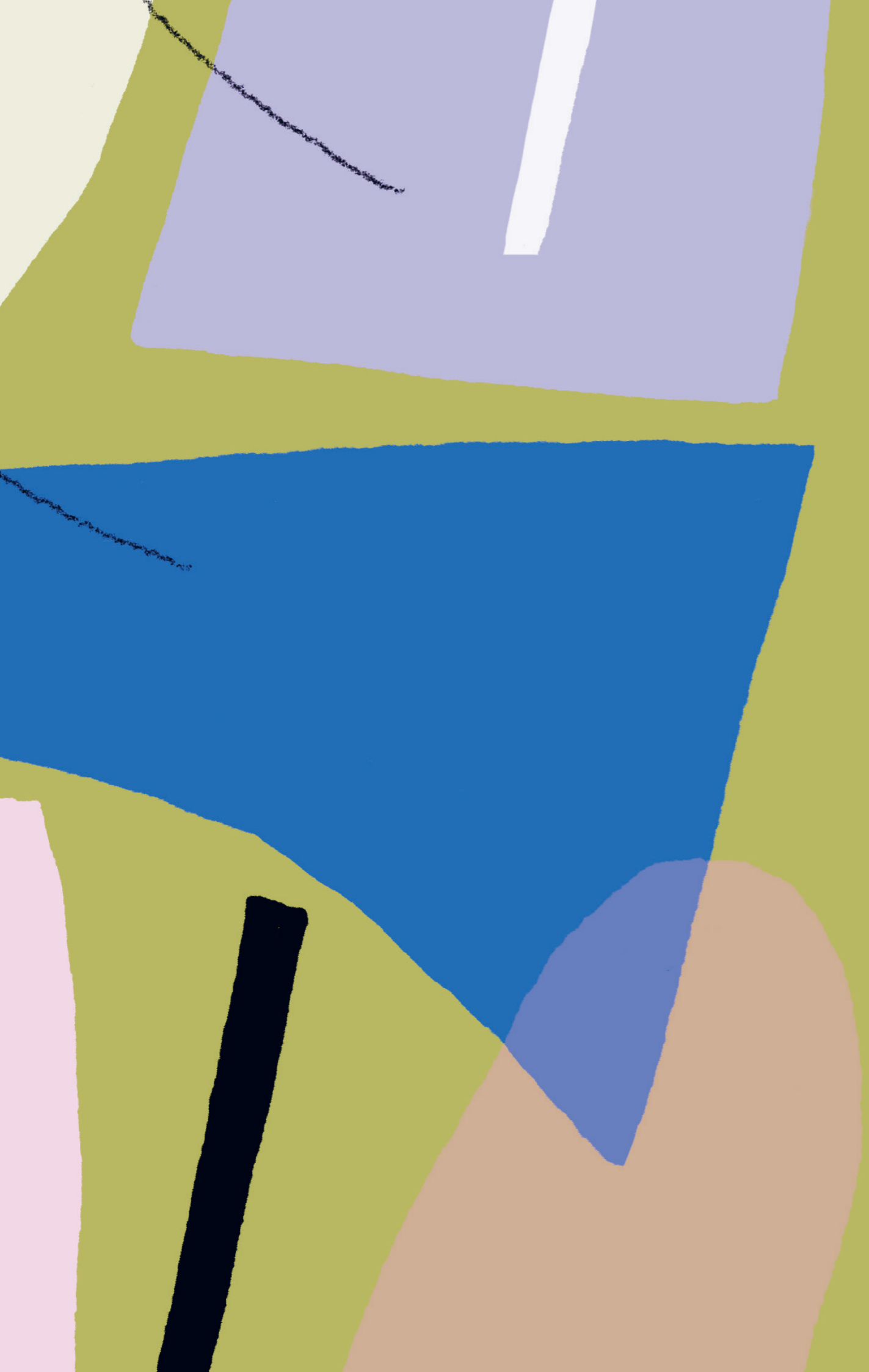




Reimagining Technical Assistance

*Insights & Opportunities Report
April 2019*



About this document

What this document is

This document is a deliverable of the Explore phase of the design process to re-imagine technical assistance in the DRC: The document contains a high level descriptions of the activities conducted and detail descriptions of the outputs generated.

The key outputs of the Explore phase is:

- A deep understanding of the technical assistance ecosystem in the DRC
- A strategic mapping of the barriers and challenges with current technical assistance delivery
- An exploration of diverse opportunities for future technical assistance delivery

The deep understanding of barrier and challenges is framed through through a set of insights, a depiction of the people who come in touch with technical assistance, their relationships with each other and their journey with technical assistance programs. These depictions highlight challenges and barriers to offer a rich understanding of the current state TA landscape in the DRC.

The exploration of diverse opportunities is framed through a set of How might we questions that were generated at the co-creation workshop as well as the initial conceptualizations of opportunity areas identified.

What this document is not

This document is not a detailed research report analysing the process of research and co-creation and describing methods and data analysis.

The Strategic Context

What is this project about and why is it important?

What problem(s) is it trying to solve for?

What does future state success look like?

What is this project about?

What is the background?

The Sustainable Development Goals' 2030 vision for children has shifted the global strategy from child survival to Survive, Thrive, and Transform.

As a result, the need and scope for technical assistance in child health programs has expanded in low and middle-income countries (LIC and LMIC).

For national governments in low and middle to low income countries to implement evidence-based and integrated child health interventions that can achieve the 2030 Survive, Thrive, and Transform vision, then the engagement model underpinning how technical assistance is planned, coordinated and delivered needs to change.

How does this project fit in?

With support from The Bill & Melinda Gates Foundation, the Child Health Task Force is supporting the ministries of health in the Democratic Republic of Congo (DRC) and Nigeria to re-imagine the engagement model underpinning technical assistance delivery.

Using human-centred design to do this means exploring the current user experiences of technical assistance and co-creating a new shared vision between all stakeholders. This approach focuses on the needs and motivations of the end users of technical assistance such as MOH at national and subnational levels, implementing partners and funders.

In the longer term, it is anticipated that a co-created vision for technical assistance engagement will support improved conditions for countries to provide evidence-based, integrated child health services.



Summary of Intent

To reimagine technical assistance so that it can have greater potential to save lives on an enduring basis.

What are the current state drivers for change?

Technical assistance has been criticized for being externally imposed, poorly coordinated, disempowering, short-sighted, self interested and not holistic/systematic in solving for public health challenges.

There is a lot of money being spent on technical assistance – yet, the rate of reduction of maternal/neonatal mortality is slowing down and in some places are reversing. It is estimated that 3-4 billion dollars are spent annually on technical assistance, but if these dollars are not creating impact that endures and saves lives, then there is an opportunity to understand and explore alternative possibilities.

What is our hypothesis for change?

This project is about using human-centered design (HCD) as an approach to exploring current user behaviors and experiences, igniting new types of conversations, and co-creating new visions for technical assistance.

It is hypothesized that the output of this process could begin the process of altering dynamics and influencing the collective behavior of agents who ‘spend money in the guise of technical assistance, and in the name of countries.’

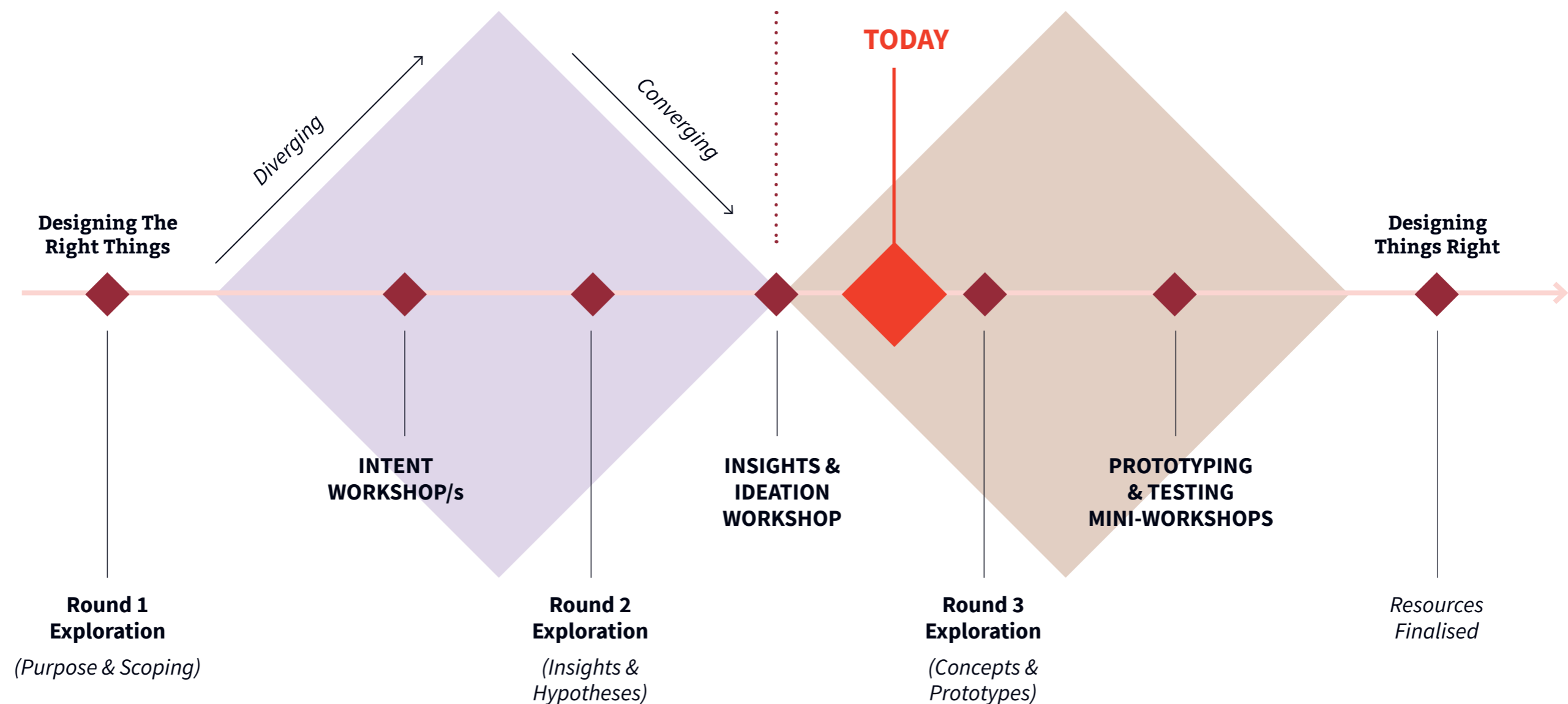
We are leveraging Child Health networks as a window to work in this space. However, the broader ambition is not technical assistance that rests exclusively in Child Health only.

What is the desired future state outcome?

A world where technical assistance is country-driven, coordinated, regulated, accountable, needs-based, adaptive and aligned in a two-way exchange.

This work aims to invest in generating the ideas and building the systems that can produce this outcome on an enduring basis. This work is considered more part of a marathon, not a single event or activity.

What does a human centred design process look like?



In all design process cycles, there are times for diverging and converging thinking. Diverging involves gathering insights to gain understanding. It encourages deeper, more original exploration than other approaches because it seeks to break free from constraints, existing perspectives and models.

Convergent thinking uses focus and the prioritization of opportunities to emphasize meeting user needs. It embraces constraints and drives a testing mindset, prototyping and experimenting to validate solutions.

The Approach

What is our approach? What did we do?

What specific questions does the exploration phase aim to answer?

What is the country health system context?	Who are the actors in this context?	What are the best practices and challenges currently experienced by the actors?	What are the future opportunities imagined by the actors?
<ul style="list-style-type: none">What is the country health system model and how does it work?	<ul style="list-style-type: none">Who are the users and influencers of technical assistance? What differentiates them?	<ul style="list-style-type: none">What are the barriers and enablers of technical assistance?	<ul style="list-style-type: none">What are the desired future user experiences of technical assistance?
<ul style="list-style-type: none">How does technical assistance fit in to the health system?	<ul style="list-style-type: none">What are their motivations, needs and frustrations?	<ul style="list-style-type: none">What are the underlying user insights on why these barriers exist?	<ul style="list-style-type: none">What user attitudes and behaviours need to be changed?
<ul style="list-style-type: none">What are the different ‘types’ of technical assistance? What works, doesn’t work?	<ul style="list-style-type: none">What are the dynamics at play between different users?	<ul style="list-style-type: none">What are users’ workarounds to solve problems? What can we learn from these?	<ul style="list-style-type: none">What is the future vision and values (design principles) for reimagined technical assistance?
<ul style="list-style-type: none">What are its informal and formal processes?	<ul style="list-style-type: none">What are the user experiences with technical assistance?	<ul style="list-style-type: none">What are the specific touchpoints/ areas to prioritize for change?	<ul style="list-style-type: none">What are the emerging ideas and specific concepts for change?

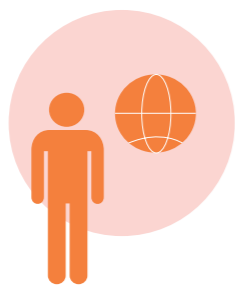
Format and objectives for the exploration phase field work conducted

Week 1: Feb 18 - 22	Week 2: Feb 25 - Mar 1	Week 3: Mar 4-8
Field work and intent activities		
Hospital + Zones de Santé Healthcare Practitioners 1:1 & Group Co-creation sessions, Site Visits 2 rural zone de santé 2 urban hospitals	International and Implementing Partners 1:1 and Group 1:1 & Group Co-creation sessions	MoH Civil servants 1:1, Group Co-creations sessions

Objectives for field work	Format	Activities
<ul style="list-style-type: none"> Allow participants to share their personal experiences with TA and identify the major barriers, facilitators, key influencers along the process and offer potential solutions (i.e. illustrative examples, ideas) Discuss participants’ current perspective on power and relationship dynamics with other stakeholders during the current TA process and in their ideal roles & scenarios Understand participants’ definitions of TA from their perspective (current state) Revise mission statement as necessary to reflect their needs, gaps and visions (future state & design principles) 	<ul style="list-style-type: none"> 1:1 Interviews: 30 min - 1 h Group Sessions (3-4 participants): 1.5 - 2 h <p>In addition to this formal format, the informal moments waiting for stakeholders, driving to clinics, attending all-day MoH meetings, navigating the MoH protocols, and a second more long-term presence in-field were fruitful ways of acquiring data.</p>	<div> 1:1 Interviews: 30 min - 1 h </div> <ul style="list-style-type: none"> Ethnographic Conversations/Interviews: using empathy, shared language and probing, the an anthropologist navigates group dynamics and personal interests to get to feelings, stories, perspectives and experiences. Defining TA Card Sorting: participants select and create cards with key areas & adjectives to describe TA process Actors’ Journeys: participants will be asked to react to others’ experiences, identifying issues to which they can or cannot relate
		<ul style="list-style-type: none"> Make your own TA Journey: participants build their own journeys from their personal experiences, identifying delight and pain points at key touchpoints and proposing solutions Circle of Trust: Key stakeholders map with respect to the relationships and power dynamics experienced Revise Mission Statement: Emerging themes will be recapped and included in the group’s own mission statement

Who did we meet in our research group co-creations and 1:1s?

Over the course of the intent and exploration phases, we met with over 60 people. It is important to note that over our 7 weeks in-field we also met and observed everyday occurrences and had impromptu conversations with many other Congolese who fed into our insights in informal ways.



17 Partners

7 Donors

[+2 in first phase “intent”]

7 Implementing partners

[+1 in 1st phase “intent”]

Many partners were away for the first 10 days of our research because of the MSCP close-out and a USAID meeting outside of Kinshasa this pushed many partner interviews and co-creations to the last week of our research. Still we met important users at USAID, Unicef, Prosani, Sanru, to name a few.

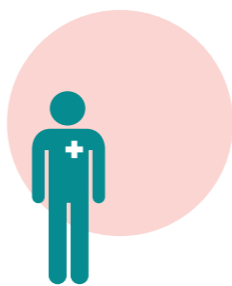


9 Ministry of Health

7 Civil Servants

[+2 in 1st phase “intent”]

The MoH employees were difficult to reach because of Ilunga’s absence (our main MoH touchpoint) till the Thursday of the last week of our research phase and government instability and new role attribution due to recent elections. Though we had hoped to meet more MoH employees, needing to navigate the difficult protocols necessary to organize a workshop and research in this context were fruitful in insights about the ecosystem.



35 Practitioners

31 practitioners

[+4 in 1st phase “intent”]

We met practitioners at all levels, spoke to hospital directors, had clinic nurses take us through their administrative books, drove with data collectors across Zones de Santé and co-created with Zone directors and their head staff. We acknowledge the absence of provincial actors as the political situation made it difficult to go outside of Kinshasa.

Format and objectives for workshop conducted

Week 4: Mar 11-15	March 19	March 20
Insights & Ideation workshop		
Synthesis + Preparation for Workshop	Introduction to day activities Insights Presentation Case Study Enactments Journey Map and Pyramid Presentation Purging Conversations 'How Might We' Presentation First Round of HMW Ideas Creation	Recap of Yesterday, Presentation of Day Future State Fill the "future state" template 'How Might We' Second Round of HMW Ideas Creation Clustering of Ideas Vote for best Idea clusters Concepting for the 4 best Ideas Filling of the 4 Concept Templates

Workshop goal

Work shop Goal: The purpose of this workshop was to develop a synergistic understanding of the current technical assistance (TA) challenges and opportunities faced by various actors of the DRC health system, and foster collective ownership of the redesign process.

Format

The first day of the workshop, the group was familiarized with each stakeholder’s perspectives through the insights and case studies. They were introduced to the underlying assumptions of TA, identified opportunity areas for the project, and collaborated in the solution-oriented ideation phase.
On the second day, the group attempted to further develop ideas into concepts to inform the scope of the project moving forward.

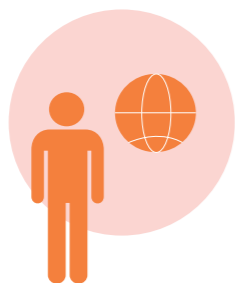
Output

Participants shared their perspectives on the health system while having the opportunity to hear different viewpoints on the health system from other actors. Participants were able to empathize and begin to understand the underlying reasons for the behaviors of their counterparts.
Participants produced over 90 ideas based on the opportunity areas presented and created 4 concepts to be further developed into preliminary prototype of the TA Redesign.

Who came to our workshop?

And key takes aways for next time

The workshop ran over the course of two days and there were 26 attendees present. The event drew a diverse group of participants from government and non-government institutions and civil society.



10 Partners

5 Donors + 5 Implementing Partners
[1 from provinces]

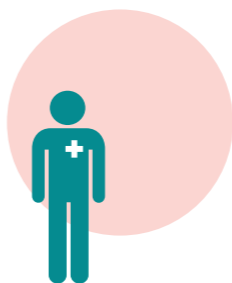
- Need of more donors, especially non-USA.
- Need more implementing partners from the provinces.
- Takeaway: Insure presence of more donors, perhaps more European presence and getting key stakeholder such as Unicef in the room (they were invited but did not stay both days)



8 Ministry of Health

[2 in from provinces including one only for 1 day because of last minute invite]

- Lack of provincial presence
- Takeaway: Insure invitations are sent earlier for protocol to be respected for provinces.



3 Practitioners

+ 3 Civil Society

- We may have missed the perspective of the religious leaders that manage hospitals.
- Takeaway: include religious organizations

The Country Context

What is the country health system model and how does it work?

How does technical assistance fit in to the health system?

What are the different 'typologies' of technical assistance?



DR. PRABHJOT SINGH

DIRECTOR OF SYSTEMS DESIGN
AT THE EARTH INSTITUTE

*“We spend a lot time
designing the bridge,
but not enough time
thinking about the people
who are crossing it”*

What is the DRC Health system model?

This is the basic organigram of the DRC’s healthcare system created. Created during the first phase of research (intent), it is composed of the central, provincial and zone levels. Overall, it can be described as hierarchical, functioning primarily in a top-down fashion and displaying complex informal and adaptive pathways (see insights section). This visualization was used as a discussion tool during the second research phase (exploration) to understand how its parts speak to each other and how its actors interact with external ones during the technical assistance process. It was also used to map the sequential steps of the technical assistance process and helped determine the key challenges along it (see Journey section).

