern Mediterranean, and South-East Asian regions (and ideally multiple regions)
- Ability to work in multiple languages

Fourthly, they jointly developed a SOP with the partner organizations. Finally, they informed countries about the Mechanism through a range of existing channels, especially with the support of key partners such as FP2020 (now FP2030).

With regard to the objectives of the Mechanism (what did we want the Mechanism to do?), she noted the following three aims:

1

To provide TA to countries that will help them achieve the goals/ commitments on AYSRHR

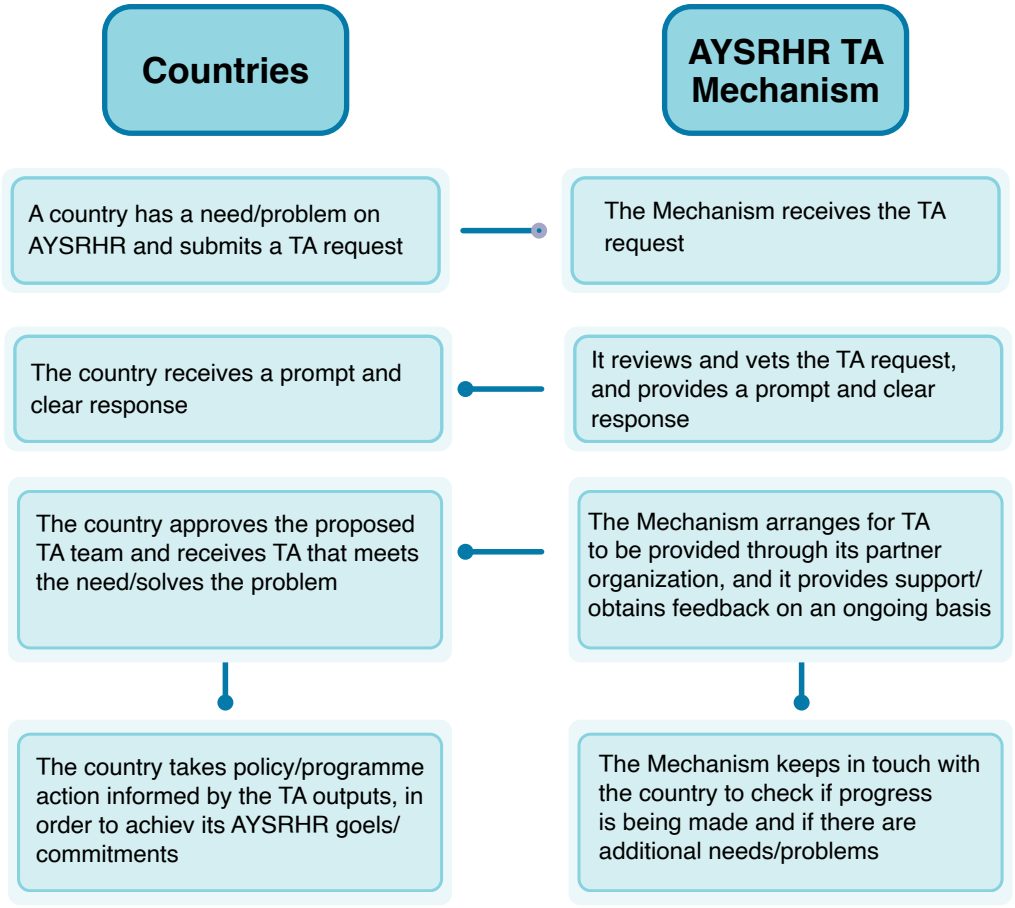
2

To do this in (innovative) ways that are timely, effective, efficient and contribute to capacity development

3

To contribute to overall thinking and lessons learned about the provision of TA.

With regard to the process used by the Mechanism (how did we want the Mechanism to function?), she took the participants through the following schematic:



With regard to the principles of the Mechanism (what considerations did we want to guide the Mechanism?), she noted that the following dos and don'ts:

What did we want to do?	What did we NOT want to do?
❋ Allow countries to self-select and ensure the MOH is in the driver's seat	❋ Respond to all requests indiscriminately
❋ Foster collaboration between partner organizations	❋ Be a 'go to' place for donors to pass on TA requests for their priority countries
❋ Select individuals/organizations based on proximity and experience	❋ Identify TA providers from a large roster of consultants (largely based in the global North)
❋ Avoid arriving with a predetermined agenda	❋ Leave it to consultants to liaise with the country and not assure quality in process/outputs
❋ Build local capacity	❋ Leave the country before responding to new/emerging TA needs identified during the initial phase of TA provision
❋ Meaningfully engage young people	
❋ Assure quality of process and outputs	
❋ Provide long-term phased engagement	
❋ Learn-by-doing	

Finally, with regard to where the Mechanism is at now, she took the participants through an overview of the objectives, requestor, modality, TA team, and status of the 11 TA requests received since the start of the Mechanism's operations (see Annex 4 – Overview of the TA requests).

Key lessons learned from various perspectives

Next, representatives from the governments that requested TA and from the organizations that provided TA shared the key lessons learned from their experiences working with the Mechanism, using standard templates (See Annex 5 – Detailed lessons learned from various perspectives). Due to time constraints, five countries were selected for in-depth discussion, followed by a shorter overview of three additional countries.

In their presentations, government representatives were asked to reflect on the following three questions:

1. What were the positive and negative aspects of the TA that you received?
2. In what ways was the TA that you received different (in positive and negative ways) from other TA that you have received in the past?
3. In what ways do you think the TA you received could have been improved? (i.e., problems and possible solutions)

Meanwhile, the organizations that provided TA were asked to reflect on the following three questions:

Remain:	What worked well & needs to be continued/strengthened?
Review/ refine:	What worked but needs improvement? (i.e., problems and possible solutions)
Rethink:	What didn't work? (i.e., problems and possible solutions)

Day 2 began with B Dick providing a synthesis of the key messages from the Day 1's presentations and discussions.

General comments about the presentations

- Some problems raised are not specific to the TA Mechanism (e.g. missing deadlines as a result of COVID-19, security issues, organizational changes, staff changes, etc.)
- Some of the issues raised have both positive and negative impacts (e.g. COVID-19, working collaboratively)
- Some challenges are inevitable in terms of how the TA Mechanism was designed (e.g. collaboration between different organizations takes time/effort)
- Not all countries/Partner Organizations had the same experiences (e.g. clarity about roles and responsibilities) and are at different phases of designing/ delivering the TA
- Some of the issues raised have already been raised through ongoing communication with the relevant countries and Partner Organization and are being dealt with (e.g. the need for an Inception meeting, ways to better engage MOHs, better ways of disbursing funds, ways of strengthening collaboration/ communication between partner organizations providing TA, meaningful youth engagement/International Youth Alliance for Family Planning)

Following this he provided a synthesis of the feedback on what needs to remain and be strengthened; what needs to be reviewed/refined; and what we need to re-think because it has not functioned well:

Remain: **What worked well & needs to be continued/strengthened?**

Key facilitators/strengths included:

Working together:

a collaborative approach, the multi-person/multi-organizational teams, and building on existing in-country collaborations

The roles of key actors:

the MOH, the Partner Organizations, the TA Mechanism secretariat and the WHO system (regional and country offices)

Processes and principles:

the development of a clear plan/activities, regular meetings/communication, flexibility, and commitment to involving young people, developing capacity, a phased/long-term involvement

Review/refine: What worked but needs improvement?

Problems included:

Clarity:

the purpose and functioning of the TA mechanism and roles and responsibilities

Processes:

developing tools and reviewing/commenting on outputs; setting and keeping to timelines; processes that are sometimes very time-consuming; the limitations of current contracting approaches

National level considerations:

capacity development, involvement of national partners/consultants, maintaining engagement of MOH, involvement of young people

The solutions proposed are incorporated below.

Rethink: What didn't work?

Problems included:

Planning

timelines are often unrealistic and not maintained; the development of tools/methods for data collection/analysis/ prioritization takes too long; clarity about focus (contraceptive uptake, ASRHR, adolescent health); budget guidance unclear and limited ceiling

Implementation:

multiple methodologies with insufficient cross-fertilization; unavailability of TA providers as a result of competing responsibilities; too many meetings and processes too complex for limited funding (e.g. contractual arrangements, details required for the development of initial plans/ expressions of interest); consideration of risks and mitigation planning

The solutions proposed are incorporated below.

Selected questions raised in the Zoom chat

A number of questions were raised in the Zoom chat, often directed to specific presenters but that have implications for the TA Mechanism more generally, including:

- How have the TA Mechanism Secretariat and TA teams worked with countries to identify and support strong MOH leadership and decision-making for the TA?
- What are the advantages/disadvantages of in-person vs virtual TA?
- How have people taken different cultural contexts into consideration?
- How much is "enough" (e.g. for thinking/finding out before taking action): is the level of effort commensurate with the likely solutions that will be identified?
- Do MOH's feel that they are in a position to push back and say "we no longer need this" (e.g. if there have been long delays and the TA is no longer useful), without negative repercussions on future support?

Priorities for the future: Building on what works, changing what doesn't

Based on the discussions on Day 1, the TA Secretariat selected the following topics for further discussion:

1. **Who's in the driver's seat?**
2. **Too many cooks in the kitchen**
3. **Everything takes sooooo long**
4. **Beyond tokenism**
5. **Teaching people to fish**
6. **The point of the spear**

This session included:

- A short recap of the problem statement, actions taken thus far, and proposed solutions (from the Secretariat's April brainstorming and Day 1 presentations and discussion)
- 10 minutes of discussion per question, including comments in the chat

01 Who's in the driver's seat

Problem statement

While the Mechanism has worked hard to ensure that the TA requests are country-owned and driven, MOH leadership and continued engagement has been a challenge in some countries (e.g. with staff changes, competing priorities, etc.)

Actions taken thus far

- Be explicit from the start that the TA is for the MOH and that the MOH is in the driver's seat
- Create space for the MOH to decide on the TA team, as long as it includes a Partner Organization
- Identify clear roles and responsibilities for the MOH and provide contracts/budgets to support activities for which the MOH is responsible (e.g. the roles that JKP is playing in the Kenya TA)
- Specify necessary data to support the TA and request assistance from MOH to obtain it (e.g. county-specific data)
- Provide periodic updates to MOH about the TA (e.g. findings, requests for support, etc.)
- Request feedback from MOH on specific activities/outputs

Possible solutions

- Continue to have introductory calls (with clear agenda) and inception meetings

- Provide more regular (e.g. monthly) updates to MOH using a standard template
- Seek permission from MOH staff to contact them directly, if needed
- Identify the “movers-and-shakers” in the country who can provide alternative channels of communication and insider-perspectives
- Expand/nurture the role of the RO and WCO with the legitimacy/political clout to nudge progress
- Establish a TA steering/coordination committee with relevant stakeholders in-country
- Agree on focal points/decision-makers and their preferred ways of working (e.g. phone calls not emails)
- Agree on timelines and regular check-in points, including realistic pause/restart (or pull-the-plug) timelines
- MOH to be encouraged to propose potential partners, capacity development needs

Discussion

- Within the MOH who is the best person to be communicating with (about the process, for decision making and to discuss the deliverables)
- Different people in the MOH have different responsibilities and therefore different people may be in the driver’s seat for different aspects of the TA - it may therefore be important to have a team of drivers rather than an individual driver
- How can the TA strengthen the capacity of the drivers and their ability to drive effectively?
- How much of a priority is this TA within the MOH: is it just another project or is it a priority programme? - important to have realistic (low?) expectations
- How to link to the SDGs (important for sustainability and regular reporting)
- At the time of the TA request, MoH Teams can articulate the key leadership team that will drive the process and the specific roles/commitments
- Take into consideration the fact that the decision-making structure is often complicated, that decision makers are not implementers and there can be a disconnect between planning and action.
- How to be flexible or identify solutions when there are human resource challenges within the MOH, when they are understaffed, overcommitted, and this activity might not be their #1 priority?
- There is no dispute that MOH leadership are drivers for the greater vision and ambition, but other stakeholders should not be excluded - they can co-drive, as the context/needs differ, and perhaps provide support to the MOH, including through seconding technical personnel to the MOH
- Importance of keeping the MOH engaged and regularly updated – don’t want to be presenting them with something that will surprise/shock them at the end of TA

02 Too many cooks in the kitchen

Problem statement

While collaboration between partner organizations was consistently noted as something positive and useful, it introduces challenges for leadership, coordination, and efficiency of the TA.

Actions taken thus far

- Spend time early in the process to develop clear roles and responsibilities, expectations, and timelines
- Support creation of a “responsibilities matrix” (e.g. the planning process in Afghanistan, Malawi and Kenya)
- Encourage regular (e.g. weekly) meetings to review progress/timelines/outputs (e.g. Malawi and Kenya)

Possible solutions

- The Secretariat to lean in to support collaboration for the TA but not to take on the routine facilitation role for ongoing activities
- Find a balance between having equitable partners in the TA response and having one partner lead so that there is a decision-maker
- TORs to be drafted by TA Mechanism and agreed upon by TA team, with a clear responsibilities matrix for all involved (i.e. Partner organizations, MOH, youth organizations and other national stakeholders)
- Clarify all TORs first and set realistic timelines to abide by
- Develop more detailed scope of work, identifying interim deliverables, roles and responsibilities, and clarify level of effort and time requirements
- Risk assessment/mitigation planning: establish parameters in advance to adapt to crises and competing responsibilities/timelines
- Find an effective balance between group consensus and individual productivity
- Make sure that the different components of the TA are coordinated/integrated (e.g. through the Summary reports that will be developed in Afghanistan and Malawi)
- Allow partnerships at the call for applications/expression of interest stage i.e. applicants can seek partnerships among the partner organizations
- Agree on preferred ways of working between collaborating partner organizations, with external consultants, etc.
- Explore systems for quality control of non-TA Mechanism partners/consultants

Discussion

- It is likely that during the process there will be different points of view: someone needs to be responsible for arbitrating
- Someone needs to “lead” the TA partnership and take responsibility for ensuring progress, collaboration, etc.