LEGEND

Admin (Central level)

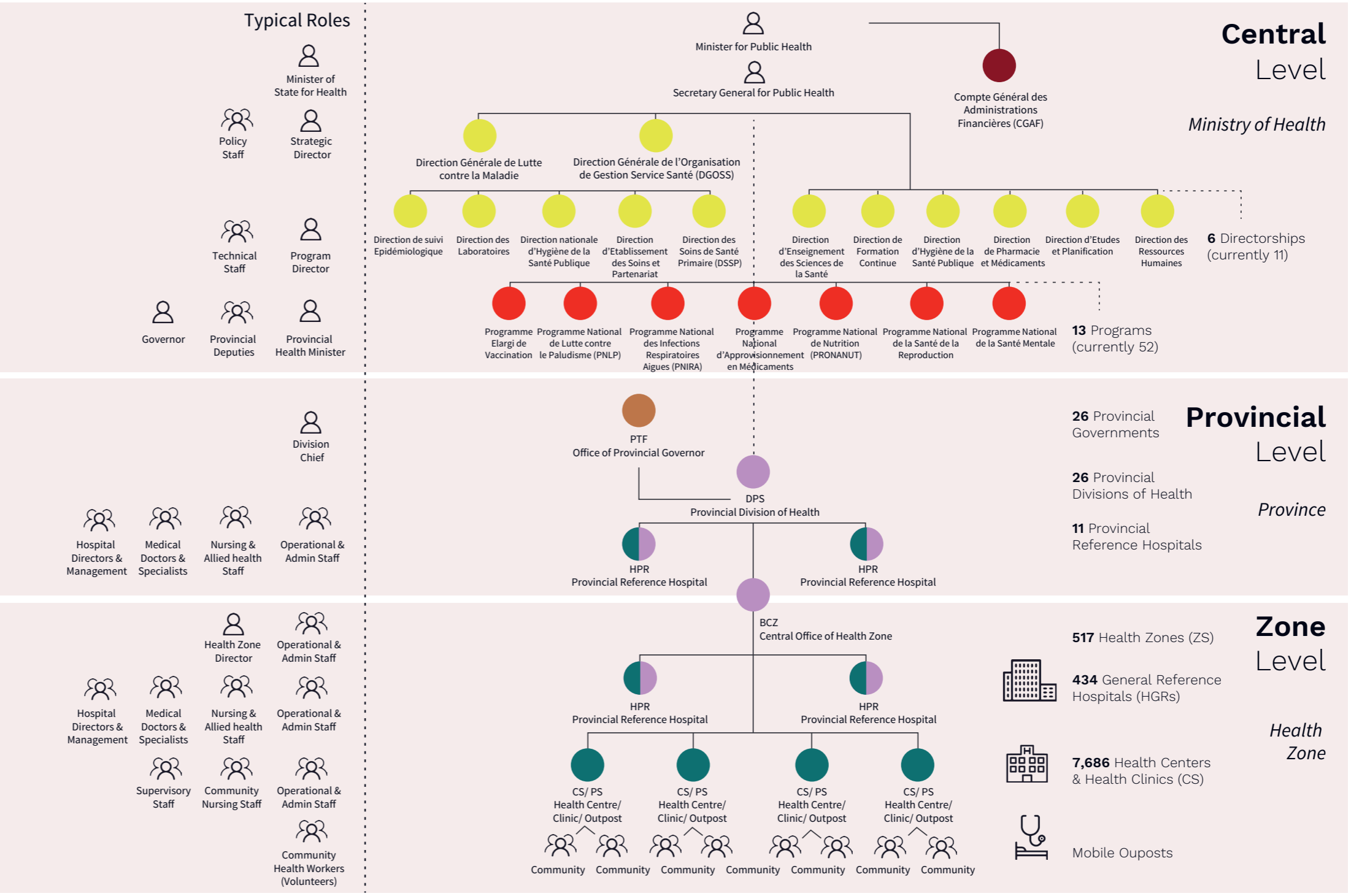
Strategic Planning & Policy

Programmatic & Technical

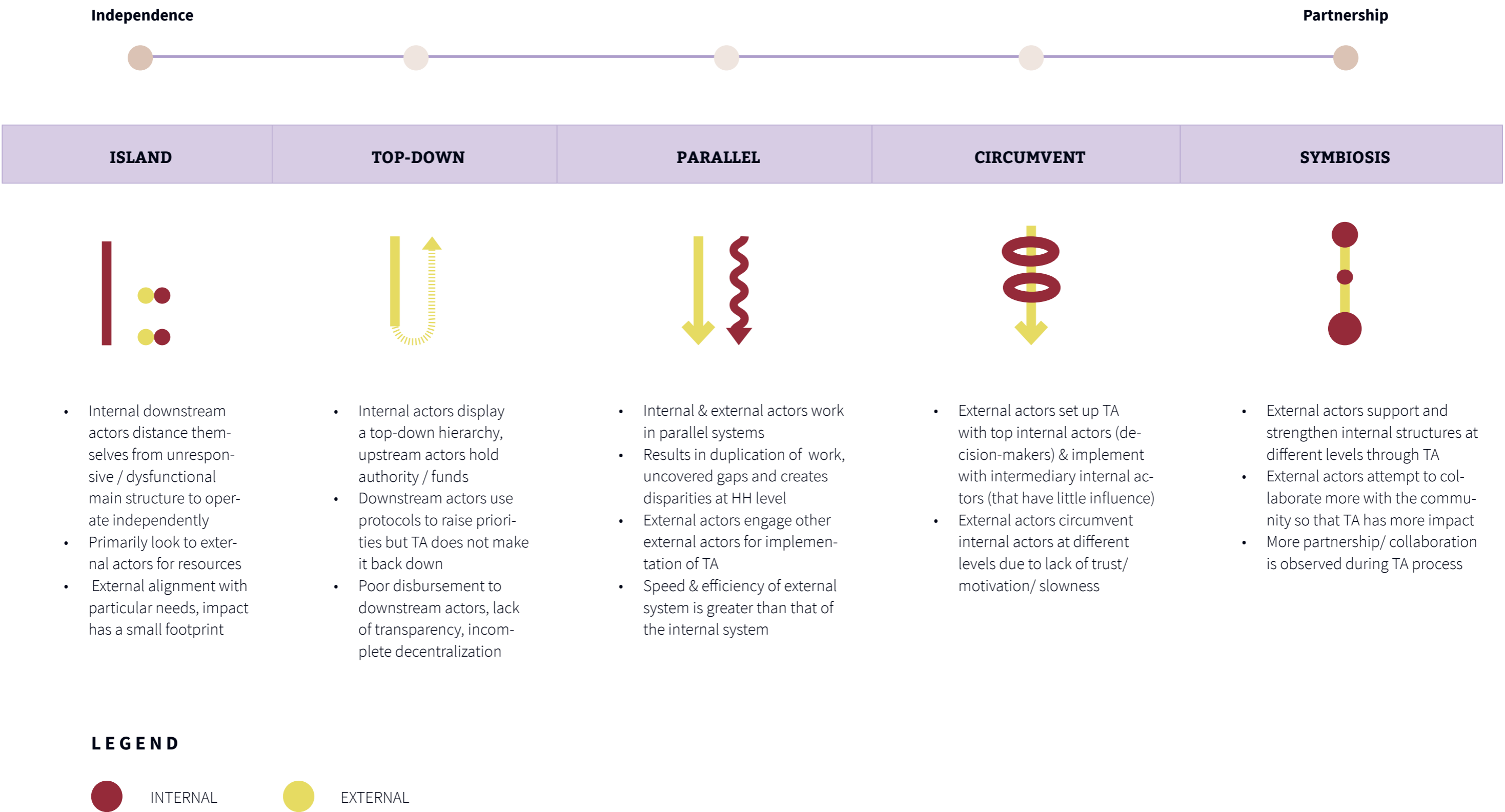
Political (Non-Health)

Operations & Admin

Clinical Health Provision



How does technical assistance fit into the health system?



The System & its challenges

What are all the nuanced insights and quotes from the research?

What are the insights and theoretical framework that explain the behaviors in the ecosystem?

What are the insights?

What is an insight?

Insights are underlying ‘truths’ that explain the system -- the reasons for its dynamics and challenges. They help us gain a more in-depth understanding of the root causes for why we observed what we observed, why the users experience and feel what they experience and feel when they interact with the technical assistance ecosystem. Insights are the result of both the ethnographic fieldwork (interviews, observations, stories) as well as the anthropological analysis that comes after the research is done.

Insights take into account the root causes and help ideate for the cultural system as a whole.

What is an insights framework?

In this presentation the insights live under an overarching framework about the “Gift-Giving Economy.” This framework helps situate the insights in the larger context of why humans give, which is the premise underlying the technical assistance ecosystem.

What is the structure of the insight slides?

First Insight Slide:

- Title, subtitle, short summary and more in-depth description

Second Insight Slide:

- Quotes: verbatims about how each of the typologies of users experienced this insight
- Provocations: thought-starters to ideate creatively and find solutions addressing the context more holistically as well as its less visible forces.
- Topics: main observable consequences of the insight on the users of the TA ecosystem
- Case Study Associated: specific case study with quotes from the different typologies that illustrate this insight
- Journey Steps: the moments when this insight most impacts the TA journey

Technical Assistance exists in between two Gift-Giving economies

The underlying dynamic animating technical assistance is the idea, developed by anthropologist Marcel Mauss, that humans “give to get.” In his work on gift-giving Mauss demonstrates that all economies are dominated by acts of gift-giving, acts of giving in order to get...

- Power (Information and Finance)
- Status (Recognition and Meaning)
- Social Bonds (Network and Protection)

If one is to schematize, in societies where an economy is more “moral,” gifts serve to reinforce one’s network and standing in a social hierarchy; while in a society where an economy is more “liberal” gifts aim to strengthen individual rights and responsibilities as well as means of production. For instance (see graph) in a moral economy people will prioritize belonging to networks over producing market value, and in liberal economies the individual will trump collective responsibility. Obviously these tendencies exist on a spectrum, but overall while both moral and liberal societies ‘give to get’ power, status and social bonds, they do this differently.

Technical and financial assistance are “gifts” from which different actors expect to get different returns depending on whether they exist according to more moral or liberal economies. This moral-liberal scale helps to place the DRC state and civil society as valuing more moral economic returns, while most donors and partners tend to aspire more liberal ones.



Moral Economy	Liberal Economy
Prioritizes Networks and Patronage	Prioritizes Market and Entrepreneurship
Founded on Belonging	Founded on Production
Founded on Belonging	Rule of Law
Imposes Norms of Collective Behaviour	Rewards Independent Will
Direct Reciprocity	Civic Reciprocity

How this Manifests: The Insights

The next 9 insights articulate how the different actors in the healthcare ecosystem navigate between these two economies to negotiate power, status and social bonds in their lives in the context of technical assistance.

1/ A Paternalist Hierarchy

→ where reinforcing your network is more important than individual initiative

3 5 6 11 15

2/ Informal Privatization

→ generating alternative means of income erode trust between actors

2 11 15 10 12 16

3/ Immediate Gratification

→ priority is given to minimizing losses instead of maximizing development

4 8 10 11 12 16 17

4/ The Advantages of Opacity

→ many of the ecosystem’s actors rely on non-transparency to remain employed

1 2 3 4 5 9 10
11 12 14 17

5/ Parallel Systems

→ disjunction in value systems between state and donor mean they have difficulty aligning

1 2 3 4 5 9 10
12 15 16

6/ Temporary Collective Solidarity

→ communities with strong feelings of equality more efficiently carry out their will

1 2 10

7/ A “Bon Leader”

→ a person who embodies the political and the technical

3 4 7

8/ A Second Occupation

→ people have parallel activities and generate a sense of security

10 11 12 14 15

9/ Contagious Irresponsibility

→ in a context where few actions generate results many resign to passivity

4 5 6 8 9 10 11
13 15 16 17

1/ A Paternalist Hierarchy

where reinforcing your network is more important than individual initiative

A paternalist hierarchy is characterized by relationships between employer and employee akin to familial ones: a leader is a parental figure that assumes the authority and responsibility over his or her employees who, in exchange, similar to children, owe him or her respect and obedience. When one derogates from this framework, one risks exclusion from the system as a whole. This hierarchy is very present in the Ministry of Health. It promotes the strengthening of networks and protects those who respect its existence; it does not encourage independent thinking or individual proactive action.

The DRC ministry of health operates under heavy procedures and protocols that are constitutionally designed to serve and represent the needs of beneficiaries and practitioners, but that in reality mainly result in strengthening the system's own existence and authority. Not complying to official administrative protocols can result in retaliation against civil servants such as loss of employment, public shaming or exclusion from one's network.

Thus, even when these cumbersome procedures slow the system and do not have the officially expected results, such as the replacement of a working tool, hospital funding or better motivation, all ranks continue to abide to them.

Furthermore this reframe suggests that instead of thinking about work procedures and tools as their official function it is best to think of them as reinforcing network membership within the government. The action plan (Plan d'action Operationnel - PAO) is a good example of this: its official function is to prioritize but currently is mainly perceived by lower ranking employees as demonstrations of their affiliation to authority.

In a more liberal system, in which implementing partners and donors work in, networks are secondary to production, and law to paternalism. These different set of values lead partners to have to do a "gymnastics" to support the state without imposing their own rhythm.

1/ A Paternalist Hierarchy

Impact on MoH Office

- Lack of independent thinking
- Strict on protocol to keep control
- Little accountability
- De-prioritize people outside of one's network

PROGRAM DIRECTOR

“The program’s officers are the ministry’s officers, and in the State there is no openings of positions to select the best by competitions. So who gets appointed? A friend, brother or sister.”

PROGRAM DIRECTOR

“If we call “Papa Government” he is not going find a place to find the money we need to organize our workshop [or other program activities]. And the government machine is very heavy. So this is where partners come in: they help in solving the logistics. Because today the theoretical solutions come from the government. But what’s blocking us is the inability to do them. “

Impact on Practitioners

- Heavy administrative assignments
- PAOs completed to please partners and authority
- Lack technical and financial support
- Ask more from partners that their state representative

NURSE IN HEALTH AREA

“The state stays in the shadows in regards to wages for example but we must do the PAO anyway with our needs.”

HOSPITAL DOCTOR

“In the government of “My Big Brother” you can’t go through the informal without going through the director, otherwise we will say that you want to destroy his position... and besides, if you do that he will destroy you. I’ve spoken too much in the past and I was replaced by the nephew of an important politician... he did not last a year.”

Impact on Partners

- Extends timelines
- Government is not proactive enough, creates tensions
- Reduces individual ownership

IMPLEMENTING PARTNER

“The relationship we have with the department is very sensitive because at one point the department feels that we want to replace it. Sometimes when we go beyond the limits in our relationships they do not hesitate to remind us of it, sometimes courteously and sometimes in a brutal and tense way. Sometimes it’s weird letters coming in, we are given a cold shower in front of people in our meetings that we accept sportively and consider as incidents of course. “

Provocations

- The fear of retribution means few people request the State fulfill its role and invest in civic infrastructure and systems. **How would a mechanism be put in place to collect complaints without punishing those making these suggestions?**
- At the cost of individual initiative and responsibility, networks offer rewarding benefits such as protection in a very unstable context. **How could a TA model inspired by the positive aspects of networks’ small scale collectivism that would offer similar long-term stability as well as encourage individual empowerment?**

Topics

- Absence of Beneficiaries
- Authority without Responsibility
- Administrative Heaviness
- Importance of Networks
- Protocol Rigidity
- Difficulty to Prioritize

Case Study Associated

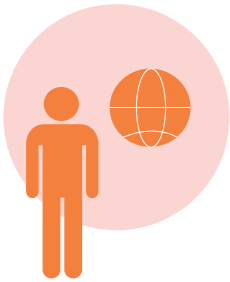
- What Goes Up Rarely Comes Down

Journey Steps



The PAO, What goes up rarely comes down

Summary	The PAO (Plan d’Action Opérationel) is an document filled at all levels of the State (Aire, Hospital Departments, Hospitals, Zones, Programs). Completed with field data, it informs leadership with unit needs for the year ahead, though rarely do these requests get answered.
Takeaway	The PAO does not help collect data, instigate priority projects or clarify initiatives, rather it helps reinforce the hierarchical system and strengthen the networks between the actors of the ecosystem.



Partners (Implementing Partner)

We assist the Zones de Santé in the elaboration of their PAO but we really feel like they are pretty much abandoned to figure it out on their own... I really doubt they have the capabilities to elaborate them on their own because most of the data they are requested to contribute are impossible to find...

The government has a different rhythm and sense of obligations which affects their capabilities. For instance we know that the ministry has this many days after the end of the semester to hand in its report, and we, as partners, if that was our deadline we would work till 10pm, come in on Saturdays and Sundays to get it done. At the ministry, on the other hand, you can hand it in 2 months, even 4 months late, no problem. And that has consequences on plans, priorities, etc. So that’s why even when we try to help, even spontaneously, to get the ministry to write their plans on time we don’t always manage because if we are too active we feel a resistance on their end... they are nervous we will replace them. But we just want the priorities of the country!

Ah! When the question is moving their staff into an Aire when there is a partner project, the ministry is very efficient and proactive... It’s a question of priorities, and the ministry will prioritize immediate gratification instead of the concrete effort of striking to their long term PAOs. As a consequence their hospitals have 4 doctors per bed and their teams are totally demotivated because their salaries are cut by the number of new people in their Aire.

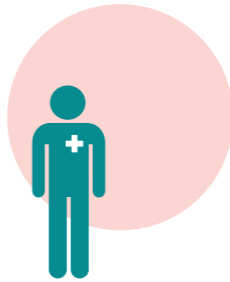


MoH (Program)

Our PAO is the result of data taken from the field as well as what we’ve identified as a problem with their solutions. But it’s very hard to do, because we don’t have fuel and our terrain is large so a lot of the data is hard to collect. I think that if we motivated our community better to collect the data for us, we could better assess what is happening in our Aire.

In the PAO of the program we have to place all of our problems, but our “priority” causes are those that we know we can have financing for so we have to align with the partner priorities. We follow the PNDS, sure, and our data, but the partners are the ones that give us feedback for us to ‘recadrer’ [reframe] our program’s PAO.

The plans are not always entirely put in place; that’s the why the logic of the strongest comes into play. When people are pulled left and right by the need for money, they can not always remain faithful to their priorities and set approach. The complexity stems from that we don’t have direct state funding, so if we want to get things done we depend on the partners.



Practitioners (Aires de Santé)

Our PAO is the result of data taken from the field as well as what we’ve identified as a problem with their solutions. But it’s very hard to do, because we don’t have fuel and our terrain is large so a lot of the data is hard to collect. I think that if we motivated our community better to collect the data for us, we could better assess what is happening in our Aire.

We create our PAO annually. Then we send it to our directors who then combine it with the PAOs of the other Aires of the zone. I think then that goes up to the provincial ministry... Generally we never hear back but we do it anyways because... because it’s the pyramid. They send us the “canevas” and we complete it.

There is over-staffing here, we’ve all sort of fighting over money. There is a plethora of civil servants and bad organization... No one answers our requests for ‘primes’ or for civil servants to be ‘mécanisés,’ however sending us staff, that the state is very good at doing!

Partners also send us projets without telling us much about who will be part of it, or what they will be doing and how they will be doing it. In general they come tell us they their prioritize and then we have to send three people to collect data for them to prioritize which Aires will get their project intervention.

2/ Informal Privatization

Generating alternative means of income erode trust between actors

As the state fails to ensure salary payments and consistency in the functioning of their structures, officials are setting up informal payment systems for their services. Although, these paralegal financial flows feed their direct networks such as the human resources of programs, family units, health zones, areas and sites, as well as the basic functioning of health centers but progressively deeply erode the trust between health actors which mainly impact the health of the beneficiaries.

Starting in the late 70s to early 80s, the DRC government began to disintegrate: the state no longer paid the salaries of its civil servants and public services in general began deteriorating. With the state can no longer able to afford wages and equipment, civil servants began to set up a process of "informal privatization" that is, "débrouillardise" or "Article 15."

These small acts of "privatisation" such as needing to pay for one's "fiche" (record), taking someone "hostage" or buying drugs from a private pharmacy, are rampant throughout the system at the community level. However, they are tolerated, if not encouraged by supervisors, as they themselves, need these to make up their own incomes.

Forms of informal privatization are normalized through a set of semiological expressions that help justify the normalization of corruption and state dysfunction. Words such as "fuel," "motivation," "transportation," or "se retrouver" (to find oneself) mask a profound scarcity of resources where it would be perceived as selfish not to take a position or make a decision that could increase one's income and help the larger network that he or she is part of.

This leads to a general state of mistrust between all players - donor, partners, practitioners and beneficiaries. While state officials, practitioners, partners and donors have some tools to gain agency by putting in place more forms of privatization (practitioners), retracting financial aid (donors) or refusing to sign documents (state officials), the ones with the least power are the beneficiaries. Though, today they pay about 40% of health costs and thus are an important "donor" resource, they have few resources to defend themselves against these forms of negligence and financial abuse.

2/ Informal Privatization

Impact on MoH Office

- Poor Governance
- Fatalism
- Little oversight Self-interest decreases chance of changing the system

PROGRAM DIRECTOR

“We can not tell a father who can’t support his family, how immoral asking for fuel is.”

PROGRAM DIRECTOR

“Building the capacities of the health zones can be done only through giving them responsibility. In the country’s texts about health zones, they are given the capacity to manage funds. But due to the donors’ lack of trust in the government, NGOs are the ones that receive and manage the money allocated to support the health zones.”

Impact on Practitioners

- Constantly tinkering to find income
- Mistrust of MoH
- Lower morale because of inability to provide good care

HOSPITAL DIRECTOR

“People tell us we are holding people by force in our hospital, but we need to be paid if we want to continue providing our services to other children.”

HOSPITAL DIRECTOR

“I totally refuse to take money from donors. If they give me money everybody comes to get their share ... The state is a predator and the rumors are going well. So now I say what I need in consultation with my staff and they send me the material, point to the line.”

Impact on Partners

- Mistrust of Practitioners
- Mistrust of State
- Discrepancy between donor accountability requirements/ and reality

IMPLEMENTING PARTNER

“Over-medication is a real problem. Since the structures need to find some form of profit, they will sometimes over-prescribe and this erodes trust between beneficiaries and health professionals.”

IMPLEMENTING PARTNER

“Working for a donor lets me have guaranteed fuel every morning to get to work whereas if I worked for the state it would not be a sure thing, so I understand when [state officials] ask for per diems, but it does make things more complicated.”

Provocations

- The pressures of being a contributing member of one’s network means some people are more easily swayed in generating paralegal income. **How might a TA model reward one and their network when good care is provided?**
- Some forms of informal privatization can lead to long term benefits for a community - for instance selling free medicine to start a collective insurance policy. **How might other examples of informal privatization inspire long-term empowerment of communities in relation to their health?**

Topics

- Importance of Networks
- Corruption in Precarious Contexts
- Impunity
- Lack of Accountability
- Absence of Beneficiary Voice

Case Study Associated

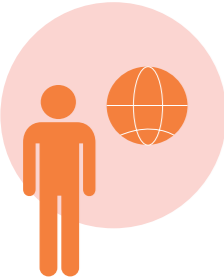
- Losing One’s Credibility

Journey Steps

- 2
- 11
- 15
- 10
- 12
- 16

Loosing one’s credibility

Summary	After the WHO changes their treatment guidelines about a disease, a program director organizes a workshop with DRC experts to create booklets with the national directives. The booklets are never sent to the practitioners.
Takeaway	National level programs lack basic capabilities to fulfill their mission, thought sometimes they also prioritize protocols and their own credibility rather than tinkering with potential solutions to accomplish their mission.



Partners (Donor)

It’s very delicate because we to assist the state in its role as representative and defender of Congolese children, but motivation is a real problem within the ministry, as much as traceability. So we are a little distrustful and that’s normal. I think sometime the state can’t always have the luxury of getting the amount they request when there are more pragmatic and less expensive solutions available. But on the other hand we also understand that the state requests basic things like printing or air conditioning with which they can demonstrate their technicité.

We organize workshops on good governance but are the guests going to do with their knowledge? Sometimes it’s really depressing, we really have the impression they just wander around the big city and come just to eat good food, before going back to their respective home and behave like little local kings.



MoH (Program)

It’s the ministry that has the leadership to organize meetings and workshops to develop our country’s new strategies based on the WHO’s new directives. It’s me that’s responsible, as head of my program to do that, but according to the laws of this country I can’t do it alone, I have the obligation to organize a 4 or 5 day workshop with experts in the field to elaborate ways of implementing these new directives in our country.