- There need to be clear roles and responsibilities, and clear identification of tasks and division of the tasks in a well-rounded manner - where tasks overlap, it becomes difficult: this also applies to any additional international/national consultants, who should be limited (and the TORs shared)
- Consider selecting a core steering team that includes representative from each of the TA partners and has clear, agreed roles
- Need to agree on who will be the final arbiter for QA - should probably be WHO/the TA Mechanism Secretariat
- The coordination for the TA needs to be integrated within existing coordination structures and technical working groups (e.g. on SRH or Adolescents Health), and needs to be discussed and reported-on regularly
- The TA Mechanism secretariat role is evolving over time as the TA Mechanism gains experience – it will be important to be clear about "must" play roles (e.g. overall quality assurance), roles that the Secretariat will sometimes play (e.g. facilitation between partner organizations and MOH), and those parts of the process where the Secretariat doesn't need to be involved
- Conflict is not bad per se! – good partnerships depend on complimentarity, which will often bring different perspectives to the table
- The "too many cooks in the kitchen" problem is not unique to the TA Mechanism!

03 Everything takes sooooo long

Problem statement

While it is helpful to spend time up front to co-create and build consensus among stakeholders about the objectives and workplans, the preparatory work is too long/ complicated for the relatively small awards.

Actions taken thus far

- Wait to request detailed proposals from Partner Organizations for a TA response until the TA team is formalized (e.g. Liberia)
- Support creation of a "responsibilities matrix" (e.g. Afghanistan, Malawi, Kenya)
- Have started the process for WHO Requests for Proposals (RFPs) which will allow for pre-qualification and higher budget ceiling (submissions will be requested from all partner organizations)

Possible solutions

- Use standard templates for workplans/budgets, while avoiding being too prescriptive
- More streamlined approach; consider seeking advice from a group like Hewlett Foundation about how they approach their processes administratively, recognizing that when smaller funding is available, processes should reflect that.
- Share expected (and realistic!) timelines for project preparation and contracting – and stick to them!
- TORs to be written by WHO staff in advance and agreed upon by TA team
- Provide resources to cover the co-creation approach

- Consider more flexible funding mechanisms, to counteract the budget limitations and allow more comprehensive thinking/strategy (in process)
- Share budget guidance and initiate pre-qualification process so that the TA providers could have budgets greater than $25K (in process)
- Include risk assessment/mitigation planning in order to be aware of likely bottle-necks/ delays
- Include ways to adapt to crises and competing responsibilities/timelines
- Review TA Mechanism materials/SOP: are there opportunities to make the processes more flexible/streamlined
- Be clear about the levels of detail that are required during initial assessments, and identify carrots and sticks in relation to timelines :)
- Consider having examples of methods for carrying out situation assessments, landscape analyses, programme reviews, etc. that can be adapted
- Important to find an effective balance between group consensus and individual productivity!

Discussion

- Again, this is a problem that is bigger than the TA Mechanism – always challenging in Ministries that are very linear/vertical
- Importance of a clear workplan and roles/responsibilities, time-line and monitoring framework
- Place the TA within existing national ASRH/adolescent health coordination structures
- Recognize that it takes time to have frequent back-and-forth's that are sometimes needed as tools and products are developed
- Can simple reporting templates speed up the processes?
- Need to reflect on different forms of "rewards" - is it only monetary or are we working for a larger cause
- More focus at the planning stage may shorten the time needed later in the process
- Consider including the TA partnership (consortium) approach from the expression of interest stage, with partner organizations identifying complementary organizations and applying together with specified tasks for each partner base on their competencies - this way much of the strategy/methodology work will have been put together at the application stage
- How to avoid "mission creep" e.g. where the TA is initially on SRH but there is then increasing interest to include information on COVID, nutrition, mental health, risky behaviours, etc., which has time implications for data collection, among others
- Consider "freezing" the time period for reviewing the data included initial assessments in order to avoid requests for more and more details
- This may sometimes also be about MOH's capacity to coordinate their request or expectations, and to share these to fit what the TA mechanism can support. There is an important "honest broker" role for the secretariat, but how can the partner organizations be more involved in co-creating the TA needs/request with clear expectations/outcomes?

04 Beyond tokenism

Problem statement

While individual TA responses have incorporated elements of meaningful youth engagement, the Mechanism could and should do more.

Actions taken thus far

- Encourage partner organizations to identify opportunities for meaningful youth engagement (MYE) in the individual TA responses (e.g. consultation with young people as part of the prioritization exercise in Afghanistan, the involvement of youth committees in Kenya and Senegal)
- Engage IYAFP as a partner organization and issue formal contract for their support to review/vet new TA requests and propose options for MYE in the responses

Possible solutions

- Include young people in all phases, including the introductory meetings/calls

Discussion

- Young people are not really represented in this meeting - it might have been useful to hear their perspectives?
- Involve young people/youth-led organizations in community consultations, in landscape analyses and in any surveys that are carried out - many useful inferences could be drawn about prioritization of health problems in Afghanistan when adolescents and young people were reached out to through Focus Group Discussions.
- Identifying young people as consultants who could be engaged throughout the TA as part of the broader team - leveraging local or regional YP networks or committees already engaged with partner organizations
- Use the TA to support MOHs to strengthen their partnerships with young people (capacity development) and build accountability mechanisms/frameworks into MOH activities (e.g. the use of score cards and community health boards) - how can the TA mechanism provide guidance to MOH's to help them understand how to do a better job of partnering with/facilitating youth participation?
- The involvement of youth is crucial, and some partner organizations (e.g. IPPF) are currently concretizing concepts around meaningful youth engagement with the idea of moving MYE from conference rooms to board rooms, with the emphasis on young people being in the space where decisions are actually made. Can we think of bringing this into the TA mechanism, ensuring that MOHs are conscious of this and bringing young people into decisions about the development of their TA needs - the partner organizations who respond to TA requests also need to indicate clearly how young people are/will be involved in the delivery of the TA
- Partner organizations can include young people working in their organizations (e.g. affiliated youth champions/advocates, etc.) at the application and TA design stage. Similarly the MOHs - most countries have youth representative in the TWGs supported by various organizations, and this can be an opportunity for engaging them
- Share preliminary findings of the TA with youth councils, youth-led organizations to see if we are missing any points that they believe are important

05 Teaching people to fish

Problem statement

While capacity development is an explicit objective of the Mechanism and has occurred to some extent, the Mechanism could and probably should do more (although expectations need to be realistic)

Actions taken thus far

- Encourage engagement from individuals at different levels of partner organizations: global, regional and national (e.g. Sierra Leone, Kenya, Senegal)
- Engage local organizations/consultants as part of the TA team (e.g. Malawi)
- Offer blended-learning courses on AYSRHR to country stakeholders (e.g. the Afghanistan MOPH participating in the Geneva Foundation for Training and Research MENA course)

Possible solutions

- Ensure the TA team has an in-country presence (national counterparts)
- Need to be opportunistic and intentional with capacity development
- MOH to be encouraged to propose what capacity development would be useful from their perspective
- Involve national partners/consultants, but ensure systems for quality control
- Organize site visits for MOH staff in other similar countries

Discussion

- Consider carrying out a needs assessment for capacity development at different steps of the TA during the initial planning phase (what is the capacity, what needs to be done by whom?)
- Identify the key capacity gaps in order to target mentorship and sensitization sessions.
- Capacity development/building needs to be intentional (a capacity transfer plan) - it should be a deliverable but it needs resources if it is to be done effectively
- “Learning to fish” needs on-going support, and need to know what skills the TA providers have for capacity building/mentoring/coaching?
- It would be helpful to agree on priority thematic areas of interest for capacity development (e.g. adolescent contraceptives/contraception; AYFS; etc.) and develop simple approaches to strengthen capacity in these areas - this would enable TA team members to deliver appropriate capacity development within the context of the TA, whilst recipients would also be enabled to request themes that meet their needs
- If there is to be a serious focus on capacity building this will have significant implications for the timeframe/resources for the TA?
- Could consideration be given to country exchanges, so that TA recipients can benefit from the experiences of a partner in a different country?