I prefer when technical assistance in financial. When the ministry executes, we become responsible for the quality according to our standards. You can ask for a format but sometimes what comes back from the partners, for instance, isn’t what you were expecting. I prefer that if there is a mistake I take the blame, because I’m the one responsible for vulgarizing the directives. Is there is a small mistake and I have to explain that it’s a partner that made the mistake, I lose all my credibility.

So we produced 10,000 booklets of norms and directives; and now it’s been 2 years and they are all here ready to be delivered throughout the country.... except they are waiting for the adequate financial support to be distributed.... and we have not had the right partner with the right “distribution” rubric to send them out.. And now the information in these booklets is outdated...

A partner asked us that we give them the booklets so that they could distribute them around the country during their missions, but we did not find that to be very reliable so we kept them here.



Practitioners (State Hospital)

Theoretically it’s the government that should help because we are a public hospital, but in reality we feel lucky when the government gives us basic equipment and information to do our job properly.

We feel pretty abandoned here with our leaky roof.

3/ Immediate Gratification

priority is given to minimizing losses instead of maximizing development

DRC's current state of instability, poverty and urgency favors the privatization of present needs -- whether medical emergencies or social and political requirements -- rather than making the sacrifices necessary to put in place longer-term development strategies.

The DRC is an immense country with outdated infrastructure, inaccessible geographies and regular health emergencies. In addition, the state is financially fragile plagued by internal turmoil and the partners' tend to offer temporary assistance to respect the state's sovereignty. The combination of these factors generate a healthcare system in which the actors minimize losses instead of maximizing potential profits of long term work. While this is understandable because in times of famine, feeding one's family may be a priority over buying seeds, this vicious circle curbs all possibility of implementing a sustainable healthcare system. Unfortunately this mechanism plagues all levels of the

system. Among partners, sustainability of interventions through local empowerment is often not taken sufficiently into account. In the government, those responsible for long-term visioning and development will prioritize immediate cash flows instead of negotiating to invest in the long-term sustainability of its own structure and mission. At the level of field structures we find similar behavior with over-medication practices which erode trust with the community, the purchasing of drugs in private stores and markets which deteriorate the CDR (Centrale Régionale d'Achat) state pharmaceutical dispensary system or lax data records.

3/ Immediate Gratification

Impact on MoH Office

- Focus on finding income for oneself and immediate employees
- Takes resources away from working on long term strategies

PROGRAM DIRECTOR

“National programs must be aware of their mandate and missions, and not engage at the operational level -- their staff prefer working on the operations because they receive stipends when traveling to field-sites for supervision purposes. Motivation is a real problem with state employees. At the national programs, 60 to 80% of the staff does not receive their salary from the government; and in order to survive they must get involved at an operation level to find revenue sources, but they need to stay at an abstract strategy level. They need to analyze the data and think about how to do things instead of training health zones, or conducting routine supervisions to make recommendations that no one reads”

Impact on Practitioners

- Over-medicating beneficiaries
- Lack of serious contributions to state initiatives
- Plethora of resources
- Inability to focus on care

HEAD OF HEALTH ZONE

“We had opened a collective insurance - the price per member was very low, but the population did not understand why if he or she did not use it they were not getting refunded. We tried to keep it alive. Even at the management level of the zone we made some sacrifices to insure it stayed alive, because to be honest it was also a way for us to guarantee we would get paid. But in the end we had to end it. The population did not understand and did not contribute enough.

HEAD OF HEALTH ZONE

“Taxpayers’ taxes paid for our studies, today education is a disaster. Private medical colleges that provide poor education abound. During my last field visit there was a nurse who could not even read!”

Impact on Partners

- Priorities defined internationally
- Temporary project mean there is less focus on longer term
- Need for tangible results may limit investment in more qualitative projects necessary to cultural change

IMPLEMENTING PARTNER

“Ah, when it comes to moving staff in an area where there is a project partners, the state is very efficient and responsive. It is a question of priority, and the state prioritizes the immediate gratification and the development of a long vision on the motivation of its workforce, for example.”

DONOR

“I mean we have seven year plans. I think that’s longer vision than a lot of things happening in the DRC but are we being judged on the 30 next years? No, because that’s not doable. Should we? Of course!”

Provocations

- Changing behaviors and an entire culture focused on scarcity takes more than additional resources, it requires trust which takes a great deal of effort and time, and is difficult to measure. **How might we develop data points that could measure “trust” so as to encourage projects that promote more cultural/behavioral shifts -- not only biomedical ones?**
- The plethora of human resources and bad public education are quick political win with dire consequences on the moral of practitioners and efficiency of care. **How might TA encourage better resourcing and skills among civil servants?**

Topics

- Instability
- Mistrust
- Lack of Sustainability

Case Study Associated

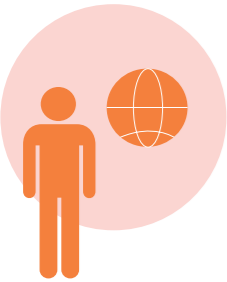
- Pharmaceutical Emergency

Journey Steps



Pharmaceutical Urgency

Summary	The State has set up the CDR (Centrale Regionale d'Achat) to centralise drug purchasing and distribution to reduce costs and implement quality control. Unreliable and unaccountable, according to practitioners, they rather buy medication at local markets.
Takeaway	All of the actors -- partners, state employees and beneficiaries -- prioritize urgent needs which means that projects with short-term gains take precedence over long-term development investments that, in their turn, can never take off.



Partners (Donors)

Our politic is free care for one specific disease. We don't budge from that vision; it was created too high up to be questioned. And anyways, the populations are too poor for us to imagine them being able to pay.

We have our part of responsibility for how confusing the distribution of drugs are in the country... because we aren't always aligned or communicate very well -- I imagine there are lost resources because of our own way of doing things -- some partners bring medication, others drop it off at the center while others give fuel. We could be better coordinated as partners to bring our drugs to the Zones we work in. In fact it's another factor in the "soupoudrage."

There is a donor that wanted to make sure we wouldn't get screwed again. I think the first time they had purchased vaccinations they had also paid the state to distribute it to the provinces... but in the end the vaccinations stayed at the port and never got to the provinces. So the second time around the donor made sure that the vaccinations would get to the beneficiaries by getting the state to invest in the purchasing of the vaccinations. The second time around it worked!



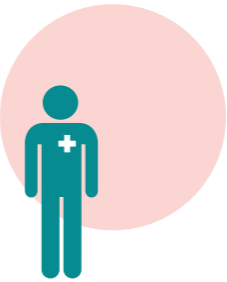
MoH (Civil servant)

The partners have used the population of getting things for free, and that isn't good on the long term because it doesn't empower them to become more responsible about their money. Once we tried to put in place a system in which the beneficiaries would pay a little to get the free medications given by the donors. This enabled the pharmacist to put a little money on the side so that once the partner gone, he could buy more medication. That system meant that once the partners were gone we didn't have to start everything from the beginning again.

We can't moralize a father who can't feed his family when he goes to buy his medication at the local market. They might be more illegal but they are cheaper and closer to him.

So we have the CDR (Centrale Regionale d'Achat), but for it to work it needs large orders... but right now the management of these structures is so bad that no one wants to go through it which reduces its profits, hence worse functioning, more lateness, more disorganization, hence less orders... The entire system needs to be rethought.

The national programs are more powerful than anyone else but they don't realize it and let the partners do what they want, like distribute free drugs, instead of thinking long term and putting in place strategies that reinforce state structures like the CDR.



Practitioners (Clinic)

We elaborate vouchers that we send to the CDR (Centrale Regionale d'Achat) in the hope that they will send the molecules to our pharmacy. In their "planification" they are the ones who should bring the medication to us, but often the head office of our Zone will call us when they are at their office and we will need to find the fuel and transportation to get to the HQ.

When we ask the sub-recipients partners for molecules, they sometimes tell us that the drugs are already at the CDR and that they have been given the means to deposit them to us; so we have to wait passively while we need drugs on the ground. And we are nervous to complain, because we don't want to get punished.

There are medicines brought to us that are sometimes close to their expiry date. And we risk penalties if we complain because the hand that gives is always above.

If the medication goes stock-out, we buy them from the private pharmaceutical structures or the market. The market is closer and often we are given almost nothing to go and get them. To be perfectly frank we almost always go to the market.

4/ The Advantages of Opacity

many of the ecosystem's actors rely on non-transparency to remain employed

Heavy informal and formal protocols, make the dissemination of information and the development of procedures not transparent. Many of the actors in the healthcare system will position themselves as facilitators or translators of the "complicated" that they are sometimes responsible for keeping in place.

Information in the DRC's health care system is opaque: data is difficult to collect (and therefore unreliable), organizational charts change often, a position can be occupied by several people, informal information networks can take precedence over last minute official invitations and decisions are made according to reasonings that remain unknown for many of those affected by them. In this labyrinth of content an actor's power stems from his or her access to a well-informed network: what are the new projects, what are the areas financed by which donors, who has to resign, who should we call to advance a file?

In a context of limited resources and general instability, those with such intangible power will position themselves as "guardians" or "unlockers" of this fragmented system. As such many in the healthcare system have little interest in making the system more transparent as this would imply they could lose their positions as employable resources to open doors, enable processes, put people in touch or negotiate the terms of an exchange.

This is true within the government where civil servants claim their subject, technicality or procedures as a territorial right that no one else can claim ownership or sovereignty over (even if they cannot always fulfill their own expectations about this territory); it is also the case with the implementing partners or donor employees who play "facilitator" and "navigator" roles for actors exterior to the healthcare system and who wish to contribute to it.

4/ The Advantages of Opacity

Impact on MoH Office

- Territorial approach to assert power
- Irreplaceable for processes to take place but not accountable for processes' actual implementation
- Prioritize political interest over technical rationality

“PROGRAM DIRECTOR

“I am the bottleneck and the key.”

“PROGRAM DIRECTOR

“Sometimes the government will block things. Even in epidemic contexts. To save the population we need figure out how to make interventions without making noise... it is very complex. For example, to intervene in the DRC the WHO needs a letter from the ministry. All the partners say that they have money to act but that to do so they must have this letter...”

Impact on Practitioners

- Double employment lowers moral
- Unequal TA between sites can create tensions
- Health areas feel dis-empowered of their responsibilities
- Little empowering

“HEAD OF HEALTH ZONE

“We can blame the partners for being many in certain zones, but I think there is also some blame on the sites that don't inform the zones that there are many partners. And that's because they have interest in having as much assistance as possible.”

“HEAD OF HEALTH ZONE

“What you do without me, you do against me.”

“HOSPITAL DIRECTOR

“The partner did an institutional analysis of the hospital and we decided to start from their report to develop our action plan. There is their expert who helps us. The expertise is not lacking here, we know the machinery works; but we don't have the means to make these analyses happen.”

Impact on Partners

- Position themselves as translators
- Little sustainability incentive for their projects

“IMPLEMENTING PARTNER

“So much of the funds disappear in the nebulous health care system... have you ever heard the expression “the state is a suction pump”? The issue, is how to change that? Punish? Inspect? All of these ‘solutions’ mean investing some more... which also tend to disappear without generating much results. I think the only real way one can have visibility and help the community is by being here a long time and establishing bonds of trust over time. But people don't like hearing that because many people depend on the nebulous chaos.”

“DONOR

“When piloting a project, it must be evaluated for us to learn lessons about its strengths and weaknesses and how to correct them. This is where a big problem arises, I think, because people want to scale without evaluating or learning from this piloting phase. That's why there are many projects that don't have positive results, or there are results but they are untapped and undocumented.”

Provocations

- Data taken for the PAO is based on the state's centers but not the community level (where 70% of data is) this means that priorities in plans are not reliable. **How might new data points or technologies ensure information is more truthful, accessible and well utilised?**
- Transparency is a privilege that must be paid for in contexts of instability where opacity insures power. **How might our TA model propose a more efficient system of information distribution that offers other forms of stability and hence may feel less threatening to those in power?**

Topics

- Opacity
- Gate-keeping
- Scattering of Resources
- Lack of Accountability
- No Sustainability

Case Study Associated

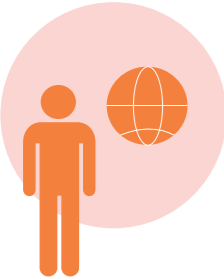
- Provincial Maturity

Journey Steps



Provincial Maturity

Summary	The “rationalisation” or re-mapping of the country is difficult to implement.
Takeaway	If on paper provinces should be empowered to be more involved in local realities, lack of trust and fear of loss of control from the central partners and state powers, keep the “rationalisation” at a theoretical level.



Partners (Donors)

Some donors do not pay civil servant salaries, while others offer bonuses to compensate for the salary gap. When the agents of the ministry are put in good conditions they work well. For example, we designed a project with the ministry which had the division head of a province put in a favorable working environment: he had a vehicle, a room that was well equipped and access to secured financing he could access in accordance with an agreed disbursement mechanism. He was co-signatory of the bank deeds too... we had set it up so that a climate of trust was created and we have saw the results... And now nothing... I think he even lost his job...

In the DRC there is a big problem of governance at all levels; this is the biggest problem in my opinion. The constitution is a very nice text but government employees are not trained or motivated to put it in place. The DPS are not mature enough. Their managers must be trained on their responsibilities. And at the central level there is little interest. We support the reform at the central level ... But in fact, people receive training but do not give back what they have learned. They return to their routine.



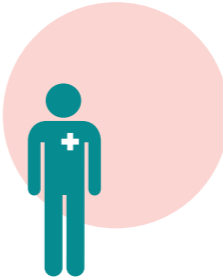
MoH (Head of Health)

The “rationalisation” takes a lot of time because, because it’s all about power... nothing more, nothing less

There are sometimes 3 or 4 middlemen before arriving at the zone level and this isn’t useful for anyone except to spend money unnecessarily.

Technical assistance needs to support national structures to become strong... especially the provinces. DPS agents have the skills but are not empowered to fulfill their missions; me, for example I was recruited through a serious and committed process. I was recruited thanks to my knowledge and expertise and want to do a good job but we get very little support from the central level to get things done.

We receive salaries and premiums, but we do not receive enough resources. There is very little support from the central ministry for the supply of drugs or the cost of operations. And we are also still forced to employ under-qualified employees sent by the central level.



Practitioners (Zone de Santé)

The partners and the central government come sometimes, but often they do not go through the protocol, so we do not know who is where or what. It’s not effective or coordinated. Honestly even academics... I recently learned that there was research being done in my area around malaria but I never signed anything and as chef de zone I should. And of course the results could be useful for our advocacy or better care. Everything is controlled at the top.

NGOs come to the DPS for implementation not to think about the priorities or to employ the provincial civil servants; and that makes people feel uncomfortable. Local parties should become stronger instead of having this send of being duplicated or replaced. Instead of strengthening the community, the projects can not have an impact they aim to have because once they leave the state employees have learned nothing except to realizing they are replaceable.

5/ Parallel Systems

disjunction in value systems between state and donor mean they have difficulty aligning

The ways of working and value system of the donor and state are fundamentally different which mean that these two poles of power in the DRC healthcare system have a hard time aligning.

This insight is the clearest manifestation of the tensions that arise when moral and liberal economies must coexist, as they do in the DRC healthcare system. As previously stated generally speaking donors exist in the liberal realm while the MoH works according to a more moral value system. As such donors encourage innovation, change for more efficient productivity and individual responsibility, and the MoH promotes the strengthening networks, social belongingness and patronage. These fundamental different priorities mean that the MoH and the donors exist in different temporalities. State initiatives are regulated by slow protocols that can be sped up if an individual accountable to his or her network sees it necessary, while the donors are more accountable to people outside of their networks which translates as needing to demonstrate more tangible gains according to more objective schedules.

While these two poles are caricatures, without one actor fully being one or the other, their definitions propose a spectrum on which to place the donors, the implementing partners, the practitioners and the MoH as a way to schematize their ways of working and value systems, so as to offer avenues for better comprehension between actors and possibly find more efficient ways of collaborating.

Indeed currently the financial contributions of donors encourage the actors of the healthcare ecosystem to appropriate donor language and align with donor priorities, while the State's powerful long-term presence encourage the actors to execute and respect the MoH's administrative requests. Implementing partners, closer to the liberal order, and practitioners, closer to the moral one, constantly must navigate between these two poles to get their work done. To give care, implement priorities, repair machines, get paid, they know they need to please both the State and the donors. This leads to the scattering of resources, low sustainability of projects, poor ownership and undermining of both the State and donors efforts.

5/ Parallel Systems

Impact on MoH Office

- Feel Replaceable and undermined
- Compare their conditions to partners, creates jealousy

“PROGRAM DIRECTOR

“Partners should use the civil servants. I have the impression that they say they assist but they actually replace. And after they leave, they are surprised that nothing takes!”

“PROGRAM DIRECTOR

“I was in Europe where there are people paid a ton of money to do hyper complex mathematical modeling to demonstrate the very small gains of a new anti-malaria net, let’s say... And then, the DRC government also needs to finance other models employing other experts paid lots of money to demonstrate the same thing to donors for them to finance solutions... It seems totally absurd to me.”

Impact on Practitioners

- Feel as affiliated to either systems
- State tends to be seen as more predatory and less efficient
- Too reliable of donors
- Feel undermined on their own territory
- Fosters culture of complaint

“HOSPITAL DIRECTOR

“I don’t care who helps us - the state, a private company or the international - as long as it is done and that it meets the needs we define. But to be honest right now the state are akin to vultures, so I prefer when assistance comes from elsewhere.”

“NURSE IN A HEALTH AREA

“In February 2019, we received operating expenses for the second quarter of 2018 for our site from implementing partners. Beyond the fact they were really late, the funds needed to be picked up by us at their central office in Kinshasa, not the central office of our health area which from a state hierarchy perspective we depend on.”

Impact on Partners

- Create their own workarounds (GIBS)
- Nervous about entrusting initiatives to government
- Feel more efficient than government

“DONOR

“People complain to us all the time, but it’s not the donor’s responsibility to fix your hospital’s need for air conditioning or electricity, it’s up to our government. Sometimes I feel we’ve put some very bad dependency habits in place.”

“IMPLEMENTING PARTNER

“Foreign financiers trust private organizations more than the State because they know we are making an effort to meet their international standards and keep improving every day.”

“DONOR

“Everyone wants things to work: the donors put money because they want the project to succeed, and the ministry is indebted to the government to guarantee good health outcomes. I think what opposes them is the way they do it. We must look for ways to have a common language”

Provocations

- The GIBS was a workaround created by the donors to insure they were not in multiple Zones at the same time. While it works, it clarifies data that the State should be able to provide. **How might TA, through, workarounds or deeper initiatives, respect and empower long term state sovereignty?**
- Moral and Liberal economies have different understandings of the place and manifestation of “civil society” and state sovereignty. **How would our TA model define civil society and sovereignty of a State?**

Topics

- Protocol Rigidity
- Moral vs. Liberal Values
- No Common Language
- Alignment Issues
- Scattering of Resources
- Lack of Sustainability

Case Study Associated

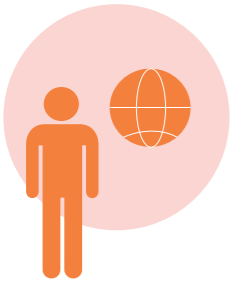
- Are They Ready?

Journey Steps



Are they ready?

Summary	An implementing partner who has worked on a database to input and analyze field data, is nervous that as the end of their project looms, the government will not be able to upkeep the tool appropriately once they are gone.
Takeaway	Data is essential for measured decision-making and prioritisation, while technology can help aggregate data, there are geographical and motivational issues that are bigger barriers to achieve this goal.



**Partners
(Implementing partners)**

Data entry is based on health information that is on paper for both our database and the national one. At the central office, the information of the health facilities is coded like it is at our implementing partners’ offices. Currently we are moving towards one database that would be led by the Ministry of health. In the state data-base there is often category confusion and information mix-ups; or example, a hospital considered a health center. As partners we try to clean the data and give feedback to the State to improve it.

Our sub-recipients currently help the Zones de Santé to capture the paper information and input it into the system in a decent manner. They provide this technical assistance to enable the national system to be stronger and less prone to error.

I am very nervous about the moment when the state takes over the data base entirely ... They told us themselves that they weren’t ready! Many of us are afraid that all the work we’ve put into this new system will be lost.

The problem isn’t only the coding it is mainly motivation. As implementing partners we are demanding; we select our employees for this project based on their effectiveness. We put in place the conditions for the people inputting the data to be motivated. This is how we have better quality than the state even if we are using the same paper data. In addition, we set criteria in terms of the staff to be recruited in relation to the terms of reference we give them. So they have a clear idea of our expectations and they are well paid.

But look - the budgets are public are online and nobody goes looking for them to ask for more or make changes, so do you think that with this “cleaner” data the state will do better? The state is not proactive enough.

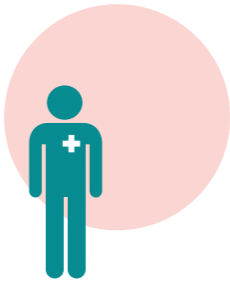


**MoH
(Civil servant)**

For two years now the country has opted for the DHIS2 system which seems to be a little more organized because all the areas of the country are connected through this network.

Partners should use the civil servants more because, with the database for instance, I have the impression that they say they support but in fact they replace because they have no interest in us becoming independent after they leave. And then everyone is surprised when nothing takes.

The country has invested a lot into the DHIS2 for its computerization but when you consult it there is almost nothing or the quality of the data is so very mediocre... And this isn’t that surprising, because have you seen how data is taken? Have you been to the Equatorial region?! It’s so difficult to enter that tropical forest...



**Practitioners
(Aires de Santé)**

Collecting data is very complicated. We have no fuel or pink card [need this card to legally drive in the DRC] to drive our motorcycles and our area is very large, so how can we recover this data in a systematic manner?

Everything is very fragmented at the community level for data [says a state supervisor who only notes site data useful to a partner].

6/ Temporary Collective Solidarity

communities with strong feelings of equality
more efficiently carry out their will

In the context of a state deemed unreliable, some groups create spaces of solidarity outside the official system. They operate thanks to a strong sense of cultural unity based on cooperation, transparency and individual concessions for the group. These initiatives are fragile and often exist thanks to the strong will of a few well-networked individuals that tinker with various opportunities to sustain the group.

Since the sovereign state is unreliable, temporary communities come together in the margins of the official health care system and its processes. In our research we encountered a number of these communities, hospitals or clinics, where something anthropologist Victor Turner coined "communitas" was palpable. "Communitas" is a cultural moment for a given group of people to come together through strong feelings of solidarity, equality, and a responsibility to give shape to an unstructured world.

Participants in these models demonstrate a high affinity for do-it-yourself activities. Claude Lévi-Strauss, defined do-it-yourselfers or tinkerers, as people who improvise and constantly, devise new and creative

ways to achieve goals even though they do not have access to the appropriate or specific tools and expertise to change their overall condition. Tinkerers set their own rules and goals which are dynamic and adaptable to whatever new obstacle life sets their way.

While these collectivities exist in the margins of the healthcare system they still abide to some of the healthcare's ways. For instance they use "informal privatization" but do so at a collective scale, and not an individual one, which means profits of informal privatization are shared among the community. Furthermore they also adhere to the strong sense of paternal hierarchy, except their leader is often a tinkerer driven by a strong moral sense of justice and accountability.

6/ Temporary Collective Solidarity

Impact on MoH Office

- Not included in initiative; in fact the success of this grassroots collective is thanks to its exclusion

“PROGRAM DIRECTOR

“It’s the training and sensitization that helps change people. But not just the type done in rooms; we need to put in place long-term support because it takes time to embody to change”

“PROGRAM DIRECTOR

“We are responsible for the country as a whole so we are aware to the needs in the East and in hospitals here in Kinshasa.. We are the only ones working at that scale.”

Impact on Practitioners

- Sense of belonging
- Feel Respected
- United through strong vision and leadership
- Trust in community
- Platform to articulate tensions and find concessions for resolutions
- Need to use ‘do-it-yourself’ approach to survive

“HOSPITAL DIRECTOR

“Now that they [implementing partner] are gone, it is more difficult, of course, but social cohesion is still our priority and we are looking for our own solutions. A few years ago the president’s wife came - visiting sick children it’s always good for elections - and we made her promise on TV to help us build a lab. Once the promise was recorded and made publicly she was stuck. So she put us in touch with a private British mining company, who built us exactly what we needed.

“HOSPITAL NURSE

“The government is a failure, so we have to work as a community, make sacrifices as a community, buy as a community so that we can do our job -- saving children’s’ lives.”

Impact on Partners

- Need to invest long term
- Changing culture goes beyond more money

“DONOR

“Something quite sad, actually is one you realize that the hospitals that do well are the ones that have a convention protecting them from state intervention. There was a past minister who had a lot of foresight and without him giving the hospital the convention it would have been much harder to stay on course with our initiative there.”

“IMPLEMENTING PARTNER

“I wanted to do some things for the kids and this director showed me they were serious here - people are supportive, and what the director says is respected. I helped the hospital to rebuild a room that had burned, for example by organizing fundraising events among my friends. So now it’s a real partnership between them and me, but I can not be alone... this hospital needs so much help and the state does nothing.”

Provocations

- The success of smaller states of collective solidarity demonstrate that with time, partner projects can have a sustainable effect on good governance, transparency and collective consent. **Could such learnings be scalable to TA models with larger scope and how?**
- To successfully foster a culture of “communitas” and “tinkering,” we observed that protection from ill-intentioned civil workers needed to be put in place. **What learnings can we take from this, and include in our TA model?**

Topics

- Good Transparency
- Strong Leadership
- Tinkering Activities
- Forms of Solidarity

Case Study Associated

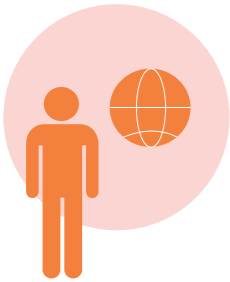
- Tinkering one’s independence

Journey Steps

1 2 10

Tinkering one’s independence

Summary	With the 15 year assistance of a consultant from an implementing partner, a hospital changed its culture to become one of compromise, transparency and solidarity.
Takeaway	In the context of an unreliable if not at times predatory state, efficient smaller scale initiatives can emerge out of adaptive partner support, the will of resourceful leaders and a dedication to hearing out divergent voices to agree on concessions that need to be made for the good of the collective.



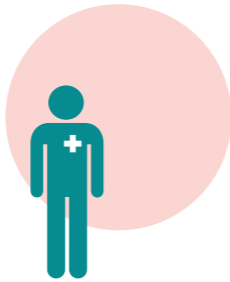
Partners (Donors)

We had a historic relationship with this hospital and we wanted to make sure that it did not lose the abilities we knew it had. So an agreement was signed between us and the state ... and today the hospital is still using this convention to shield itself from some state employees and behaviors.

We paid for an auditor to work with the hospital team for over ten years. He was really part of the team. After a few years it was no longer an external person but more someone who helped with the management: he managed the big repairing the purchasing of the equipment, helped with the accounting, disbursed the insurance policies, helped with the internal tensions by supporting the meetings so that all could express themselves as freely as possible. It was real accompaniment because when he left, he had empowered them to create a culture of their own.

Another important element that allowed the hospital to flourish was the support of the minister of the day. Without him and the convention it would have been much harder to stay the course.

This hospital proves to us that people in the DRC can be ready to receive funds directly, if they are accompanied in the long term and put in the terms that they have defined for themselves as a respectful community.



Practitioners (Hospital)

It started with the partner doing as audit of the entire hospital, our numbers, our results, our salaries, our finances, our equipment, our units and departments. It was brutal but it was thanks to this auditor, for example, that we realized that at the time we had a mortality rate of 20%.

The person the partner sent organized huge collective meetings to dispel tensions around the changes some of us saw as necessary to make. He invited everyone: unions, trades, nurses associations, directors, managers even cleaners. It took two years but with these meetings we created a solid action plan in which the social peace we still exists still is rooted. Still today when issues arise, like last year we had a few difficult months we invited everyone to present possible concessions we would have to make as a team. And we agreed to cut all of our salaries temporarily and take out a loan to fix our xray machine.

This collaboration between us and the partner worked because it started with our needs, not the needs of the partners. Moreover, the person who did the audit was on our side and made sure our voice was heard at the international level of the partner. For example, very early on in our conversations the need for a fund of indigence for people who were having trouble paying for their care or for repairing a machine was identified and he was able to insure we had one. Back then every month the hospital received money in the cashier that the auditor supervised.

I totally refuse to take money from donors. If they give me money everybody comes to get their share... The state is a predator and rumors spread easily. So now I say what the hospital needs based on consultations with my staff and then partners, donors, private companies, whoever wants to help (I don’t care who to be honest) sends me the material, nothing more.

Now that the partners and their support are gone, it is more difficult, of course, but the social cohesion is still one of our priorities and we are looking for our own solutions. A few years ago the president’s wife came - visiting sick children during a campaign is always good for elections - and we made her promise on TV to help us build a lab. Once the promise was recorded and made publicly she was stuck. Eventually she put us in touch with a private British mining company, who built us exactly what we needed.

We don’t ask the government why they aren’t supportive, because we do not know what the realities of the rest of the country are like... Maybe there are more urgent needs elsewhere... There is afterall ebola, cholera... So they aren’t helpful but maybe they have bigger fish to fry?

7/ Un Bon Leader

a person who embodies the political and the technical

The position of the individual in a moral economy stands on a paradox: the collective takes precedence over individualism, but the individual who makes the network work is essential and irreplaceable. Thus a “bon” or “good” leader plays a key role in initiating collective change. A good leader is a person with a strong vision and work ethic and an unwavering moral sense of duty.

In our research we met a few of these “bons leaders” and many more were mentioned during interviews. In a moral economy leaders are essential to the good functioning of networks as they are structured around patronage systems that depend on a paternal figure at the top. This can be incredibly detrimental when these leaders are self-serving and short-sighted, but it can also generate great change when leaders have long-term visions and an unshakable sense of accountability. These leaders foster networks where individuals are rewarded for their work and are empowered to generate their job descriptions and goals.

These “bons leaders” are also characterized by their adaptability and confidence that protocols and traditions may need to be broken in order to benefit

the communities that need care. The talent of these leaders is their ability of doing so by being both “technicians” and “politicians.” Broadly speaking this means that as technicians they have a foot in the reality of beneficiaries and will defend their needs, but also a foot in the political game (often supported by a strong network) which enables them to get things done and move processes forward in a timely manner.

Interestingly in our research many expressed that strong leadership was what was most necessary to make the system better: our participants felt as though constitutionally speaking the DRC healthcare system is “perfect” and does not need an overhaul, but rather that it is those in power need to be better chosen and made more accountable.

7/ Un Bon Leader

Impact on MoH Office

- Inspire change and work
- More efficiency because merge political with technical

“PROVINCIAL CIVIL SERVANT

“The human resources of the Ministry need to be optimized to have the right people and the right levels of motivation to do their jobs. I am a true supporter of performance indicators that build on the mandate and goals of positions. Here at the provincial level I was very happily impressed that I was hired as chief because it was based on a serious process that focused on my qualifications not my network.”

“EX-PROGRAM DIRECTOR

“He [talking about an ex Minister] made us work hard. We had to be in the office at 7am, and for several months I did not go home before midnight. But it was with this will and discipline that he read all the files and pushed the system forward. “

Impact on Practitioners

- Unity under a strong vision
- Empowered to do jobs like role model
- Sense of Stability

“HEAD OF HEALTH ZONE

“Today there isn’t any solidarity left. Today’s leaders ride in beautiful chariots and it is the private sector who has to sacrifice themselves. It does not do us any honor. “

“HOSPITAL DIRECTOR

“A donor taught me an approach to solving problems. It is a state of mind but with simple implementation methods: how to prioritize daily, tidy so that anyone in my staff can easily find documents, systematize ... It really changed our leadership. When I came back I organized a training around these methods here, and it really helped. You see everything is clean here, we are all a lot more efficient and focus on what matters which is provide care.”

Impact on Partners

- Increase trust in practitioners
- Source of efficiency

“IMPLEMENTING PARTNER

“If there are people who have a vision, good governance and strong leadership, we are committed to supporting them. The DRC does not have strong leadership or good governance, right now... so it’s hard for us to trust the State.”

“IMPLEMENTING PARTNER

“When I was the Head of a Health Zone, the office was made up of 7 to 8 people at the most, but recently I found 47 people in an office, including 11 managing directors (human resources, materials, medicines, mosquito nets, etc.). No good leader would let this happen... it’s all short sighted and done with self-interest in mind, to thank their electors.”

Provocations

- There is a saying that power corrupts. However in our research we met leaders and heard of some leaders who had a “volonté” (will/conviction) that the DRC could offer better care to its children. **How can our model identify these individuals and give them the protection and stability necessary for them to materialise their visions?**
- People in positions of power in the State are required to deal with the “base” (teams) of their predecessors, which can weigh down on their aspirations for change. **Could our TA include some best practices to change state culture (like partners working in state offices)?**

Topics

- Long-term Vision
- Empowering Leadership
- Good Alignment
- Accountability

Case Study Associated

- Tinkering one’s independence

Journey Steps



8/ A Second Occupation

people have parallel activities and generate a sense of security

The lack of motivation or stability in the long term leads actors to develop their own resources such as orchards, work a few hours in a private clinic, have their own medical office or go on international missions for parallel income.

These secondary economies may allow some to more personal security and more independence in their thinking, but also lead to less focus on their primary function.

Scarcity drives people's need to tinker their stability. While the topic of secondary occupations was not broached during our official research activities such as hospital visits, interviews or participatory activities, it was a recurring theme when waiting for colleagues or during impromptu conversations. Indeed the great majority of the healthcare actors engage in other activities to generate some form of income in an ecosystem that is deeply precarious.

Partners are in uncertain situations because their contracts are temporary, while state civil servants may be employed for life, but aren't sure when they will be paid and how much. Some of the secondary activities we came across included, tending to fruit gardens, owning farms, going on out of country mis-

sions for a couple of weeks or working as a specialist in a private clinic.

These activities weaken the system as it takes resources away from their official job tasks; however we also met people who, because they had such security systems, were more vocal and had taken more risks in their positions. An ex-program director who recently lost his position to a younger more "political" doctor told us he would be fine thanks to his orchard. So perhaps these activities could allow healthcare employees to feel more valuable -- the outcomes of their secondary occupation generating remuneration -- and offer a form of security to encourage more initiatives in a healthcare system that is plagued by low initiatives and independent thinking.

8/ A Second Occupation

Impact on MoH Office

- Takes leaders away from their responsibilities
- Slows protocols
- Breaks information flows
- Erodes the system
- May foster independent thinking

PROGRAM DIRECTOR

“I was away on a mission in Central African Republic for the WHO for the past five weeks.”

EX-PROGRAM DIRECTOR

“I’ll be fine. I have a large fruit orchard outside of the city. I can go there and make a living just fine.”

Impact on Practitioners

- Takes public healthcare away from patients
- Creates jealousy and suspicion among colleagues

HOSPITAL NURSE

“I can’t really speak about this because my boss is here [laughter] but I have my own clinic, sure. To live in Kinshasa no one can survive only on the income provided by the State and the primes.”

HOSPITAL DIRECTOR

“I think it’s the big untold story about all medical staff and that is that we all work in private clinics. We can’t do otherwise. Especially specialists, we all work at least a day or two.”

Impact on Partners

- Takes them away from partner activities especially towards end of project

IMPLEMENTING PARTNER

“The program is closing, and it’s incredibly sad. But I have a farm... Well it’s more my husband’s but it needs tending -- you can’t really trust employees with your own animals. Like a lot of chickens went missing this winter, if you know what I mean. And my husband works for a partner in the East so he can’t supervise it as much as he would like. So that’s my plan after the project ends. Making sure our farm makes profit for our family”

Provocations

- Engaging in secondary activities may distract health care providers and civil servants from their main occupation, however **could our TA model integrate these secondary activities in a way that encourages their independent thinking and sense of empowerment?**
- Secondary occupations exist for individuals, but the DRC’s hospitals and programs face similar issues of funding security, **could our TA model inspire itself to create ‘secondary occupations’ for whole institutions (orchards for hospitals, etc.)?**

Topics

- Fostering Independence
- Lack of Accountability
- Contexts of Scarcity
- ‘Do-it-yourself’ activities

Case Study Associated

- Tinkering one’s independence

Journey Steps

- 10
- 11
- 12
- 14
- 15

9/ Contagious Irresponsibility

in a context where few actions generate results many resign to passivity

Existing in a paternalist hierarchy that is often described as political, ungrateful and "complicated" leads many actors to take a passive position. Disengaging from one's responsibilities and moral values due to a lack of financial motivation and sense of agency is something that exists throughout the system.

In the grueling, administrative, political and geographical, DRC context efforts such as caring for patients, speaking up for injustices, filling PAOs, fulfilling the goals of a partner project, or collaborating with the State, rarely get rewarded. As such actors of the ecosystem feel like they have little agency over their working conditions and outputs.

A program director told us that he was happiest in his career when, as Head of a Zone, he could see the tangible results of his efforts to curb mortality rates. In his current position, he explained, he sees none of that and instead is relegated to navigating meetings and signing meaningless paperwork. Arguably, even with the practitioners we met at the Zone level similar feelings of defeatism were expressed. For instance a Head of Zone had very little clarity as to how partners pick or design their TA projects in his Zone. When one

cannot correlate their work or efforts with the most successful initiatives in their area, why make the effort?

Another important factor to this malaise is the plethora of staff. The more people in offices, the more the primes need to be shared, which reduces the income of each individual. We went to hospitals where there were 4 doctors for each bed. Furthermore the lack of motivation leads to absenteeism which makes a bit of a mockery of those who do show up. As such jealousy, feelings of disrespect and general contentious atmospheres fester.

While we can look at personal means of “re-motivating” people through more respectful pay, better work conditions or handing out t-shirts for volunteers, the root cause of this contagion of irresponsibility sits at a cultural systems issue.

9/ Contagious Irresponsibility

Impact on MoH Office

- Alienation from field results
- Defeatism
- Not Reactive

PROGRAM DIRECTOR

“We must start by closing the churches that put people to sleep and promote passivity. They promise people better days as the colonizers did, people agree to live under the table, to live sheltered from the reality, to fall below human dignity because they are afraid and prefer to believe that it is God who will save us. What we see churches doing in this country, is no longer religion, it’s opium.”

PROGRAM DIRECTOR

“Everyone goes to the other side [the programs], strengthens this parallel system and then complains about the system. Maybe they could try changing it from the inside instead of passively complaining.”

Impact on Practitioners

- Inter-colleague jealousy and tension
- Poor Care
- Lack of Accountability
- Absenteeism
- Defeatism
- Not active action

HOSPITAL NURSE

“Luck was on our side and we were on a list and we received 24 million Congolese francs.”

HOSPITAL DIRECTOR

“It doesn’t feel great to not have the tools to get the job done. Like we go to trainings, hear about these cutting edge practices we could use, but then come back to our reality where there is no electricity. It’s incredibly disheartening. Makes you want to quit entirely.”

Impact on Partners

- Difficulty working with State
- Low Sustainability effort
- Defeatism
- Absenteeism

IMPLEMENTING PARTNER

“The problem though we are the main recipient we work in concert with another principal recipient who is the ministry. We work in synergy with them, we do not pretend to say that we are assisting the ministry, but we sometimes feel like we need to take them by the hand because their motivation is so low.”

IMPLEMENTING PARTNER

“The state also has very beautifully written procedures that nobody respects. So what next? The texts are all there...”

Provocations

- The ability to achieve a sense of individual agency in a system that is broken should not be placed solely on the individual; yet **are there small tokens our TA model can put in place to stimulate a sense of fulfillment?**
- In the field we met many people who felt they couldn’t assert their needs to do their jobs properly because they didn’t know where to look or understand how the system worked. **What kinds of tools could our TA model offer to palliate this and bring a sense of empowerment?**

Topics

- Lack of Accountability
- Defeatism
- Low Morale
- Lack of Reactivity

Case Study Associated

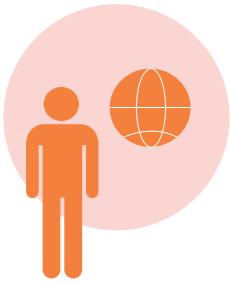
- A good start

Journey Steps



A good start

Summary	A project that both the MoH and partners all agreed was a success because by involving all the parties in its conception it was well-respected fails at having long-lasting.
Takeaway	Just because an initiative is participatory, empowering or bottom-up, does not necessarily translate into lasting ownership and continuity.



Partners
(Donors)

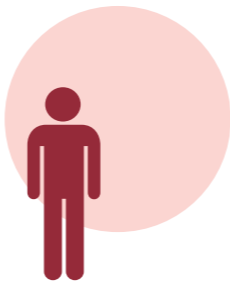
All models are good; none of us are here with the intention of elaborating technical assistance projects that hurt development. But perhaps there are the projects that give more results, and others less. Everything depends on the feasibility conditions. A successful model in Nigeria, for example, may not be successful in the DRC. Just as a model that has failed in Nigeria for example may find the feasibility conditions in the DRC and succeed. All the models are good but we have to contrast them to their implementation context and for this project we really seriously considered the local to imagine it, then test it, then make it grow.

After having worked with the state to clearly define the project’s strategy, a call for implementing partners was made to look for the ideal executing agency.

The project was initially for 5 to 6 Zones de Santé but following the early results, the DPS asked that the project be extended to other areas, which it was. The project and its model were scaled and continued generating great results but when the government had to take over and scale it nationwide... well I’m not sure what happened but I heard rumors it didn’t go great.

We work in assistance to the ministry but when we leave, the state never fills the emptiness. Sustainability is the state. Our projects, even those, like this one that were very successful, have a limited duration because they are the sovereigns of their people, not us.

One of the criticisms against us, the partners, is that we did not prepare the end of the project well enough and that it should have been a dynamic topic throughout the project.



MoH
(Civil servant)

The real problem is with the submission of projects. A good project for us, as ministry, is one for which the partner consults the Ministry of Health during its development so that we can give advice that will really help the Ministry.

In this project what was great was that more than presenting us with a concept note for reframing, the ministry was asked to collaborate and input as the project was being developed and before the project was submitted. The project was successful because of our input and advice was taken into account. When the new minister visited the project’s activities, he said that these are the kinds of projects that the Ministry of Health is looking for.

Millions of dollars were poured to reach thousands of children and now nothing... The figures have fallen back to where they were before the project... There is no shortage of money, we lack the political will to make good initiatives as this project continue. It does not honor us.

Most partner interventions are urgent and do not exceed a year. For a project around malnourished children, for example, where nutritional inputs must be imported, after the project is done, the situation is like what it was before.

For the ministry to go out in the field of do a supervision on where this project is at, I depend on partner money. I can not even go myself to follow up on the project. It’s a kind of corruption; the follow-up will not take place, so the ministry can’t learn from its mistakes or even report objectively.

The People

Who are the ‘users’ of technical assistance? What differentiates them?

What are their motivations, needs and frustrations?

What does technical assistance mean to different ‘users’?

What are the desired future ‘pathways’ (or perhaps use cases) for technical assistance?

Who are the ‘users’ of technical assistance?

Personas

The following personas were inspired by the technical assistance system actors we met in the field.

The quotes that are associated to each of them are amalgamations of stories and experiences that were shared with us in the DRC. These personas reveal users’ everyday realities (through the quotes), emphasize the values they adhere to and the behaviors they enact in their everyday life (through the scales) and show their proclivity for change (through the TTM). Appendix 1 and 2 help define the way the scales and the TTM stages should be interpreted.

Personas are a useful tool for ideation and development of concepts to prototypes by ensuring that their needs and challenges are taken into consideration while creating solutions.

TTM STAGE



For each persona you will find the following **scales**:

- 1/ Personal Financial Security** not scarce 10 ————— 1 very scarce
- 2/ Stability over time** very stable 10 ————— 1 very unstable
- 3/ Rank in the Protocols** Gatekeeper 10 ————— 1 submissive
- 4/ Connections in the Informal Networks:** Very connected 10 ————— 1 very alone
- 5/ Professional Priorities** Technical 10 ————— 1 Political
- 6/ Amount of Will** Proactive 10 ————— 1 Passive
- 7/ Power over Money Flows** Key to creating money flows 10 ————— 1 no say on where money flows
- 8/ Percentage of overall income that is Informal Privatization** High 10 ————— 1 Low
- 9/ Rank in the Paternal Hierarchy** High authority 10 ————— 1 Low authority

Who are the ‘users’ of technical assistance?