- Engage the MoH/national counterparts in the entire process, including the development of methods/tools etc. and where possible/appropriate support them to lead key processes while the TA partners play a technical facilitating role, together with mentorship and coaching?
- Important to remember that MOH staff are very busy and might not be able to "learn to fish" at the present time - they might just need someone to give them the fish right now because adolescents need the information/services NOW.
- Does the TA mechanism always want to strengthen capacity (and if so, would it decline TA requests where the MOH is not ready/interested to have capacity built) - or is it more a question of including capacity strengthening where it is desired (and resource it)?

06 The point of the spear

Problem statement

While the Mechanism tries to use adolescent contraception as the entry point to addressing AYSRHR more broadly, there have been challenges in defining the problem and/or the scope of the TA.

Actions taken thus far

- Support the MOH to clarify and confirm the problem(s) and objective(s)
- Onboarding/introductory calls with various stakeholders at the start to reach consensus
- Include key issues that go beyond but are related to ASRHR (e.g. nutrition in Afghanistan, HIV in Malawi)

Possible solutions

- Identify opportunities to link with other on-going processes in countries
- Support the MOH to better formulate the problem(s) and objective(s) and identify ways to include other adolescent health problems (e.g. mental health)
- Onboarding call with all relevant parties (including the WHO country and regional team) before the TA to reach consensus
- Where possible, include and/or link to other related areas (e.g. GBV) – but not too many of them!
- Be clear about links between TA and other in-country processes for AYSRHR and beyond …
- Accept that opportunities to strengthen on-going adolescent health processes are not a sufficient reason (on their own) to accept a TA request – there must be a partner organization involved, there must be a central ASRHR component, etc.

Discussion

- General agreement that this is a very complex issue: finding a balance
- General agreement that our experiences so far indicate that MOHs are keen to include a number of related issues: SGBV, early marriage, mental health, nutrition, substance abuse

- Adolescent pregnancy/contraceptive uptake is what is drawing in the interest of countries, but to address the issue opens a Pandora's box of issues!
- The TA Mechanism (Secretariat, WCO/regional offices, and partner organizations) needs to do a better job of documenting how we are dealing with/responding to this issue
- Everyone is open to other issues being included - just want to ensure that contraception is a central concern and that we and do not take on too much
- While thinking broadly it is important to remain focused - the are many linkages and determinants that need to be thought about and emphasizing them is important, but remaining focused is also important …
- May be strategic to help the MOH draw the link between adolescent contraception and the SDGs, and human rights, social/economic development more generally.
- A focus on contraception raises many issues, for example the stigma related to adolescents and contraception, which need to be confronted (e.g. challenging societal norms)
- While the TA Mechanism stays focused, it will be important to understand and link with strategies that address the cross-cutting issues and a more comprehensive approach that includes addressing the structural (policy/culture etc.), biomedical and behavioural issues
- The complexity of addressing multiple health issues with multiple sectors and partners at various levels can be overwhelming - having clarity about what needs to be done, who needs to (and can) take action in relation to what others are doing is crucial for moving forward.
- An approach that builds champions/advocates within other sectors/programmes, rather than AYSRH trying to tackle all these other fields, may be more efficient and sustainable (e.g. championing ASRH within maternal and neonatal health

Additional points from the general discussion

1. The model for TA is/will be different for different problems, and different countries, situations, contexts - need to be aware of and document the similarities and differences
2. Need to document the lessons learned about/from different mechanisms for providing TA
3. Need to identify/explore the implications of doing things differently: to encourage flexibility and provide a "safe" environment for trying out new approaches/processesa

Closing & next steps

At the end of the workshop, participants agreed on the following next steps.

First, a meeting report would be developed.

Secondly, the decisions made during the course of the meeting would be integrated into the Mechanism's Standard Operating Procedures.

Thirdly, the challenges that could not be discussed during the meeting due to time constraints will would be discussed on an ongoing basis during the monthly partners meetings.

Fourthly, a journal paper would be developed to contribute to the broader evidence-base on the provision of TA.

ANNEX 1 – OVERVIEW OF THE AYSRHR TA MECHANISM

The AYSRHR Technical Assistance Coordination Mechanism World Health Organization – Family Planning Accelerator Project

This report summarizes the proceedings of the 'Review meeting for the WHO Adolescent and Youth Sexual and Reproductive Health and Rights (AYSRHR) Technical Assistance (TA) Mechanism,' organized by the World Health Organization's (WHO) Department of Sexual and Reproductive Health and Research (SRH) and the Human Reproduction Programme (HRP) in June 2021.

Objective:

To deliver TA that countries need for designing, implementing, monitoring, reviewing and documenting their AYSRHR programmes*, in ways that are timely (through a mechanism that can respond in a punctual manner); effective (from individuals with the right technical and practical experience in a similar context, with back-up from evidence-based programme-support tools); efficient (from experts located as close to the respective country as possible, using methods that are cost-effective); and, where appropriate, in ways that contribute to strengthening national capacity.

*While the focus of the TA Coordination Mechanism is AYSRHR, particular emphasis will initially be placed on improving adolescent and young people's uptake of contraception as an entry point.

Rationale

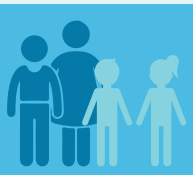
At the end of the workshop, participants agreed on the following next steps.

First, a meeting report would be developed.

Secondly, the decisions made during the course of the meeting would be integrated into the Mechanism's Standard Operating Procedures.

Thirdly, the challenges that could not be discussed during the meeting due to time constraints will would be discussed on an ongoing basis during the monthly partners meetings.

Fourthly, a journal paper would be developed to contribute to the broader evidence-base on the provision of TA.



Adolescents and young people in many places are unable to obtain and use SRH information and services.

Laws and policies can hinder the provision of SRH information and services to adolescents and young people based on age and marital status.

Health workers may impose their own restrictions due to personal biases and are not held accountable for doing so.

Adolescents and young people are often not empowered or supported to obtain/use AYSRHR services. For example, they face barriers that prevent the consistent/correct use of contraception (e.g. pressure to have children, stigma surrounding non-marital sexual activity/ contraceptive use, fear of side effects, lack of knowledge on correct use).

AYSRHR programmes are often poorly designed, implemented, monitored, and documented.

AYSRHR strategies and plans are often not based on sound data and evidence.

Implementation of strategies and plans is often patchy, at best.