What differentiates them?

Ministry of Health



Sarah, The Grassroots Believer
Project Officer
Implementing Partner at Provincial level

Partners

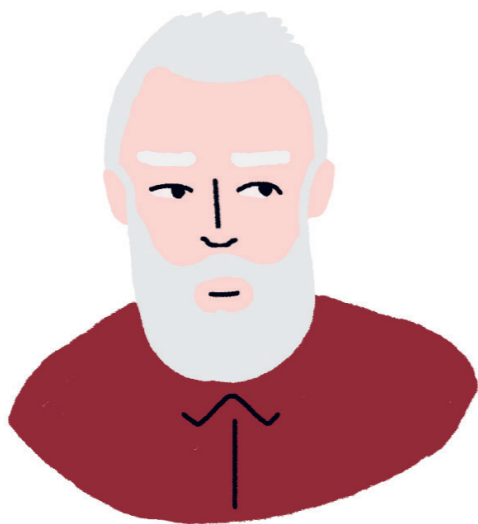


Vital, The Determined Engineer
Program Director
Ministry of Health

Practitioners



Mimi, The Traditional Careerist
Head
Zone level



Pierre, The Disillusioned Donor
Team Lead
Donor



Rose, The Optimistic Civil Servant
Administrative Staff
Ministry of Health



Petra, The Solidary Tinkerer
Director of Finances
Public Hospital

Sarah

The Grassroots Believer



Project Officer Implementing Partner
at Provincial level
Office Worker, late 40s

“I worked as a doctor for the state and specifically in maternal health for over 12 years. After having worked in multiple zones as a director I decided to work for an international partner in a zone in the east that has many difficulties. I think I switched because of the better pay, of course, but also because we have more means to change things in our country’s reality when we have donor backing and the partner’s attitude.”

My opinion about TA is...

“Technical assistance offers services that can change people’s lives. In my context I see the real difference that my work as technical assistance has had on women’s lives here and especially on the perception the community has of teenage mothers. And that, that really matters to me. Not only do we help the biomedical body but also the perception they have of themselves.”

What inspires me...

“I have the impression that I am changing the culture of my country in a positive way at the local level. For instance, we don’t get involved politically on the subject of abortion, but we offer help and medications for people that have had one. Before in this area, if the abortion had been intentional the post-partum medication would have cost twice as much for the woman than if it had been unintentional. Through our program, not only are prices now the same for both women, but also through a strong relationship with the pharmacists and doctors, the community has realized that in either circumstance the end of a pregnancy is suffering.”

What I would like to see change...

“I would like the government to manage their human resources: giving clear performance objectives, reporting frameworks, and evaluations that can impact them negatively if they haven’t properly accomplished their duties. They need to be clearer about what needs to be done and by whom. It’s a real problem that affects the State’s efficacy greatly. For instance, currently we are collaborating closely with civil servants at the central zone level to organize our departure from their health areas. It’s been very complex because they work at a different rhythm than we do -- responsibility is diffused, people are absent, etc. And even if we feel we’ve involved them since the beginning of our involvement here, when we leave, I’m very nervous that the mechanisms we have put in place will not last.”

What worries me...

“Our anonymous donor has decided to place their money into new health areas and so we will have to leave the ones we’ve been working with for over 7 years. Although some are more ready than others, I have to admit that for the ones that do not have another partner in their health area, I really feel like we are abandoning them. I’m really nervous that our work was a little bit in vain...”

Who are the ‘users’ of technical assistance?

What differentiates them?

Scales

TTM STAGE



PERSONAL FINANCIAL SECURITY | ACCESS TO FUNDS VS SCARCITY



TIME STABILITY | PREDICTABILITY OF EMPLOYMENT



RANK IN THE PROTOCOLS | DECISION-MAKING POWER VS NO CONTROL



INFORMAL NETWORKS | CONNECTED VS DISCONNECTED



POWER OVER MONEY FLOWS | POWER VS NO POWER



PROFESSIONAL PRIORITIES | TECHNICAL VS POLITICAL



RANK IN PATERNAL HIERARCHY | HIGH AUTHORITY VS LOW AUTHORITY



RANK IN PATERNAL HIERARCHY | HIGH AUTHORITY VS LOW AUTHORITY)



AMOUNT OF WILL | PROACTIVE VS PASSIVE



2/ Vital

The Determined Engineer



Project Officer Implementing Partner
at Provincial level
Office Worker, late 50s

“I’ve managed this government program for about fifteen years. Before that I was working in a hospital as a pediatrician. I’m very active in everything that concerns children health.”

My opinion about TA is...

“If we call “Papa Government” he’s not going to direct you to The Place to find the money you need to organize a workshop for us to do our job properly. And the government machine is very heavy, and that’s where the partners come in, that’s their place. They help resolve the logistics of the theoretical solutions that come from us, the government. I mean what blocks everything here is the doing, getting things done is impossible without money, and the donors and partners have all of it, and why they have so much power, with all their money.”

What inspires me...

“What I would like is that there is more collaboration and harmonization between the ministry and the partners. The government understand DRC health better than any partner. We have the technical expertise and we know our priorities, the partners, on the other hand, they are the experts on the logistics and the financial. And that’s why they should work with us when they are elaborating their projects, they should include us at all points. When partners don’t consult the programs they don’t have the category in their proposals that are necessary for our operations. When decisions are made too high up, it means we can’t do our job properly. We need to work collaboratively.”

What I would like to see change...

“I would like technical assistance to be financial because then it’s the ministry that executes. When we execute then we are responsible for the quality according to our standards. You can give indications but sometimes the partners or executors bring something back to you that you aren’t satisfied with. I prefer messing up, and then I have to take the blame. If there’s a small mistake and I need to explain that it’s the partners fault, my program loses all credibility. I endorse, fine, but if it’s someone else that forces me to have to endorse, I’m going to be frustrated.”

What worries me...

“The complexity arises from the fact that we have no direct financial assistance from the State, if we want to get things done we depend on development partners. The budget for this program, for instance, is 90 to 100% dependent on partners. And that’s the tragedy because if we want to survive we have to align on their priorities.”

2/ Vital

The Determined Engineer

Scales

TTM STAGE



PERSONAL FINANCIAL SECURITY | ACCESS TO FUNDS VS SCARCITY



TIME STABILITY | PREDICTABILITY OF EMPLOYMENT



RANK IN THE PROTOCOLS | DECISION-MAKING POWER VS NO CONTROL



INFORMAL NETWORKS | CONNECTED VS DISCONNECTED



PROFESSIONAL PRIORITIES | TECHNICAL VS POLITICAL



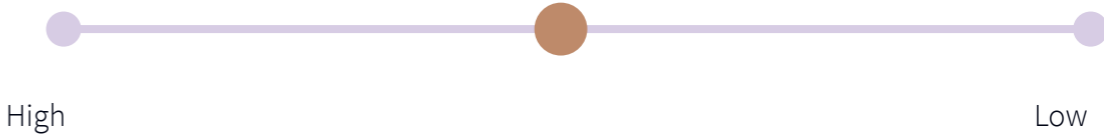
AMOUNT OF WILL | PROACTIVE VS PASSIVE



POWER OVER MONEY FLOWS |



INFORMAL PRIVATIZATION | PERCENTAGE OF OVERALL INCOME THATS INFORMAL



RANK IN THE PATERNAL HIERARCHY |



3/ Mimi

The Traditional Careerist



Head of Zone de Santé
Doctor, mid 40s

“I have a typical journey: I am a doctor and went up the ranks from working at a hospital till becoming director and then now, head of a Zone de Santé. I don’t think I’ll be here for very long... It’s been three years and I want to go up to the central provincial level and then national level. It’s the next natural step in my career.

My opinion about TA is...

“Technical Assistance, it’s complicated. We need donors and partners to assist us in our work. But, at the same time, I have very little control over which partner is working in my zone and when. Or even the power to decide or to know what they are doing in my zone. It’s hard for me to feel like I’m boss when so many things seem to escape me. I am sure what they are doing is helping, but I also am sure that in the long term with the expertise of my staff it could be even better, for the beneficiaries as much as for my team.”

What inspires me...

“Rwanda inspires me. Of course they are much smaller than us, but they are a lot more forceful and unambiguous in their relationships with the partners. All that goes into the country goes through the government that has a very clear and centralized vision. Over there, a car bought by USAID, for instance, has a huge logo of the ministry and a tiny logo of USAID. It’s a non-negotiable. You don’t want that deal, then your money isn’t welcome here. That’s it!”

What I would like to see change...

“I would like the national level to send me employees that have nothing to do... Right after this interview. I need to speak to a group of ten-ish people who claim they’ve been working in my zone for a year and are asking for a salary. I think they were recruited by partners, but I can’t be sure, and they probably aren’t too sure either. Overall, I guess, I’m the boss but I have very little power and oversight.”

What worries me...

“What makes me nervous is the way partners come and say ‘we really want to work on polio, we have the possibility of financing three health areas and then give us three days to collect data for them to prioritize which need more help than another... And that’s horrible because that fosters big inequalities between areas... We need to implement an integrated vision.”

“I am lucky because I am physically close to the central level [near Kinshasa], so I can have access to the people in power and be heard by them on things like lack of motivation. I can use my networks, but I really don’t know how those in the further provinces do it to get things done. Decentralization by the way is totally theoretical. There is no political will to make it happen; provinces and zones are still totally dependent on the central level.”

3/ Mimi

The Traditional Careerist

Scales

TTM STAGE



PERSONAL FINANCIAL SECURITY | ACCESS TO FUNDS VS SCARCITY



TIME STABILITY | PREDICTABILITY OF EMPLOYMENT



RANK IN THE PROTOCOLS | DECISION-MAKING POWER VS NO CONTROL



INFORMAL NETWORKS | CONNECTED VS DISCONNECTED



PROFESSIONAL PRIORITIES | TECHNICAL VS POLITICAL



AMOUNT OF WILL | PROACTIVE VS PASSIVE



POWER OVER MONEY FLOWS |



INFORMAL PRIVATIZATION | PERCENTAGE OF OVERALL INCOME THATS INFORMAL

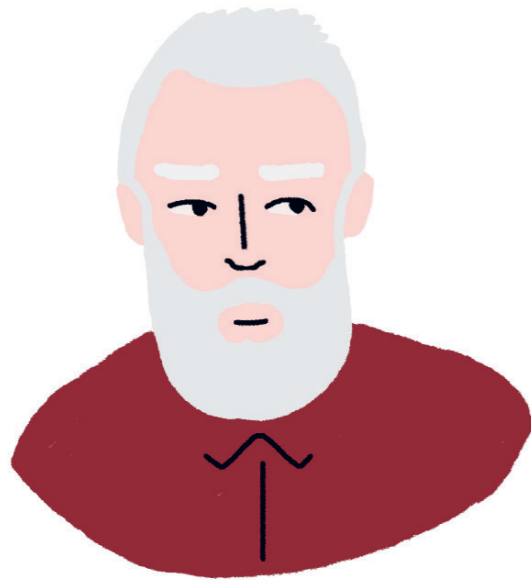


RANK IN THE PATERNAL HIERARCHY |



4/ Pierre

The Disillusioned Donor



Team Lead, Donor
Office worker, early 60s

“My first real job as a young physician, I was really idealistic and I thought I was going to change the world by being contracted by my European government to work in then, Zaïre, for a few years. I might have done a good job of saving lives, but in the big picture, I was changing nothing. It was a wake up call. But I was the only physician for 200,000 people and that was TA. After working for a number of donors, now I work with a partner to strengthen health systems. It is less direct provision of care.

My opinion about TA is...

“Technical assistance has changed over the course of my life. Every partner and donor I have worked with has had a different approach to technical assistance. Generally, though the ones with the money have a say on the way things happen. But maybe things will change... in the Paris agreement, the accent now is on the need for governments to take charge.”

What inspires me...

“A few years I worked with communities around a disease that leads to blindness. There’s a simple drug to take to stop it. In this project we explained to the community what caused their blindness and then gave them the responsibility to make sure everyone took the drug. They got to design, implement and report the drug. Each village came up with something different on the how. At that level you can help without it being too expensive: you provide the necessary drug, help them go through the process.”

What I would like to see change...

“Everything costs 20 times more in DRC because the system takes care of it – like, for example when you want to run a workshop -- because someone’s brother has a nice venue and you have to use it. This is really funny, but is also really sad.”

What worries me...

“60% of all healthcare in the DRC is out of pocket, and the state is such a small fraction so why this focus on the government?! Sure their mandate is to keep people fit and healthy – but they are certainly not fulfilling it! And the higher up the ranks you go the worst the mandate becomes. I have walked away a few times from bad situations; and I’m lucky because I can... I have colleagues who work for national programs, the donor shows up with 4 or 5 cars, and the ministry calls and asks ‘where is their car?’ What can you do? When my colleagues don’t give the car, they no longer have a job, and their wife says ‘look now, you didn’t achieve anything and we can no longer feed the children.’ It is very difficult and we always punish the small flies not the real guys with all the power.”

4/ Pierre

The Disillusioned Donor

Scales

TTM STAGE



PERSONAL FINANCIAL SECURITY | ACCESS TO FUNDS VS SCARCITY



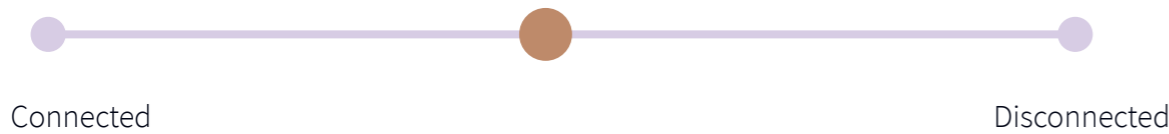
TIME STABILITY | PREDICTABILITY OF EMPLOYMENT



RANK IN THE PROTOCOLS | DECISION-MAKING POWER VS NO CONTROL



INFORMAL NETWORKS | CONNECTED VS DISCONNECTED



PROFESSIONAL PRIORITIES | TECHNICAL VS POLITICAL



AMOUNT OF WILL | PROACTIVE VS PASSIVE



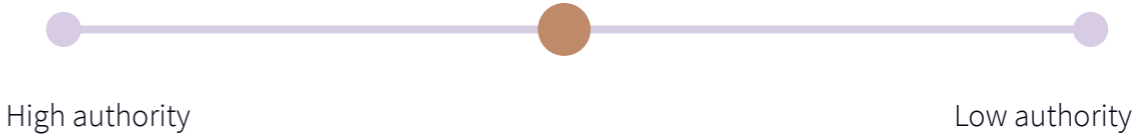
POWER OVER MONEY FLOWS |



INFORMAL PRIVATIZATION | PERCENTAGE OF OVERALL INCOME THATS INFORMAL



RANK IN THE PATERNAL HIERARCHY |



5/ Rose

The Optimistic Civil Servant



Administrative Civil Servant,
Ministry of Health
Accountant, early 30s

“I work in the management of one of the directions of the Ministry of Health. My father was a doctor and I think that is why I think health is so important. After having graduated with my MBA in Belgium, I decided to come back and become a civil servant to work on government accountability. I think that my country needs people with a clear sense of justice to change things!

My opinion about TA is...

“It makes me sad when I realize that our government does not feel the right to negotiate the terms with which it interacts with the partners. Too many of us underestimate the power we have. Many things are in place in the texts to empower us, and yet it seems like we lack the will or the right management skills to put that in place.”

What inspires me...

“Rwanda inspires me. Of course they are much smaller than us, but they are a lot more forceful and unambiguous in their relationships with the partners. All that goes into the country goes through the government that has a very clear and centralized vision. Over there, a car bought by USAID, for instance, has a huge logo of the ministry and a tiny logo of USAID. It's a non-negotiable. You don't want that deal, then your money isn't welcome here. That's it!”

What I would like to see change...

“The plethora of human resources. I don't know how many people work in my ministry, even in my own team. But I'm pretty sure half of them don't come and that contributes to less money for each of us at the end of the month as well as a bleak work environment. I speak to partners who tell me when they need to write their reports, they need to collaborate with the state, well they end up having to send requests to seven different people instead of one and that it can take two months to get a response. They complain about how they can't make them more responsive or proactive. There is no way to make them react. And what I tell them is the same thing -- sometimes it's hard to stay positive and want to do your work properly when there are so many people whose abilities are sometimes often questionable.”

What worries me...

“The state thinks in the short term for its priorities not long term development. There are good reasons for this... it's very unstable here and disbursements from the higher ranks in the government are way too few in between (if they ever happen). Still the programs, for instance, should focus on the national strategy and how to strategically implement it, instead of going to do evaluations to recuperate per diems. When they are not faithful to their program's mission they lose their time and focus.”

5/ Rose

The Optimistic Civil Servant

Scales

TTM STAGE



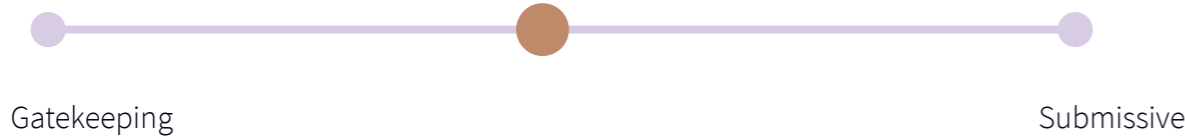
PERSONAL FINANCIAL SECURITY | ACCESS TO FUNDS VS SCARCITY



TIME STABILITY | PREDICTABILITY OF EMPLOYMENT



RANK IN THE PROTOCOLS | DECISION-MAKING POWER VS NO CONTROL



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PROFESSIONAL PRIORITIES | TECHNICAL VS POLITICAL



AMOUNT OF WILL | PROACTIVE VS PASSIVE



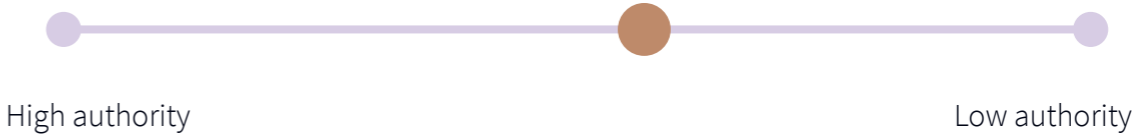
POWER OVER MONEY FLOWS |



INFORMAL PRIVATIZATION | PERCENTAGE OF OVERALL INCOME THATS INFORMAL



RANK IN THE PATERNAL HIERARCHY |



6/ Petra

The Solidary Tinkerer



Director of Finances of a Hospital
late 40s, accountant

“I’ve been working here as an accountant for ten years, including 4 when I worked in close collaboration with an auditor but he was really part of the team after having worked here for over 10 years. He was coming from an international organization but he did a lot for creating the current culture of this hospital.

My opinion about TA is...

“If it isn’t long for a relationship of trust to develop and if the actual needs of people aren’t being listened to, than technical assistance can’t work, in my opinion. It requires work and time, but I think that’s the only way technical assistance can have real impact.”
“Sometimes I have the impression that I am, myself, technical assistance. I’m not a doctor, I’m an accountant so I assist doctors in doing their work. Not sure that people see me this way, but that’s what I am, and good at it, I like to think!”

What inspires me...

“Before the international organization who paid, among other things, for the auditor with whom I worked a lot during my early career at the hospital, the hospital worked a lot like the other ones in this country where it’s the ‘me’ that trumps all. To get to the culture of cohesion, trust and solidarity that we have now, we had to work hard: we meet, we are transparent and we have to make concessions together to survive -- no rumors, no jealousies. What gives me hope is that this social peace we have achieved was established when we had more funds thanks to the organization but once their support was gone we maintained it. If at first a lot of people were very unhappy because they were losing individual power in the name of solidarity, on the long term we have demonstrated that our system is better than playing solo. And that gives me hope!”

What I would like to see change...

“I would like for the state to offer a more stable context for its civil servants. If we were more certain of our future we wouldn’t have to “kidnap our patients” to cover our costs and save children’s lives. We could offer better care, for cheaper.”

What worries me...

“I don’t think the government has the interest of hospitals in mind. For example, we fill our PAO religiously every year and yet we never hear anything back. Then randomly sometimes we’ll receive something, but that’s when they fancy it, and it’s sometimes not even what we need! We need our surgery equipment repaired and instead, they send us sheets... things like that. We can’t expect anything from them and be entirely self-sustainable. We’ve even had moments when certain civil servants would come to us like vultures, I swear: they hear that we are getting help and they come to ask for their part! They aren’t motivated, sure, but coming to grab elsewhere when it’s a question of life and death of another is deeply problematic.”

6/ Petra

The Solidary Tinkerer

Scales

TTM STAGE



PERSONAL FINANCIAL SECURITY | ACCESS TO FUNDS VS SCARCITY



TIME STABILITY | PREDICTABILITY OF EMPLOYMENT



RANK IN THE PROTOCOLS | DECISION-MAKING POWER VS NO CONTROL



INFORMAL NETWORKS | CONNECTED VS DISCONNECTED



PROFESSIONAL PRIORITIES | TECHNICAL VS POLITICAL



AMOUNT OF WILL | PROACTIVE VS PASSIVE



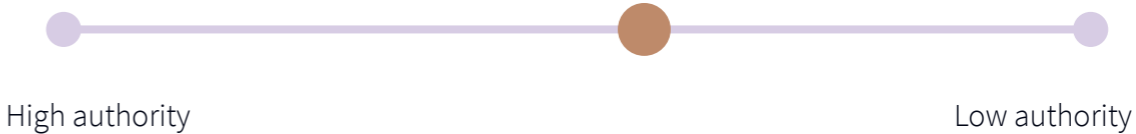
POWER OVER MONEY FLOWS |



INFORMAL PRIVATIZATION | PERCENTAGE OF OVERALL INCOME THATS INFORMAL



RANK IN THE PATERNAL HIERARCHY |



What are the relational/social/cultural dynamics at play between different users?