Measurement frameworks, regular monitoring, and periodic reviews are not in place, and relevant data are not available/used for decision-making.

Lessons are not systematically synthesized and shared. As a result, successful approaches are not adapted and replicated, and failed approaches are repeated.

However, countries are increasingly indicating interest in developing and implementing AYSRHR programmes.

Countries need support to develop **evidence-based AYSRHR commitments, plans, and strategies,** with allocated budgets.

Countries that have developed AYSRHR commitments, plans, and strategies need support to **operationalize and implement** them.

What kinds of requests can the AYSRHR TA Coordination Mechanism respond to?

Understanding the extent and causes of a problem	**Sample question:** We would like to learn more about which adolescents are/are not using AYSRHR services, and why. Could you help us better understand the factors affecting the provision and use of AYSRHR services by different groups of young people?
Understanding the extent and causes of a problem	**Sample question:** We have learned about what needs to be done to meet the SRH needs and problems of adolescents. However, sometimes we are told different things by different organizations. Could you please help us decide what to do for the different groups of adolescents in our country?
Understanding the extent and causes of a problem	**Sample question:** We think we know what needs to be done to respond to AYSRHR priorities, but we are not sure how to do it, in our context. Could you guide us on developing effective strategies and an operational plan?
Understanding the extent and causes of a problem	**Sample question:** We are clear about what we want to do to meet the SRH needs and problems of adolescents, but we are not sure about how to place these things in a broader investment case or link them with existing programmes. Could you help us do this?
Understanding the extent and causes of a problem	**Sample question:** We have had an adolescent health programme for some time but are not sure how well we are doing. Could you help us assess the programme, identify the lessons learned and develop a monitoring framework for our adolescent and youth SRHR activities?

How does the AYSRHR TA Coordination Mechanism work?

Countries interested in receiving TA through the AYSRHR TA Coordination Mechanism should submit a request using the mechanism's standard template.

The request will then be reviewed by the Secretariat using a standard set of criteria, and decisions will be made on whether to provide TA, what TA to provide, when to provide it, and how it will be provided.

The TA that is provided will be guided by a Standard Operating Procedure with standardized processes and tools, including for the development of TA plan with clear activities and milestones.

Monitoring of the mechanism will track TA requests, the TA that is provided, how the TA is utilized, and outcomes resulting from the TA in order to support an iterative process for the on-going development of the TA Mechanism.

For more information or to access a request template:

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ANNEX 2 – LIST OF PARTICIPANTS

	Name	Affiliation
1	Naziha Ahmadi	MoPH Afghanistan
2	Jamela Al-Raiby	WHO EMRO
3	Caroline Bakasa	PSI Malawi
4	Sonja Caffe	WHO PAHO
5	Venkatraman Chandra-Mouli	WHO HQ / AYSRHR TA Mechanism Secretariat
6	Paata Chikvaidze	WHO Afghanistan
7	Caitlin Corneliess	PATH
8	Bruce Dick	Independent consultant / AYSRHR TA Mechanism Secretariat
9	Jane Ferguson	Independent consultant
10	Priyanka Garg	MAMTA Health Institute for Mother and Child
11	Sheena Hadi	Aahung
12	Binyam Hailu	WHO Sierra Leone
13	Gwyn Hainsworth	Bill and Melinda Gates Foundation
14	Alain Kabore	PATH Senegal
15	Rita Kabra	WHO HQ
16	Flaura Kidere	JKP / Pwani University
17	Kauma Kurian	MAMTA Health Institute for Mother and Child
18	Cate Lane	FP2030
19	Cosima Lenz	EGPAF
20	Devika Mehra	MAMTA Health Institute for Mother and Child
21	Sunil Mehra	MAMTA Health Institute for Mother and Child
22	Kenneth Miriti	Kilifi County Government
23	Abdu Mohiddin	Aga Khan University
24	Angela Muriuki	Save the Children Kenya
25	Hamdard Naqibullah	Independent consultant / CARE Afghanistan
26	Dieynaba Ndao	WHO Senegal
27	Alan Jarandilla Nuñez	IYAFP
28	Elizabeth Okoth	EGPAF Kenya
29	Rasoul Peerzad	MoPH Afghanistan
30	Marta Pirzadeh	Pathfinder International
31	Marina Plesons	WHO HQ / AYSRHR TA Mechanism Secretariat
32	Sirazul Sahariah	MAMTA Health Institute for Mother and Child
33	Rachel Samdahl	EGPAF
34	Ishmael Selassie	IPPF Ghana
35	Sarah Shaw	MSI
36	Khalid Siddeeg	WHO EMRO
37	Callie Simon	Save the Children
38	Marie Syr	Ouagadougou Partnership Coordination Unit
39	Amy Uccello	Independent consultant/USAID
40	Hadassah Wachsmann	IPPF
41	Brian White	EGPAF

ANNEX 3 – AGENDA

9 June – What did we set out to do? What have we achieved? What have we learned? Participants: AYSRHR TA Mechanism Secretariat, partner organizations, ROs, WCOs, and MOHs		
2:30 – 2:50	Introductions and overview of the meeting Update on the Mechanism's status after 18 months	AYSRHR TA Mechanism Secretariat
2:50 – 4:30	Key lessons learned from the perspective of: ❋ People requesting the TA ❋ People responding to the TA requests *5-7minute presentations on selected countries followed by discussion in plenary*	**Sierra Leone:** MOHS and Save the Children **Afghanistan:** MOPH and MAMTA/CARE **Malawi:** MOH and PSI/MSI/Jane Ferguson/ Amy Uccello **Kenya:** JKP and AKU/EGPAF **Senegal:** MOH and PATH Cameroon, Colombia, and Nigeria: Bruce
10 June - Building on what works, changing what doesn't Participants: As above, plus Bill and Melinda Gates Foundation and other WHO HQ colleagues		
2:30 – 3:00	Summary of the key lessons learned from Day 1	AYSRHR TA Mechanism Secretariat
3:00 – 4:15	Priorities for the future: building on what works, changing what doesn't Discussion in plenary	All
4:15 – 4:30	**Closing and next steps**	**AYSRHR TA Mechanism Secretariat**

ANNEX 4 – OVERVIEW OF THE TA REQUESTS

Date received	Objective	Requestor	Modality	TA team	Status
Afghanistan	To better understand the SRHR needs of adolescents and the status of the MOPH's policies and programmes and set out options for strengthening the national response	MOPH	Briefing call with FP2020 regional focal points.	CARE Afghanistan and MAMTA Health Institute of Mother and Child	ONGOING - The desk review and landscape analysis have been finalized. The prioritization exercise is underway.
Cameroon	To develop a strategy and operational plan for strengthening demand generation and contraception service provision for adolescents and young adults in eight state-owned universities.	MOPH	Briefing at the FP2020 Francophone FPW (Dakar, March 2020).	EGPAF (country and HQ teams) and perhaps independent consultant (Pierre Andre-Michaud)	PLANNING PHASE – Planning has resumed after staff changes in the MOPH.
Colombia	To strengthen AFHS through the inclusion of the WHO global standards for AFHS in the national quality assurance system, using the entry point of adolescents' uptake of contraception (esp. LARCs).	MOH	Briefings with PAHO.	-	DECLINED - The MOH had two on-going programmes and had already identified independent consultants to provide the TA that was required. Thus, what they were looking for was not TA from the Mechanism's partner organizations but funds.