Overview of Relational Dynamics between MoH and Partners

What Partners think of their interactions with MoH

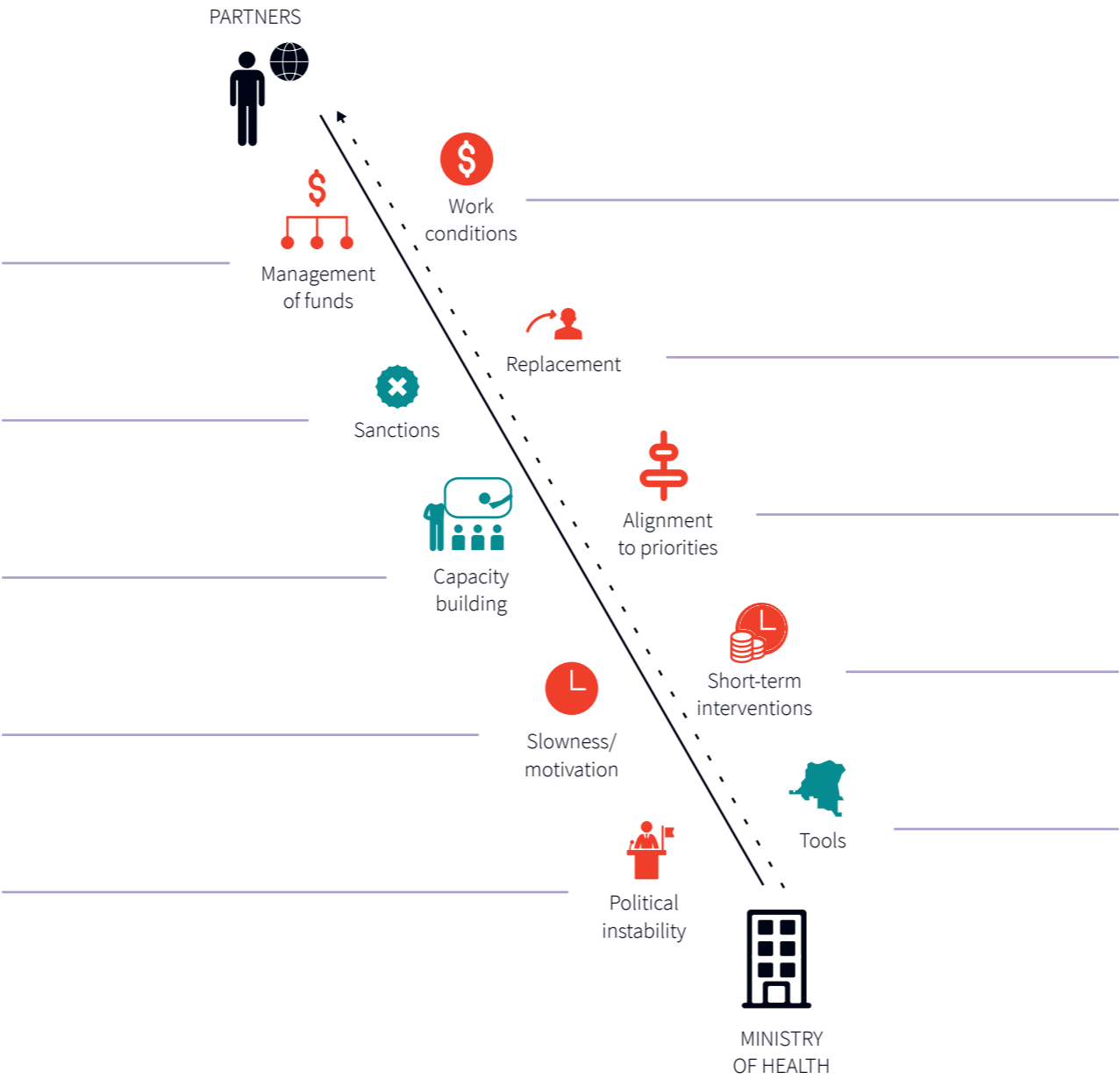
Partners are reticent to provide funds directly to MoH due to their poor capacity to manage funds.

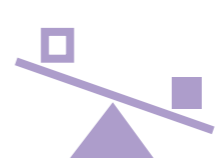
Partners feel that sanctioning MoH for not carrying out activities or mismanaging funds is necessary to change MoH's lack of responsibility.

Strengthening of government structures seems to help Partners improve the quality of TA.

MoH is perceived to be slow and unmotivated, not taking their role in TA seriously.

Political instability is a barrier to TA, as leaders change and the climate is constantly in state of emergency and not focused on development.





POWER IMBALANCE

MoH feels they have a lack of \$ and thus negotiating power. Partners lack trust in MoH to provide funds directly.

What MoH civil servants think of their interactions with Partners

MoH actors cannot help but compare their work conditions to those of Partners' (eg. airconditioned offices, cars, salaries, furniture).

MoH staff feel that their expertise is being replaced when partners engage implementation partners instead of their employees.

MoH actors feel that they have little power to negotiate because they have no funds and that Partners do not align to their priorities but that they have to realign their priorities to match theirs

Partners propose short-term Interventions that have little long term impact.

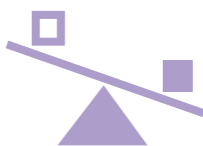
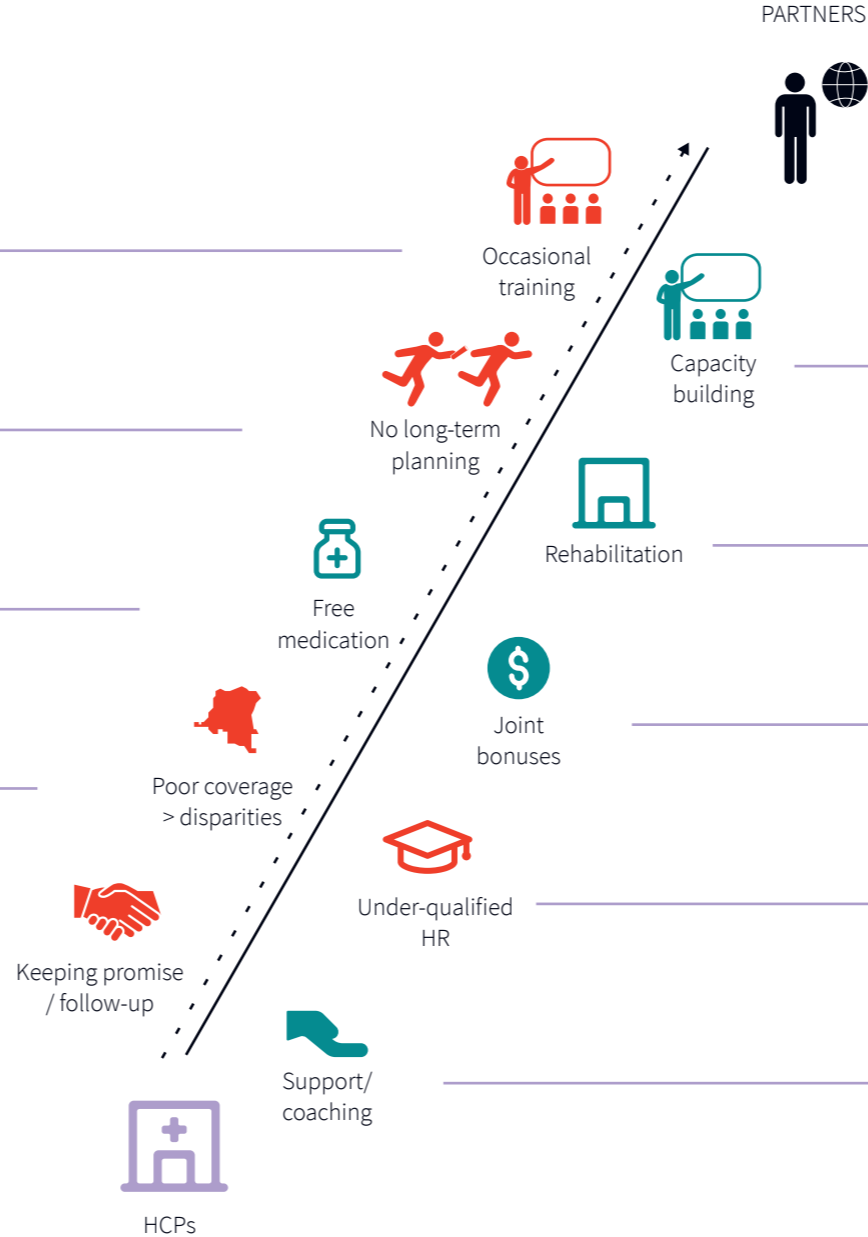
MoH actors appreciate the tools that Partners fund esp. those that are key for prioritization and implementation (eg. dashboard, maps).

What are the relational/social/cultural dynamics at play between different users?

Relational dynamics between HCPs and Partners

What HCPs think of their interactions with Partners

- HCPs desire planned training which is aligned with their needs, otherwise they rarely have access through (paid events) civil society actors (eg. Association of Pediatricians)
- Partners do not plan for the long term and there is no relay between partners after an initiative has ended.
- As facilities often lack medical supplies, it helps when Partners procure them with free medication.
- HCPs feel that areas are poorly covered by Partners who choose different areas instead of filling in gaps where another has started, creating disparities within villages.
- Facilities feel abandoned by Partners when they don't fulfill their promise (eg. bring supplies, follow-up) to carry out the initiative.



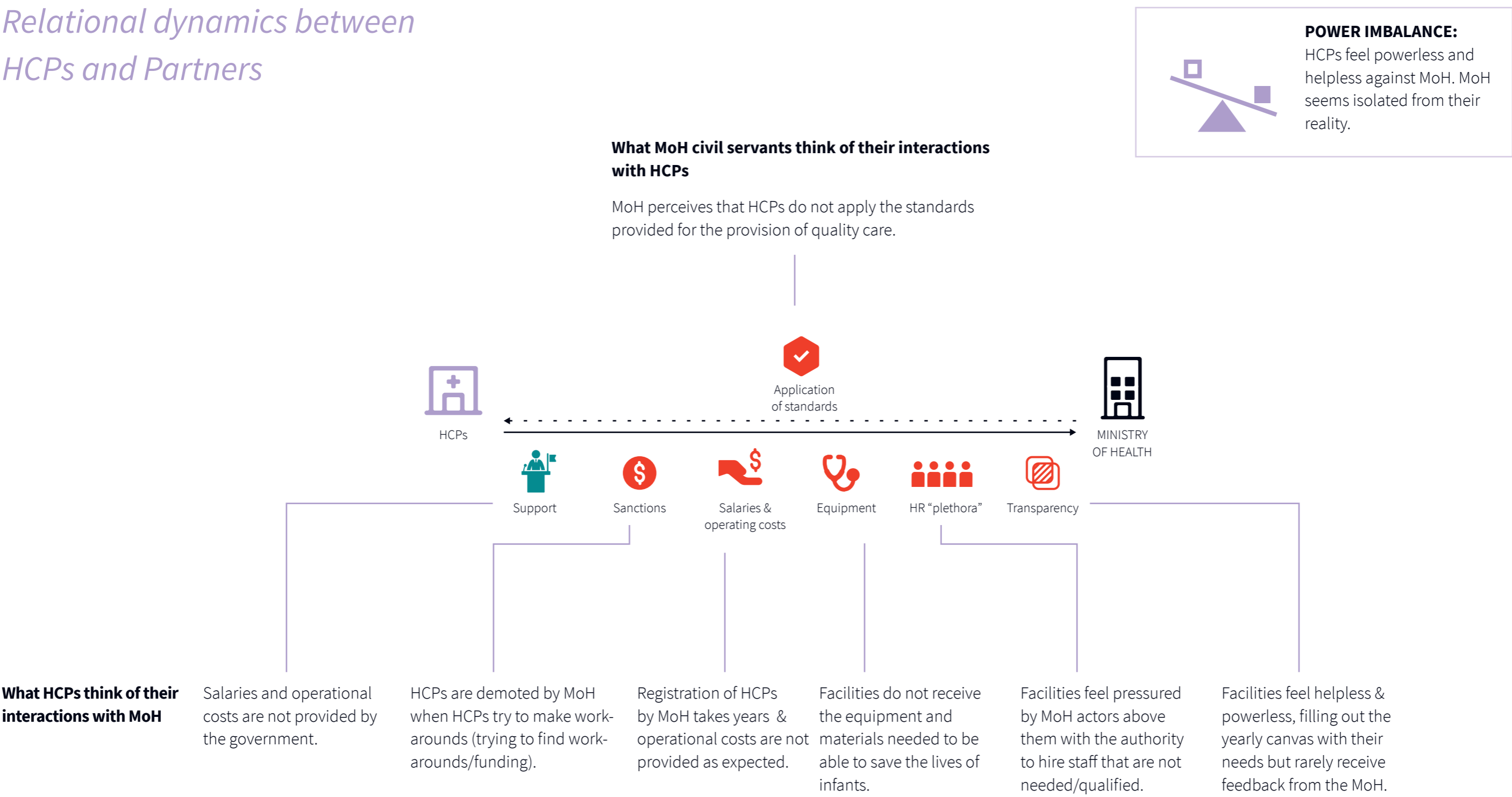
POWER IMBALANCE:
HCPs feel that the only help they can get is through Partners. Partners feel empathy towards them as they know they have little support from MoH.

What Partners think of their interactions with HCPs

- Partners see that capacity building helps HCPs improve quality of care.
- Partners would rather provide TA through efforts to improve infrastructure than provide direct funds (workaround).
- Gradual and joint bonuses ("primes") by Partners help motivate HCPs/Zone staff.
- Partners find that facilities are overstaffed (nepotism) and have under-qualified HCPs which poses an important barrier to quality of care
- When Partners personally coach and support HCPs/administrative staff on-site enables them to put the theoretical training to practice.

What are the relational/social/cultural dynamics at play between different users?

Relational dynamics between HCPs and Partners



What are the relational/social/cultural dynamics at play between different users?

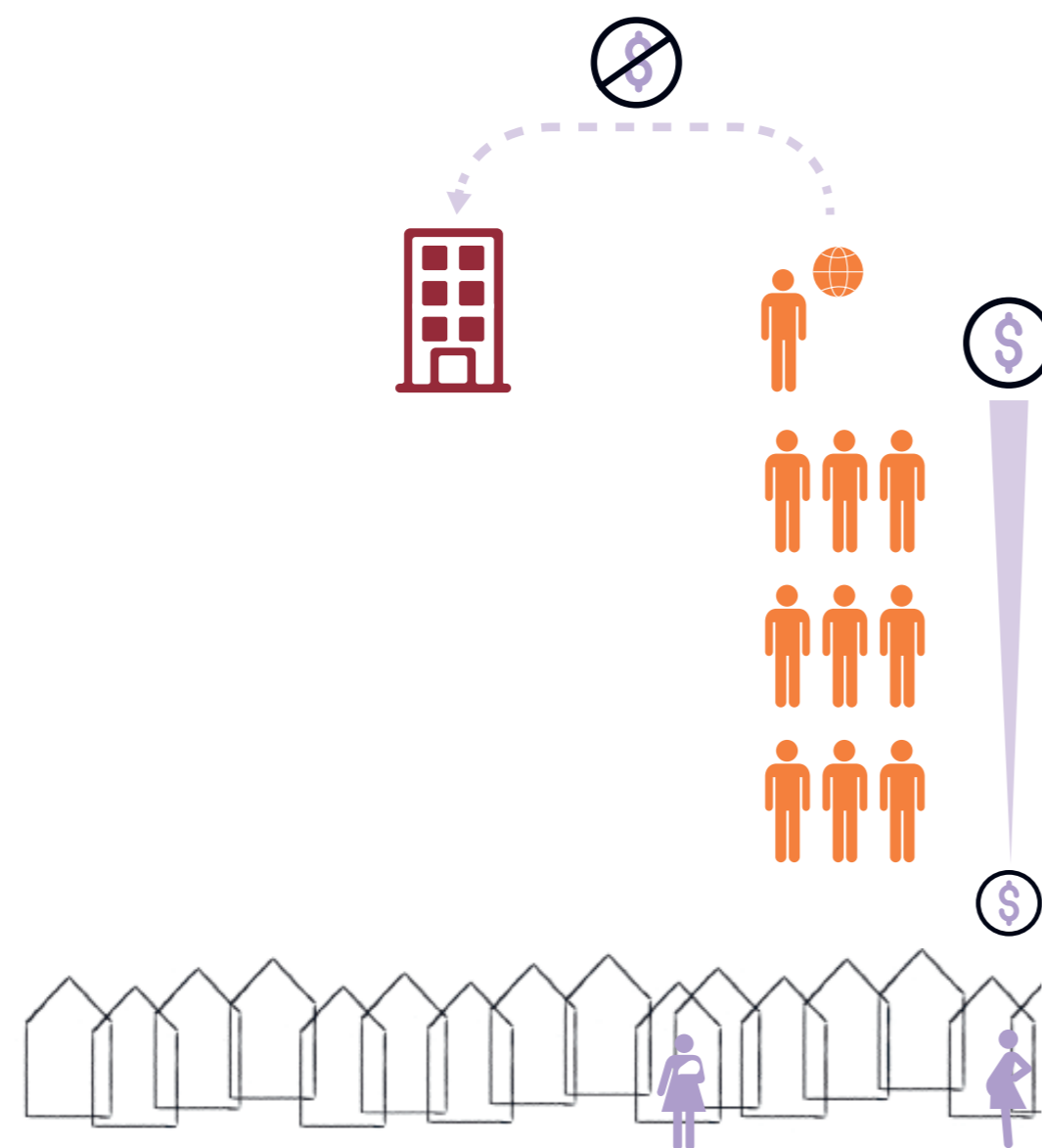
Overview of Facilitators and Barriers of TA from different perspectives

With 3 key actor groups, there are 6 perspectives to be taken into consideration.

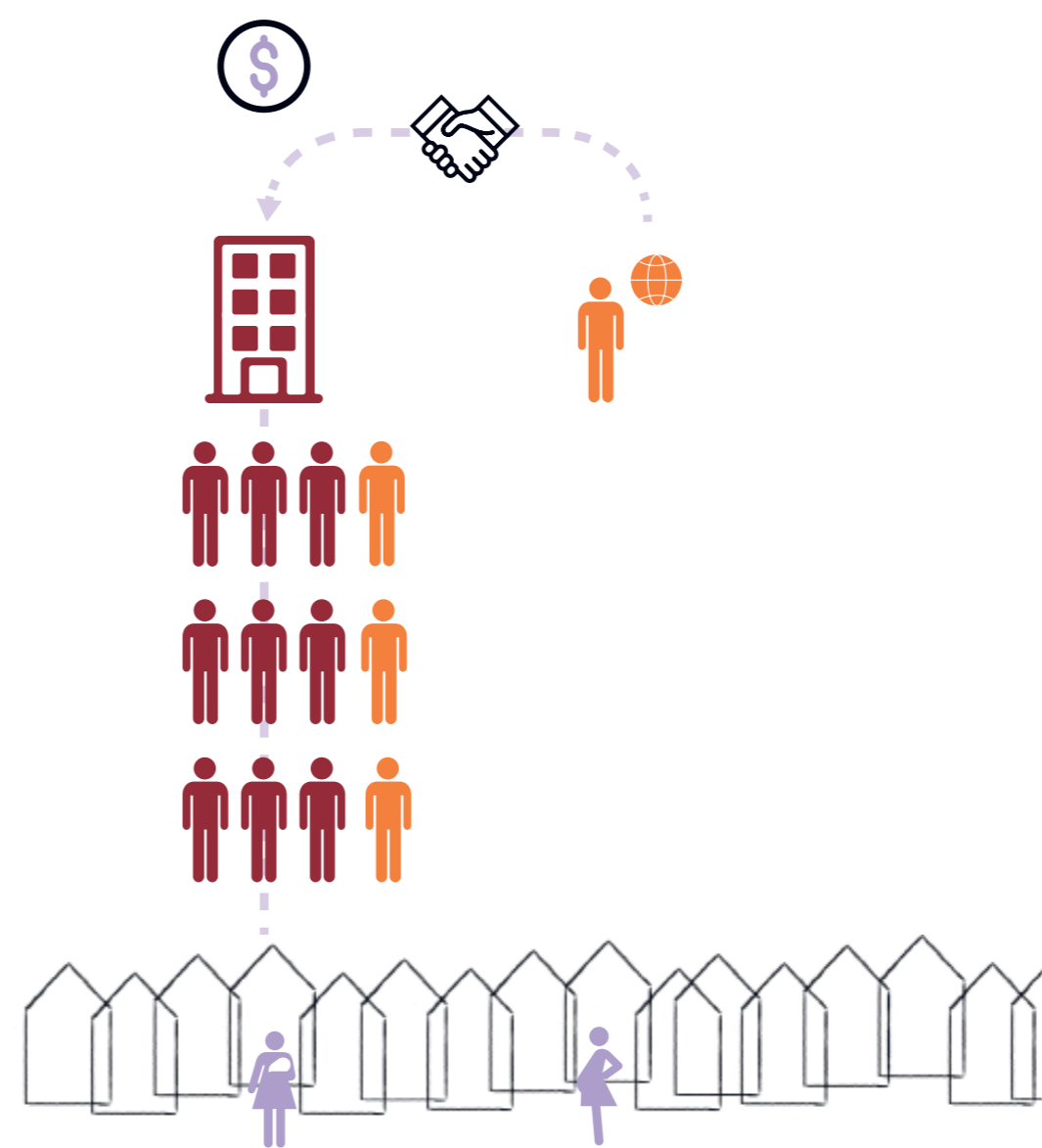


What are the relational/social/cultural dynamics at play between different users?

Relational dynamics between MoH civil servants and Partners



In the **current state of TA**, funding partners create workarounds so that their funds are accounted for due to a **lack of trust** in the MoH's capacity and 'willingness' to disburse and manage funds appropriately. Funding partners seek reliable implementing partners to run activities and can offer them the accountability they need to apply for further backing. Unfortunately, a chain of intermediaries often results in a loss of 30% of the funds only on operational costs and little impact is felt at the community level.



In an **ideal future state of TA**, MoH would enact **good governance** and be **accountable** for its part in the TA process in which they could **establish a real partnership** on the basis of trust with funding partners. In this scenario, the MoH structures would become strengthened and their technical expertise would not be 'replaced' by other actors, as is now commonly perceived. If funds were also properly disbursed further downstream (Provincial, Zone levels), the community would greater benefit from TA. Funding partners would also do their part to let the MoH lead and better align with their priorities.

The Journey

What are the user experiences with technical assistance?

What are the barriers and facilitators of TA?

What are the artifacts (objects or products) of TA?

What are the user experiences with technical assistance?