Kenya	To support the six coastal counties that are part of the Jumuiya ya Kaunti za Pwani economic bloc to plan and implement joint activities to address adolescent pregnancy.	Jumuiya ya Kaunti za Pwani Secretariat (JKP)	Workshop on adolescent pregnancy (Mombasa, December 2019).	Aga Khan University (AKU) (country team) and EGPAF (country and HQ teams)	ONGOING – The TA team is preparing for the inception meeting.
Liberia	To support the capacity building of health workers to provide appropriate, accessible, and acceptable services for adolescent health, with a focus on ASRH.	MOH	Briefing at the FP2020 Anglophone FPW (Addis Ababa, May 2019).	CARE Sierra Leone and perhaps independent consultant	**PLANNING PHASE** – The proposal for the TA team is being finalized, for approval by the MOH.
Malawi	To better understand why – despite substantial investment and efforts on ASRHR – the country is not seeing the progress they'd like to see on adolescent contraception and early pregnancy.	MOH	Briefing at the FP2020 Anglophone FPW (Addis Ababa, May 2019).	PSI Malawi, MSI (HQ team), and two independent consultants (Amy Uccello and Jane Ferguson)	ONGOING – The mapping analysis has been completed. The review of reviews, KIIs, and costing analysis are underway.
Mali	To conduct a review of the Plan d'Action Multisectoriel Santé des Adolescents et des Jeunes 2017-2021 and contribute to the development of the post-2021 plan.	MOPHH	In follow up to a briefing at the FP2020 Francophone FPW (Dakar, March 2020) and outreach by the Ouagadougou Partnership.	Equipop and national organizations	PLANNING PHASE – The proposal for the TA team has been shared with the MOPHH, for their approval.
Nigeria	Phase 1: To strengthen the SRH component of the draft national adolescent health and development policy and implementation plan. Phase 2: To strengthen implementation of the new policy at the state and local government area levels.	FMOH	At the prompting of the Foundation.	Phase 1: Independent consultants (Bruce Dick and Jane Ferguson) Phase 2: TBD	**Phase 1: COMPLETED** **Phase 2: PLANNING PHASE** – Awaiting formal TA request.

Senegal	To carry out an analysis of adolescent pregnancy in the country and develop a strategy, operational plan, and M&E plan to decrease adolescent pregnancy, with a focus on married adolescents.	MOHSA and youth-led	Briefing at the FP2020 Francophone FPW (Dakar, March 2020) and outreach by the Ouagadougou Partnership.	PATH (country and HQ teams)	**PLANNING PHASE** – The proposal for the TA team has been shared with the MOHSA, for their approval.
Sierra Leone	Phase 1: To develop national guidelines for health workers on providing quality care for pregnant adolescents and first-time adolescent mothers. Phase 2: To develop a training module that can be incorporated into the existing EmONC and FP training packages.	MOHS and UNFPA	A direct request for WHO support.	Save the Children (country, regional, and HQ teams)	Phase 1: COMPLETED Phase 2: PLANNING PHASE – The workplan is being developed, for approval by the MOHS.
Togo	To improve communication and information provision on AYSRH, specifically by carrying out a situation analysis, developing a national communication strategy and operational plan; and supporting implementation of the plan.	MOH	In follow up to a briefing at the FP2020 Francophone FPW (Dakar, March 2020) and outreach by the Ouagadougou Partnership.	IPPF (Togo member association, ATBEF, and regional and HQ teams)	PLANNING PHASE – The proposal for the TA team has been shared with the MOH, for their approval.

ANNEX 5 – DETAILED LESSONS LEARNED FROM VARIOUS PERSPECTIVES

Sierra Leone
MOHS and UNFPA

***Note:**

The MOHS and UNFPA Sierra Leone were not able to provide feedback for this meeting, so the participants instead reviewed feedback that was provided by them at the end of Phase I. This feedback included the following points:

In August 2019, Sierra Leone submitted a TA request to the AYSRHR TA Mechanism. The purpose of the TA was to support the revision of the draft guidelines on provision of quality care for first-time adolescent mothers. The application was successful and the country was notified that Save the Children had been identified to support the process. Multiple conference calls were organized with Save the Children and the Mechanism's Secretariat to clarify the expected outputs and to ensure that planned actions were on track. An in-country validation and stakeholder consultation workshop was held in the last week of February 2020. The TA process was very consultative and the TA was timely, effective, efficient and with good quality control. Two drafts of the documents were produced and reviewed by in-country stakeholders. The Sierra Leone MOHS was positive that the expected outputs would be achieved within the time frame provided.

Save the Children		
Remain: What worked well & needs to be continued/strengthened?		❋ Using a multi-person team with complementary expertise and significant experience working with and negotiating MoH processes. ❋ Added value of an in-country and a regionally based team member. ❋ Ability to leverage on expertise available within the TA mechanism. ❋ Having the MOHS and UNFPA as joint TA recipients. ❋ Having a clear decision maker particularly during the validation meeting and post-validation reviews/finalization process. ❋ The multi-disciplinary team involved in the validation process
Review/refine: What worked but needs improvement?	**Problem**	❋ Lack of clarity on the role and purpose of the TA mechanism by in-country partners. ❋ Remote TA (pre-pandemic) ❋ Lengthy review and feedback processes ❋ Difficulty in continuing with the roll out of the guideline due to competing priorities
Rethink: What didn't work?	**Solution**	❋ On boarding call with all relevant parties (including the WHO team) before the TA ❋ Agree on preferred ways of working ❋ Agree on review timelines and parties to be involved ahead of time ❋ Agree on realistic pause and restart (or pull the plug) timelines with all parties involved
	Problem	None
	Solution	None
Afghanistan MOPH		
What were the positive and the negative aspects of the TA that you received?	**Positive**	❋ Availability of Landscape analysis and Desk review as comprehensive Documents ❋ Strengthen capacity of national staff ❋ Responsive to major request of MOPH relevant to SHRH ❋ SRHR was proposed to be reflected in the upcoming National Strategy and policy of the MOPH. ❋ The TA assist us to integrate the services in to IPEHS package which is under developing.
	Negative	❋ Road map not developed ❋ National workshop was not conducted ❋ Sharing knowledge to local staff on evidence-based interventions to improve the SRHR ❋ The landscape report was too long (109 Page) compared to Desk review