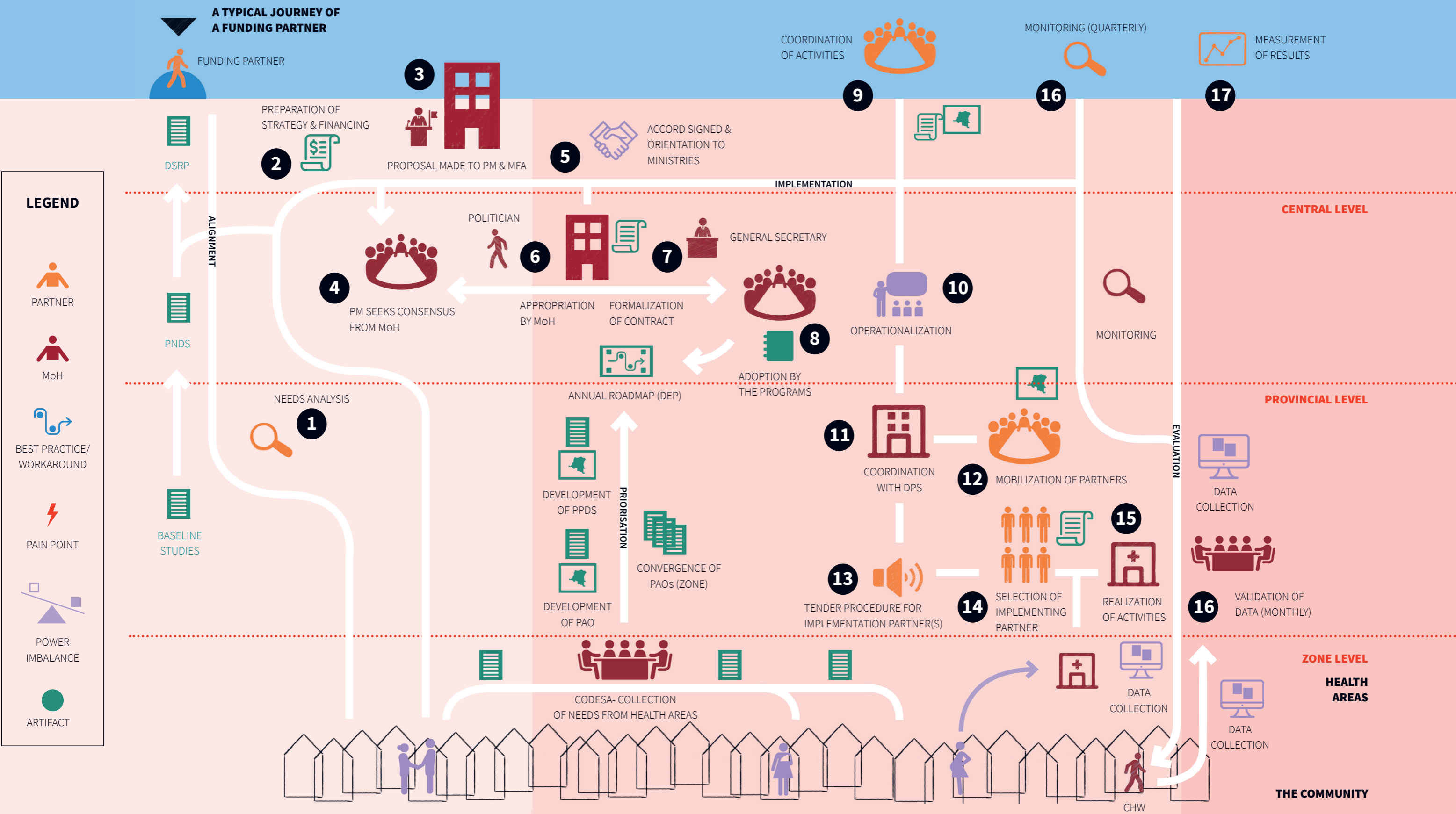
What is an experience journey?

It is a map that visually identifies and organizes every encounter a user has with a company/brand/service. These interactions are commonly referred to as steps or “touchpoints” and can be positive or negative (i.e. delight and pain points). As such it makes it evident to uncover opportunity areas for change.

Telling the story

We wish to take you on a typical (though not exhaustive) journey of TA based on the stakeholder interviews Sonder conducted during the research phase in DRC in February and March 2019 in order to highlight where the biggest opportunities for improvement and change lie. We will take you step by step in order to highlight the main challenges, best practices and workarounds (alternative solutions) and artifacts (objects or products) observed along the way in order to have a clear vision of the current state.

What are the user experiences with technical assistance?



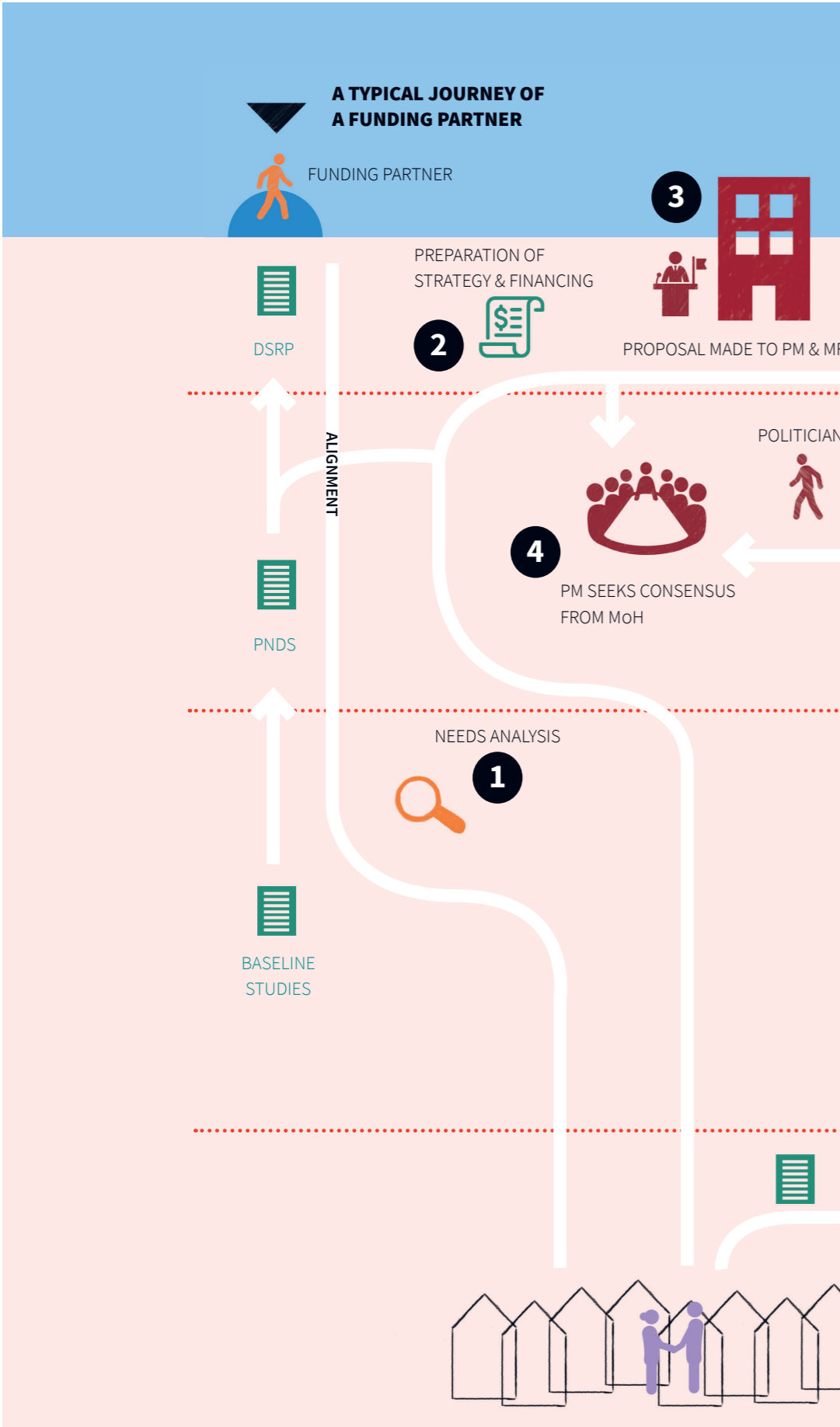
The TA Journey is composed of 3 phases:

The first is the **PRE phase** where alignment between the MoH and international partners' priorities occurs.

The second is the **DURING phase** where partners, MoH employees, implementing partners and civil society engage in the implementation process.

The **POST phase** is where TA initiatives have come to an end and evaluations are conducted.

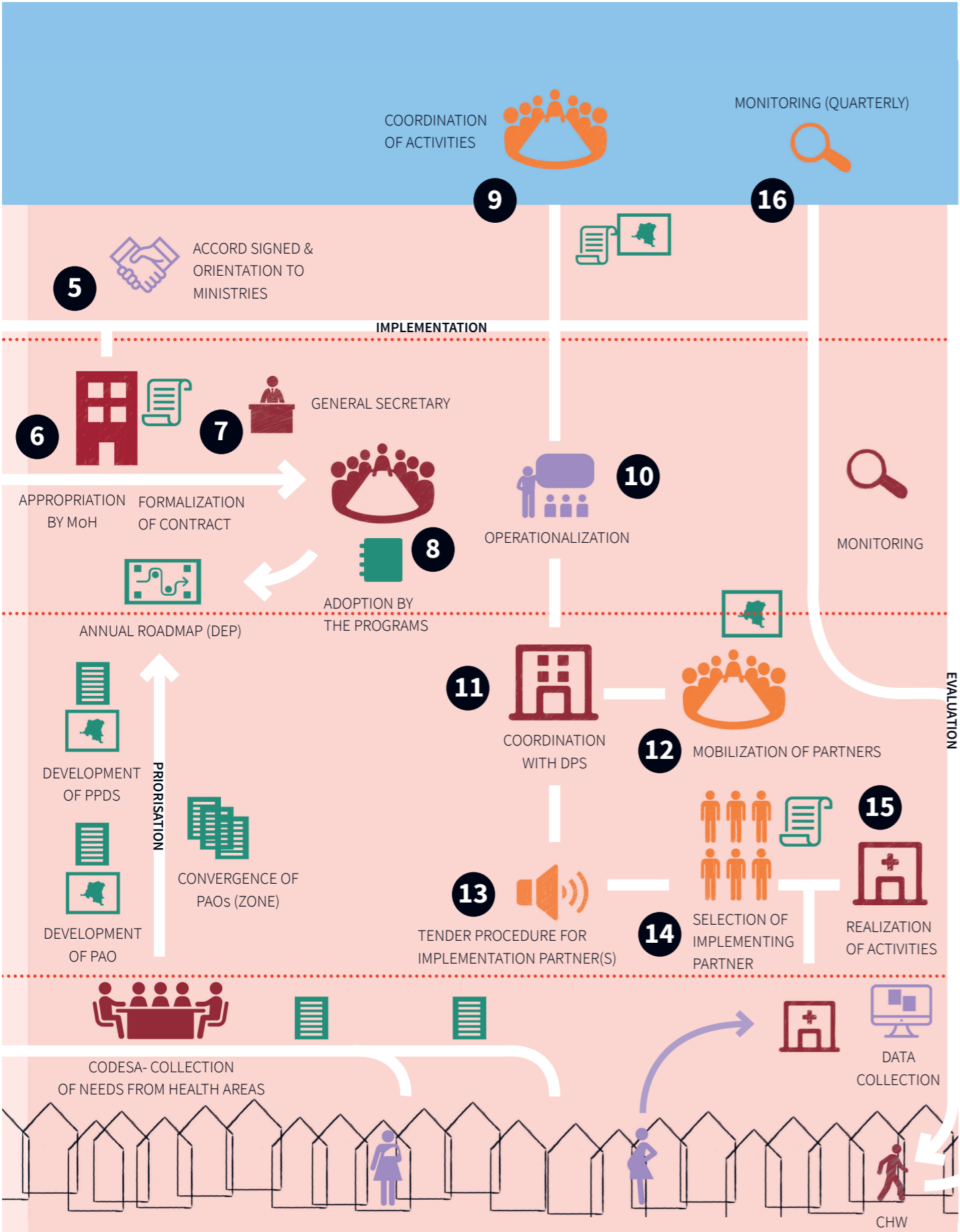
TA Journey Pre-Phase: Alignment



An international funding partner decides that they would like to provide DRC with technical assistance in the area of nutrition in order to reduce the maternal, newborn and child mortality rate.

- 1** The partner decides to first conduct a **situational analysis** of the current needs and gaps at all levels of the healthcare system, all the way down to the health areas. (Insights: 2/4/5/6)
- 2** Based on the different sources of data and observations the partner **prepares a strategic plan** that includes financing. (Insights: 1/2/4/5/6)
 - Partner's country's political agenda takes priority over those defined by DRC. Geography is often already chosen at this point without consulting MoH and is likely based on incomplete data. Diverse proposals, strategies and modes of working makes it complex for DRC to manage.
 - WHO elaborated RaCE initiative in partnership with MoH.
 - Several documents from WHO, UNICEF and MoH are considered in this process. However, the State complains that DRC's priorities contained in the Poverty Reduction Strategy Paper (DSRP) - derived from National Plan of Health Development (PNDS) & baseline studies ('Etat des Lieux') are not considered enough in the partner's decision-making process.
- 3** **The proposal is officially made** to the Ministry of Foreign Affairs and the Prime Minister, who in turn calls on the Ministry of Health for a consensus. (Insights: 1/4/5/7)
 - A strategic plan including funds is handed to PM & MFA
- 4** A representative from the Ministry of Health participates in the meeting to **validate** that **the proposal** is aligned with the PNDS. (Insights: 1/3/4/5/7/9)
 - A politician rather than a technocrat is sent to do this, causing validation to be based on political vs technical criteria.
 - National Plan of Health Development (PNDS) is taken to represent MoH's priorities but in practical terms, may not align with partner's proposal.

TA Journey During Phase: Implementation



- 5 The contract is signed** and the partner is oriented to the ministries implicated to begin the implementation process. (Insights: 1/4/9)

 - ⚡ Monitoring or Post-project planification not taken into consideration to sustain impact over the long term (repercussions felt at end of TA). Govt does not do its part and relies solely on partner's contribution.
 - ⚖ Politics vs technical expertise: Govt considers partner's financial means over DRC priorities (lack of resources, lack of negotiating power).
 - 🔄 Co-investment accords: State makes its financial contribution before partner signs agreement (eg. GAVI).
 - Contract is signed (diverse contract typologies eg. USAID Development Objectives Agreement (DOAG)).
- 6** The partner approaches the **Ministry of Health** as it **takes ownership** of the agreement and becomes their main counterpart during the process. (Insights: 1/4/9)
- 7** The **Secretary General formalizes the appropriation** of the agreement and orients the partner to the programs. (Insights: 5/7)
- 8** The Program **adopts the agreement** according to their standards and regulations. (Insights: 3/5/9)

 - ⚡ Program adjusts priorities in action plan to align with those of the partner, as it does not have funds and feels it cannot refuse. Program sees that the partner is not offering enough funds to cover needs - perceived as 'scattering' of funds. Low disbursement of funds / lack of resources from MoH.
 - 🔄 UNICEF is supporting the nutrition program (PRONANUT) with a digital dashboard PROSANI is developing a platform where the stock and material needs of each center are captured.
 - An implementation plan is rendered, program lacks access to a map (of health areas) to make decisions - priorities on the ground are not accurate/known.

TA Journey During Phase: Implementation (continued)



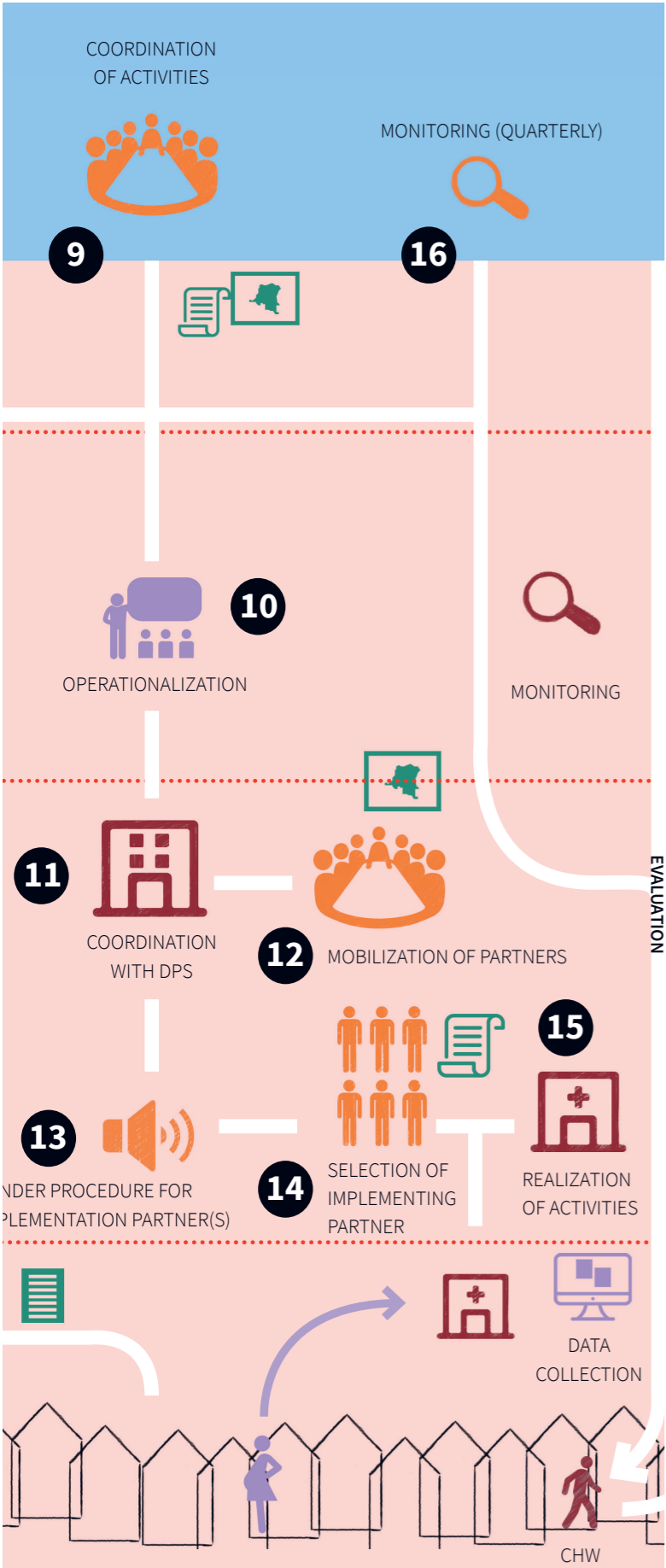
- 9** The partner then meets with a group of international partners (GIBS) to coordinate activities and define geographies prior to commencing implementation. (Insights: 4/5/9)

 - GIBS is a workaround amongst partners to avoid duplication (parallel activity apart from MoH); increased its effectiveness by reducing number of members and maintaining a high level of active members. Outreach coordination and time taken by partners to decide still a challenge.*
 - Basket Fund (“Contrat Unique”) is signed by each partner but often partners take a long time to decide or do not keep their word and choose other geographies to conduct their activities. Map of funding & activities & partners are used to coordinate amongst partners.*
- 10** Now the partner can move into operationalization mode and meets with MoH (national level) to plan the activities. Exact geographies at the health area are chosen. (Insights: 2/3/4/5/6/8/9)

 - MoH functionalities (DPS & Zones) feel replaced or that work is being duplicated by external actors
Diversity of financial and management procedures amongst partners make it difficult for MoH actors at different levels to adapt to each of them (eg. fiscal year, strategies, methodologies).*
 - PROSANI - rotating staff member works in MoH office once/week - enables collaboration, strengthening of govt expertise & a real sense of partnership and respect.*
 - Maps of activities & partners does not exist at DPS/Zone level, thus health areas chosen based on inaccurate data.*
- 11** As some initiatives take place further downstream in the healthcare system, the partner coordinates with the provincial level (DPS) before starting their activities. (Insights: 1/2/3/4/8/9)

 - Partner realizes that needs/reality on the ground are different than what they expected & planned for (due to inaccurate data and lack of coordination between national level and DPS/zones).
Zones complain that they are not consulted prior to signing contract with partners to validate that activities align with their needs. Only partial disbursement of funds by national level (40-45%), DPS/facilities lack resources to realize activities or offer quality care. Weak decentralized power at DPS level.*
 - Lack of leadership and motivation at DPS level - irregularity of meetings, does not search for solutions (staff not registered/ low motivation, paternalistic hierarchy weight). MoH’s bad governance over provinces - it does not disburse funds to make decentralization possible (DPS not independent/responsible).
Under-qualified & overstaffed staff follows new projects and funds and prioritize immediate needs over development.
Fragmentation - staff may be overwhelmed with different donor initiatives at once.*
 - PAOs not taken into consideration by partners/MoH at national level (see slide 80.)*

TA Journey During phase: Implementation (continued)



12

The DPS executives then **mobilise other partners** working at their level in order to **converge and harmonize** activities across initiatives. (Insights: 2/3/4/5/8)



Usage of incomplete data to take strategic decisions during implementation esp. which areas to prioritize as SNIS collects data only from health centers (accounting only approx 30% ; 70% of data is at community level & not accounted for).
Diversity of financial and management procedures make it difficult for MoH actors at different levels to adapt to each of them (eg. fiscal year, strategies, methodologies).

13

The partner then **launches the tender procedure** (“appel d’offre”) in order to find an implementing partner to conduct the activities. (Insights: 4/5/9)



Workaround for accountability issues and to comply with donor requirements. Partner lacks trust in the MoH’s weak governance and capacity to manage funds & thus searches for implementation partners that can work in their fashion.



MoH complains they should be involved in the selection process of the implementing partner, feeling that Partner oversteps by not making them aware of what is going on the ground.

14

An international as well as two other **local implementing partners are contracted** in turn under the same guidelines as the partner’s in order to ensure accountability and rigor. (Insights: 4/5/8)



MoH feels replaced and would like partners to use their technical expertise and reinforce their system. Partner constrained by its country’s politics and lack of trust of MoH.



Formal tender process ends in contract.