In what ways was the TA that you received different from other TA that you have received in the past?	**Positive difference**	❋ RMNCAH was involved in all process ❋ The concept note was developed by the RMNCAH ❋ Progress of activities were updated by the Partner / implementers ❋ Inclusion of capacity building of national staff in this TA ❋ Presence of local contractors to conduct the assessment (Care Int)
	Negative difference	❋ Physical absence of the principal investigator in the country ❋ Delay in implementation of each phase.
In what ways do you think that the TA you received could have been improved?	**Problem**	❋ Physical absence of the principal investigator in the country. ❋ Delay in implementation of each phase ❋ Knowledge sharing to Local staff was not done. ❋ Comparison of existing services with neighbor country considering the UHC
	Solution	❋ The principal investigator should be in the country for better implementation. ❋ Commitment of the implementer and development of comprehensive plan. ❋ Exposure visits of countries (Egypt, Iran) with successful implementation of SRHR ❋ Build more capacity of National staff on YASRHR through internal experts.
CARE and MAMTA		
What were the positive and the negative aspects of the TA that you received?		❋ The step-by-step strategy/activities that were clearly set out in the proposal ❋ Regular meetings between WHO and TA delivering organizations for updates and guidance. ❋ Internal connect between the TA partners ❋ The list of links to possibly relevant documents from WHO ❋ The joint collaboration of two organizations, one organization as an external technical expert reviewing the existing research neutrally and another organization with local presence, that collected local evidence complemented each other in the process ❋ The step-by-step feedback and support from WHO has been key for to ensure the quality of TA. ❋ The flexibility of WHO to accommodate the identified needs to further explore policy makers and community inputs into prioritization have made the TA more locally relevant and nationally owned. ❋ The support from Child Health Department (CAH) to coordinate local research activities with partners and proved as effective in tasks completion and high response rate.

Review/refine: **What worked but needs improvement?**	**Problem**	❋ Engagement of Health ministry from the country that requested TA. ❋ Synthesis of global evidence about effective intervention during the prioritization ❋ Identification of effective/feasible programs or interventions and recommendations
	Solution	❋ Preparing the list of relevant documents/reports that are not in public domain would ease the process of review ❋ A focal person from the ministry to be nominated. TA s That way, the TA delivering organizations can reach them as necessary. ❋ TA steering or coordination committee from relevant departments of ministry that requested the TA with regular monthly meetings. ❋ Global evidence may be synthesized in parallel to/as part of the landscape analysis ❋ Final recommendations/identification of effective or feasible interventions during prioritization may be done after the policy level and community level consultations is completed. Initially, a list of recommendations can be provided based on the desk review, global evidence and landscape that can be decided and firmed up in consultation with the stakeholders.
Rethink: **What didn't work?**	**Problem**	❋ Data updating as a continuous process seems difficult. It is challenging to update the data as and when it becomes available/accessible ❋ Methodology for Prioritization ❋ The timelines got too stretched than what was set out in the TOR ❋ The uncertainly and sustainability of future of the TA.
	Solution	❋ Need to freeze the period for reviewing the data on health issues ❋ Country or region-specific methodology needs to be developed based on the existing research. ❋ The methodology used here which it builds evidence, policy and community level, may be used in other countries, and can further be improved ❋ May be more realistic timeline for future TA's ❋ There is need that partners will agree future steps based on current need and at least for 3 to 5 years.

Malawi
MoH: Ministry of Health

***Note:**

The MOH Malawi's feedback was received after the meeting. It was thus not discussed during the course of the meeting.

What were the positive and the negative aspects of the TA that you received?	**Problem**	❋ Review the Health Situation of Adolescents and Youth in Afghanistan. ❋ Identifying the countries TA needs ❋ Developing own roadmap ❋ Multisectoral involvement ❋ Frequent Updates mostly inception phase ❋ Government leadership ❋ Wider consultations ❋ Guidance from WHO
	Negative	❋ Prolonged time of execution ❋ Less interactions during last phase ❋ Delayed findings and recommendations
In what ways was the TA that you received different from other TA that you have received in the past?	**Positive difference**	❋ Methodology changes ❋ Mostly research support rather than technical support ❋ TA producing expected deliverables and not government entities ❋ Focus on youths unlike married women
	Negative difference	❋ Covid 19 impact
In what ways do you think that the TA you received could have been improved?	**Problem**	❋ Working with government youth focal points ❋ Speed ❋ Time constraints ❋ Disseminating findings and allow task teams to discuss and implement the recommendations to test its feasibility
	Solution	❋ Work on addressing the problems ❋ Test each recommendation for practicality

Malawi PSI and independent consultants (Jane Ferguson and Amy Uccello)

Remain: **What worked well & needs to be continued/strengthened?**		❋ Diverse TA team offering variety and complementary perspectives and technical contributions ❋ Persons on the ground, available and knowledgeable, including involvement of country MoH ❋ Publications/progress reports widely available ❋ Participation of different types of organizations: government, INGOs, local NGOs incl. youth-led organizations allowing breadth of inputs and analyses ❋ Flexibility in timelines accounting for changing environments as a result of COVID-19 as well as professional and personal constraints ❋ Feedback from local experts mid-way through analysis to identify missing documentation, receive updates post-documentation, and refine conclusions ❋ Regular team meetings to discuss approaches and check progress ❋ Goal and aims defined by the country translated into the TA TORs
Review/refine: **What worked but needs improvement?**	**Problem**	❋ Lack of clarity about MoH throughout the process ❋ Unclear understanding of the phases & tasks and what success would look like for the country* ❋ Lack of clarity of roles/responsibilities within the framework: WHO vs consultants vs MoH ❋ Difficult to maintain timelines ❋ Methodology that did not include collection and analyses of data (data on uptake, service delivery, pregnancy, HIV rates by district, etc.), limiting data analysis as part of the overview of the actual situation
	Solution	❋ In advance clarify expectations of MOH's engagement (who, what, when) & establish regular check-in points ❋ TORs to be written by WHO staff in advance and agreed upon by TA team ❋ Clear responsibilities matrix for TA team members & MoH ❋ Clarify all TORs first and set realistic timelines to abide by ❋ Specify necessary data to support the activity and request assistance of MoH staff to obtain it

Rethink: **What didn't work?**	**Problem**	❋ Misaligned availability and time commitments as a result of multiple participants with competing responsibilities ❋ Extensive processes to develop/refine methodologies and data collection tools amongst team members & WHO exceeding planned level of effort & timelines ❋ Improvements needed to the multiple methodologies used to answer the same question (e.g., each activity needed to better speak to one another for a smoother final merge)
	Solution	❋ Establish parameters in advance to adapt to crises and competing responsibilities/timelines ❋ Develop more detailed scope of work, identifying interim deliverables, roles and responsibilities, and clarify level of effort and time requirements ❋ Effective balance between group consensus and individual productivity ❋ Streamline the methodologies; technical/financial mapping analyses remain separate

Kenya
Jumuiya ya Kaunti za Pwani

***Note:**

Because the TA in Kenya is just getting started, the JKP presented their reflections on a separate piece of TA that they received recently.

What were the positive and the negative aspects of the TA that you received?	**Positive**	❋ The geographies have developed adolescent and youth sexual reproductive health strategy documents, ❋ The TA enabled us to identify and implement several high impact interventions. ❋ The TA mechanism involved a sustainability mechanism (raise assessment)
	Negative	❋ The TA did not cover all the geographical areas hence interventions are not uniform in all the counties ❋ The TA did not address related areas e.g. mental health and SGBV interventions for adolescents
In what ways was the TA that you received different from other TA that you have received in the past?	**Positive difference**	❋ The business unusual model in which the government was to commit funds on an increasing trend as the TA commitment. ❋ The TA mechanism was expanded gradually to cover more and more units per county
	Negative difference	❋ The TA mechanism ended the same time for the first and the last geographies that were enjoined
In what ways do you think that the TA you received could have been improved?	**Problem**	❋ Varying timing in starting the TA across various ❋ Lack of means to include other outlying areas e.g. mental health SGBV and menstrual health
	Solution	❋ All the counties should have got the support simultaneously for uniformity ❋ The TA should cover other related areas like in a snowballing model

Kenya: AKU and EGPAF

***Note:**

Because the TA in Kenya is just getting started, the JKP presented their reflections on a separate piece of TA that they received recently.

Remain: **What worked well & needs to be continued/strengthened?**		❋ Client driven and owned e.g. requested by them (JKP) ❋ Collaborative approach ❋ TA providers and JKP (client) and funder ❋ Consultative, co-created, and owned by all at all stages ❋ TA Partnership approach and unique contributions e.g. AKU experience in the coastal health landscape, and EGPAF experience on ASRHR policy work. Coupled with trust and quality ❋ Clearly designated and agreed upon roles while ensuring coordinated information flow throughout activities ❋ FP acceleration is a big local gap so appropriate focus given local needs. ❋ Sustainability/ client capacity strengthening across board e.g. design, implementation ❋ Meaningful youth engagement: intentional thinking and youth engagement throughout the TA approach (YACS, CAYA, IYAFP, innovation lab youth) ❋ Flexible approach in response to COVID-19 considerations and constraints
	Problem	❋ EGPAF/AKU working ok ❋ APW funding mechanism is limiting, and confines planning e.g. Stage 1 budget of US$25k ❋ Time consuming: processes, extensive meetings (high LOE) vs resource available at initial stages ❋ Consideration of risks and mitigation planning was not done at the conceptual stage
In what ways was the TA that you received different from other TA that you have received in the past?	**Positive difference**	❋ Allow partnerships at the call for applications stage i.e. applicants can seek partnerships ❋ Consider more flexible funding mechanisms, to counteract the budget limitations and allow more comprehensive thinking / strategy ❋ More streamlined approach and resources to cover the co-creation approach ❋ Risk assessment/ mitigation planning for stage 2/ future

	Solution	❋ Allow partnerships at the call for applications stage i.e. applicants can seek partnerships ❋ Consider more flexible funding mechanisms, to counteract the budget limitations and allow more comprehensive thinking / strategy ❋ More streamlined approach and resources to cover the co-creation approach ❋ Risk assessment/ mitigation planning for stage 2/ future
In what ways do you think that the TA you received could have been improved?	**Problem**	❋ Co-creation resources gap ❋ Time taken and considerable meetings ❋ Consider focus also on other emerging ASRH issues e.g. SGBV,
	Solution	❋ Co-creation is a great strategy, and needs to be planned for including resources to cover LOE ❋ More streamlined ❋ Clients to work with TA partners to exhaust possible ASRH TA areas

Senegal
MoH: Ministry of Health

What were the positive and the negative aspects of the TA that you received?	**Positive**	❋ Juste préciser que l'assistance technique (AT) demandée par le Sénégal est en cours ❋ Echanges entre le ministère de la santé (MSAS), l'association de jeunes et l'OMS ❋ Développement de l'assistance technique (AT) par PATH en collaboration avec le MSAS ❋ Réunion entre ministère
	Negative	❋ Rien
In what ways was the TA that you received different from other TA that you have received in the past?	**Positive difference**	❋ C'est la première assistance technique demandée et qui est en cours d'exécution
	Negative difference	❋ Rien
In what ways do you think that the TA you received could have been improved?	**Problem**	❋ L'assistance technique étant en cours d'exécution, il serait préférable d'attendre la fin de la mise en œuvre pour une bonne évaluation
	Solution	❋ Rien

Senegal PATH

Remain: **What worked well & needs to be continued/strengthened?**		❋ Introductory calls between WHO, MOH, and NGO partners allow all parties to build a common understanding of the priority problem to be addressed and key points of the TA scope. ❋ Responding to AYSRH needs as they emerge and are articulated by youth-led entities in-country is a great starting point.
	Problem	❋ Introductory call was held but youth-led organizations did not attend. ❋ Introductory call would benefit from clear agenda and goals.
In what ways was the TA that you received different from other TA that you have received in the past?	**Solution**	❋ Include youth leaders at the early stage of the process, including in introductory calls. ❋ Ensure clear agenda and goals are shared for the introductory call(s), with clarity of facilitation and expected contributions by all parties.
Rethink: **What didn't work?**	**Problem**	❋ The priority problem to be addressed is not accurately defined, leading to confusion and misunderstanding between parties, or lack of clarity in scope of TA. ❋ Timeline for preparing project and finalizing contracting is protracted, unclear, and relatively complex for a small award. The stop-and-go nature of getting contracts started impacts TA team's ability to plan our work internally. ❋ Budget guidance not clear early (format, level of detail, approved rates, etc.), and limited ceiling.
	Solution	❋ Support the country to formulate problem as accurately as possible to highlight the expected results/changes and the project's priority targets ❋ Share expected timeline for project preparation and contracting. Consider seeking advice from a group like Hewlett Foundation about how they approach their processes administratively, recognizing that when smaller funding is available, processes should reflect that. ❋ Share budget guidance and initiate pre-qualification process so that the TA providers could have budgets greater than $25K.

Cameroon, Colombia, & Nigeria
Consultant: Bruce Dick

Remain: **What worked well & needs to be continued/strengthened?**		❋ Good engagement by Regional Office (e.g. Colombia) ❋ Good support from WCO (e.g. Nigeria) ❋ The "honest broker" role of the TA Mechanism helped to be clear if what the MOH really wanted was a good fit for what the TA Mechanism had been designed to do – and willingness to say "no" if it wasn't (Colombia) ❋ Patience and understanding from Partner Organizations, despite investing time and energy into developing a plan for providing the TA (EGPAF Cameroon) ❋ The processes that have been agreed for drafting formal requests for TA have helped to avoid investing time unneccesarily in developing plans to respond to "informal" request(e.g. Nigeria)
Review/refine: **What worked but needs improvement?**	**Problem**	❋ Being clear about how the TA functions (Colombia, Cameroon) ❋ Having effective channels for communication with MOH (significant time wasted in Cameroon) ❋ Identfying potential opportunities to link with on-going processes (e.g. Colombia, Nigeria)
	Solution	❋ Review documents describing the TA Mechanism: what it is/isn't, how it functions ❋ Develop/strengthen formal and informal communication with MOH ❋ Nurture the role of the WCO ❋ Accept that this is not sufficient reason for the TA Mechanism to respond positively to the request
Rethink: **What didn't work?**	**Problem**	❋ Understanding how the TA functions (i.e. working through Partner Organizations, not a funding facility) ❋ Managing situations where the MOH clearly wants to work with a non-TA Mechanism Partner and/or MOH consultants (quality control etc.) ❋ •Ensuring continuity in work when there are staffing changes in the MOH ❋ Knowing when to stop "pushing" for a proposal to be developed (e.g. Nigeria, Cameroon)
	Solution	❋ Role of WCO ❋ Review SOP to ensure clarity ❋ Trial the proposed approach that Equipop is planning for Togo ❋ MOH to decide on who to provide TA, but needs to be a Partner Organization (or a PO with others)