15

Finally the **realization of activities** occurs and the partner minimum and supplementary packages are provisioned to health centers and hospitals. (Insights: 1/2/5/8/9)

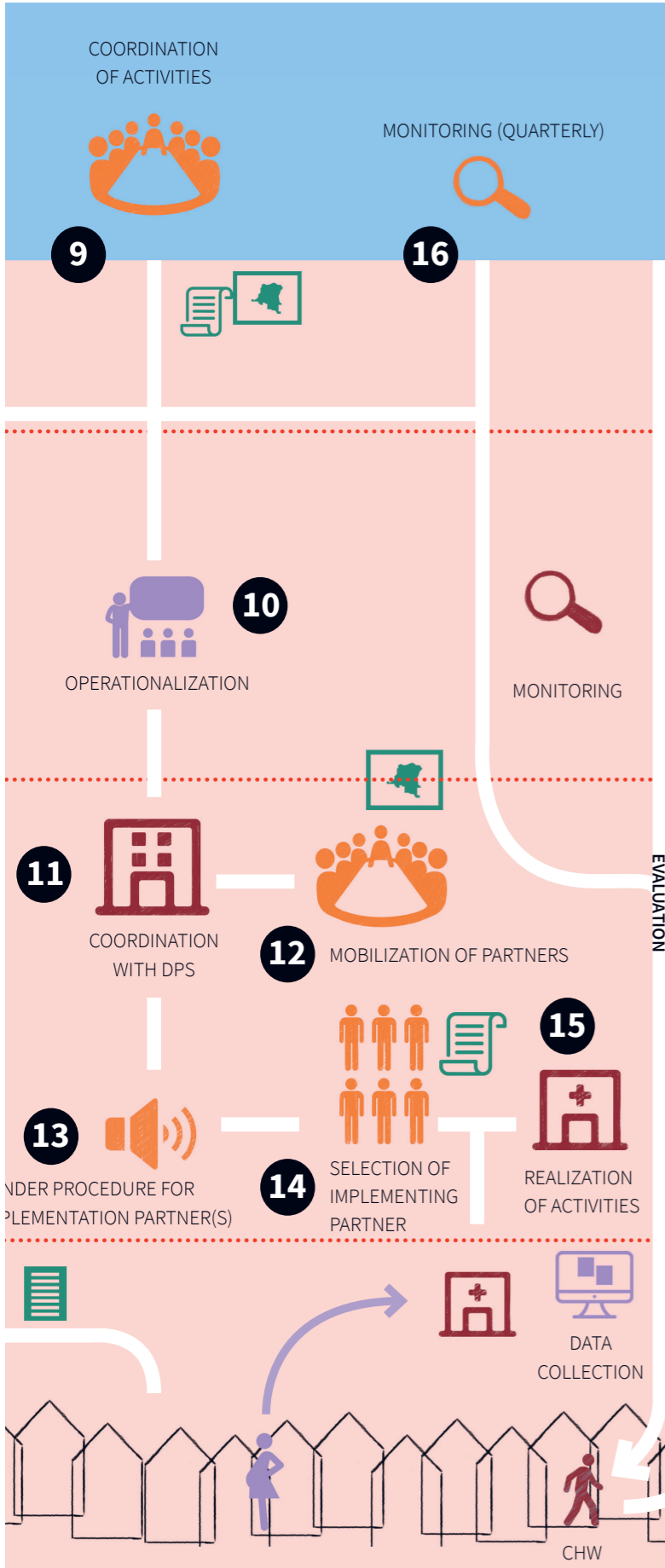


Lengthy procedures cause stock-outs of drugs or delivery close to their expiration date and field activities are conducted in a disorganized manner. Unplanned and little access to capacity building (free training through partners or paid offered by association of pediatricians).



Facilities feel ‘abandoned’ and powerless before the state as they do not receive resources nor materials to attend to patients.
Bad governance & lack of transparency - the State does not respond to needs (yearly PAO) nor disburse funds to make decentralization possible (provincial level independent/responsible); overstaffed, under-qualified HCPs (hired by governors).
Facilities feel that partners are their only chance to improve conditions but also feel that they can be unreliable especially when they do not keep to their word (eg. stop supplying medication, activities wind down after first semester etc.).

TA Journey During Phase: Implementation (continued)



16 The partner **monitors** the activities on the ground to assess progress and the quality of the implementation. (Insights: 2/3/5/9)



GBS/UNICEF conducts a quarterly visit to the field to verify that the activities are being conducted to their standards. Applies sanctions (eg. stops funds destined to carry out activities if finds that staff is not carrying them out as promised).

DPS & Zone HR often feel overwhelmed by the amount of different donor activities & methodologies and lack qualified HR for conducting them, feel time frame provided is often unrealistic.

Partners find that HCPs & administrative staff are often under-qualified to treat patients or conduct activities due to bad governance (hired based on their social connections not merit and lack motivation due to poor working conditions - scarcity of materials, lack of per diems/salaries).

MoH complains that they are unable to monitor activities downstream (quarterly visits) because they lack the resources to do so. Zones validate data from facilities on a monthly basis but there is a lack of rigor in the collection and quality of data analysis; Community data (70%) is not collected.

DPS complains that national MoH employees as well as partners conduct visits on the ground without coordinating monitoring activities with them first.



Zones complain that sometimes they feel abandoned by the partners, esp. when they don't follow-up.

TA Journey Post Phase: Evaluation

17

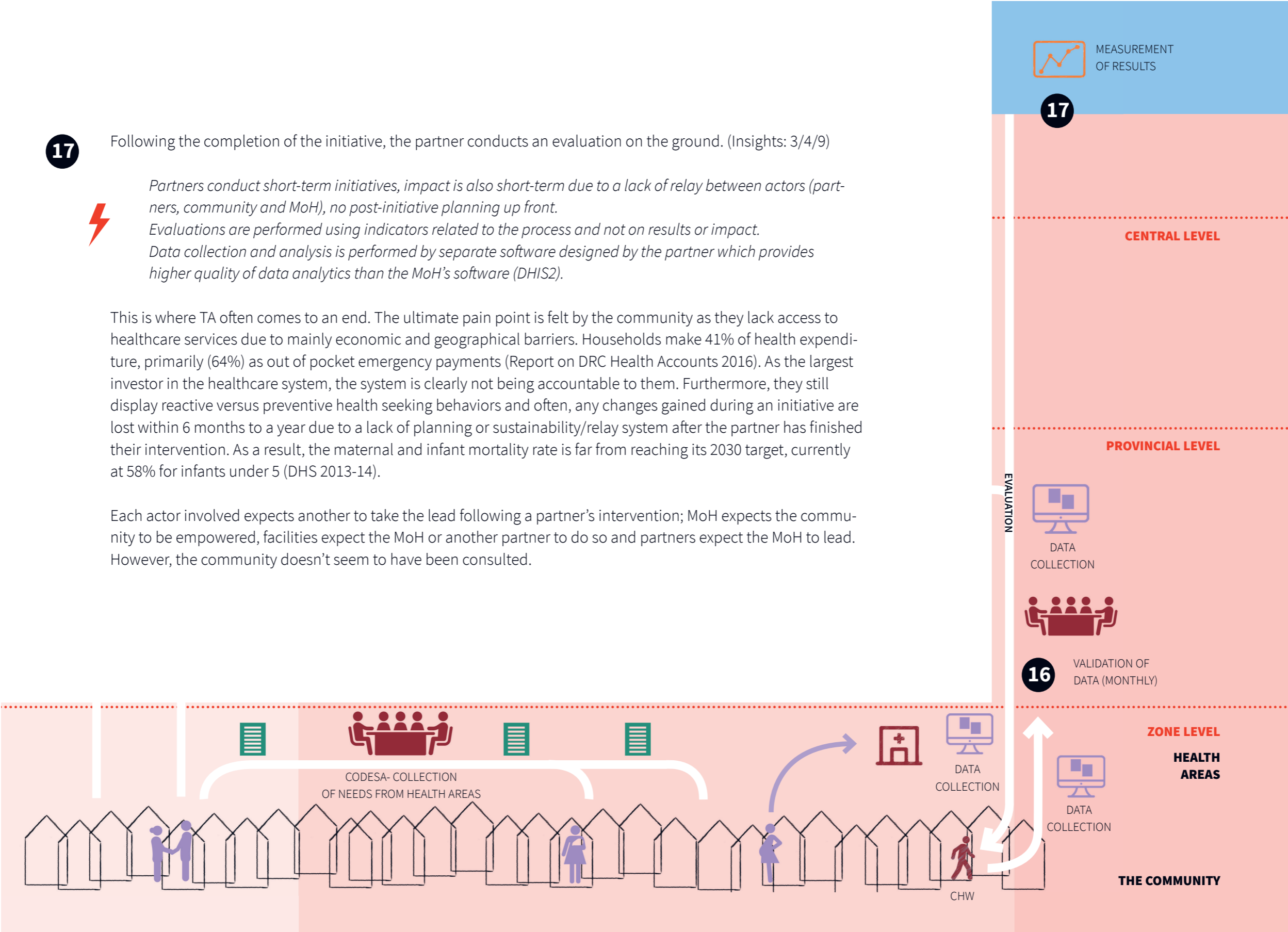
Following the completion of the initiative, the partner conducts an evaluation on the ground. (Insights: 3/4/9)



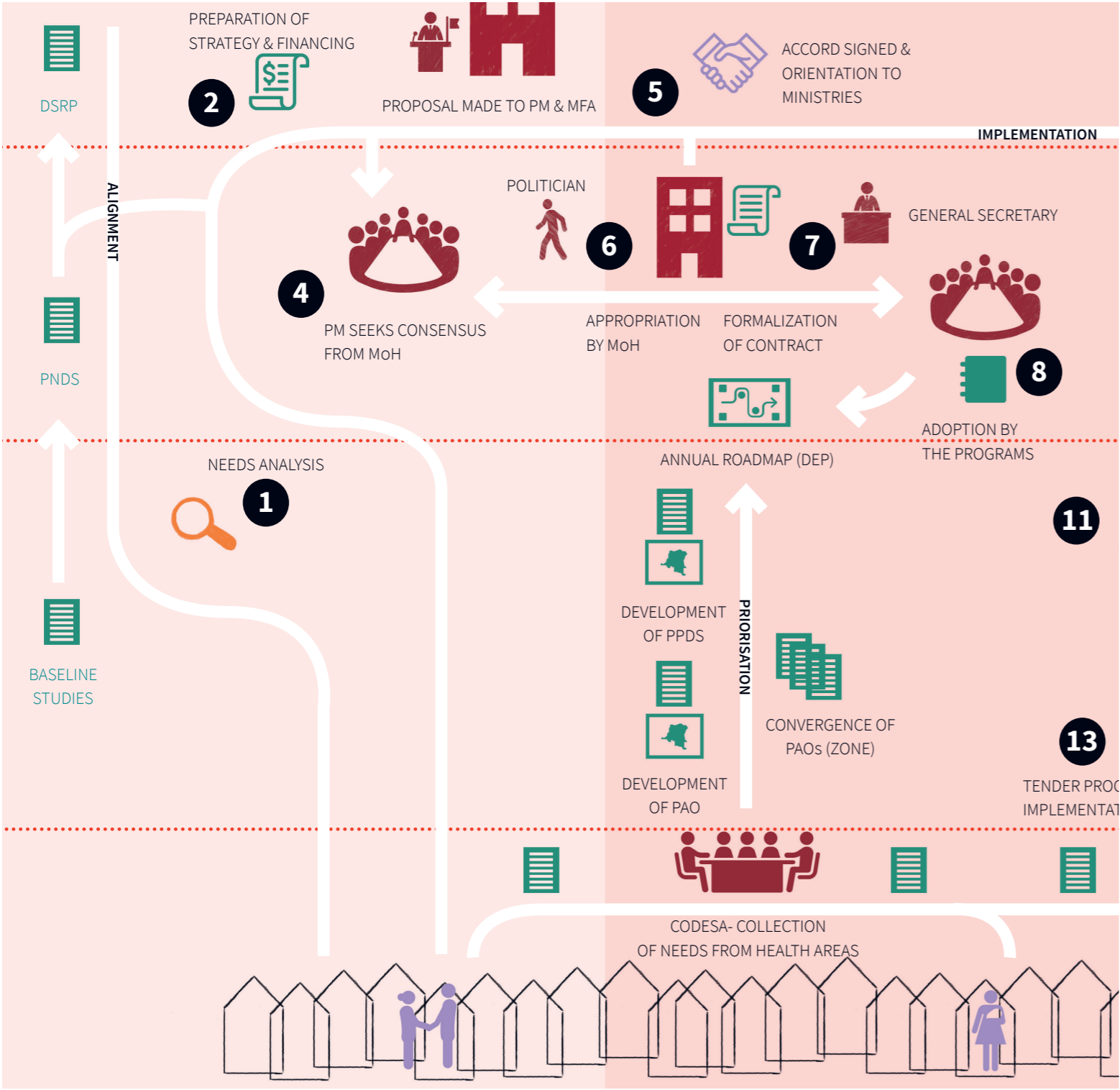
Partners conduct short-term initiatives, impact is also short-term due to a lack of relay between actors (partners, community and MoH), no post-initiative planning up front.
Evaluations are performed using indicators related to the process and not on results or impact.
Data collection and analysis is performed by separate software designed by the partner which provides higher quality of data analytics than the MoH's software (DHIS2).

This is where TA often comes to an end. The ultimate pain point is felt by the community as they lack access to healthcare services due to mainly economic and geographical barriers. Households make 41% of health expenditure, primarily (64%) as out of pocket emergency payments (Report on DRC Health Accounts 2016). As the largest investor in the healthcare system, the system is clearly not being accountable to them. Furthermore, they still display reactive versus preventive health seeking behaviors and often, any changes gained during an initiative are lost within 6 months to a year due to a lack of planning or sustainability/relay system after the partner has finished their intervention. As a result, the maternal and infant mortality rate is far from reaching its 2030 target, currently at 58% for infants under 5 (DHS 2013-14).

Each actor involved expects another to take the lead following a partner's intervention; MoH expects the community to be empowered, facilities expect the MoH or another partner to do so and partners expect the MoH to lead. However, the community doesn't seem to have been consulted.



TA Journey: What are the artifacts of TA?



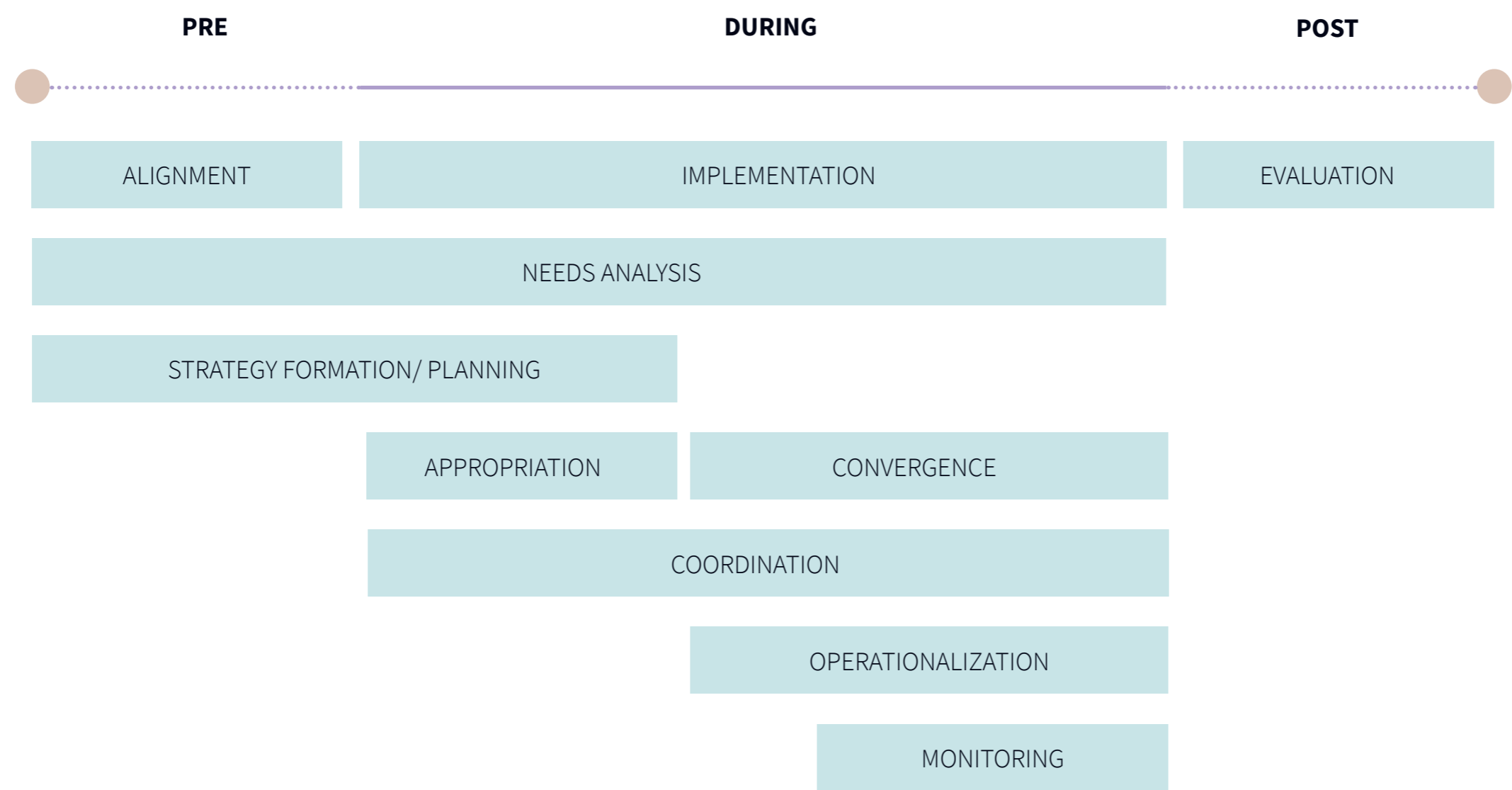
MoH actors spend their time preparing many artifacts throughout the year for their needs to be heard by the higher echelons. PAOs are transformed into yearly road maps and supposed to be included in the 4-year National Health Development Plan (PNDS) and ultimately, in the Poverty Reduction Plan (DSRP).



Actors downstream complain their priorities are not taken into consideration and that there is no feedback / transparency from the higher orders, neither in communication nor in material form.

Upstream actors say provincial level does not look at the data online.

TA Journey: What are the different functions of TA?



The Opportunities /HMW

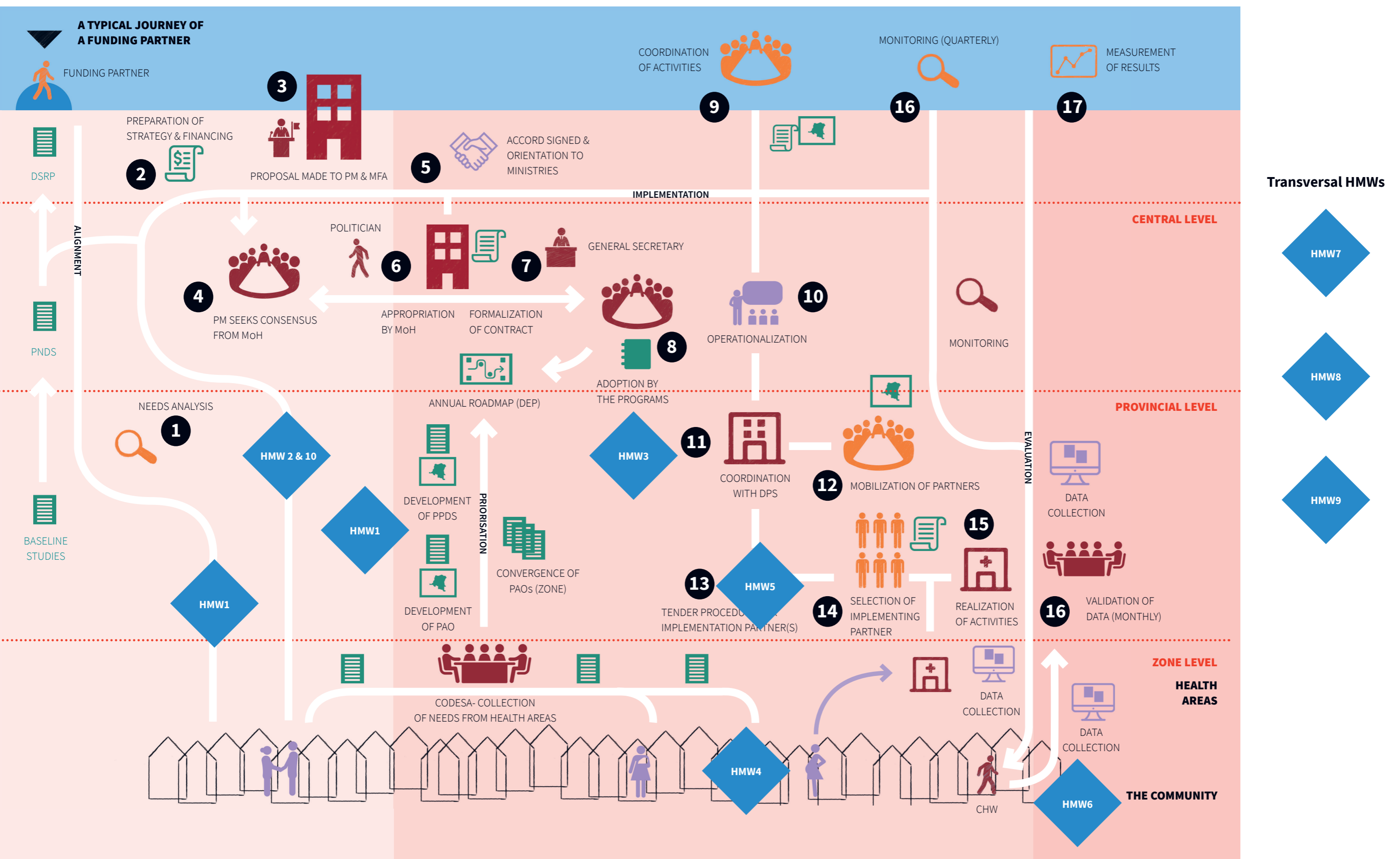
What are the big opportunity areas for change?

What are the specific 'How might we' questions we explored?

What are the emerging ideas and concepts for change?

What are the guiding design principles for evaluating future concepts?

What are the big opportunity areas for change along the TA journey?



What are the specific how might we questions we explored?

- *How might we unearth the priorities in a weak/dysfunctional health system? (created 16 ideas)*
- *How can the system actors better align themselves to the priorities? (created 7 ideas)*
- *How can we avoid replacing actors at the operational level? (created 14 ideas)*
- *How can we reduce the burden of households in the health system? (created 16 ideas)*
- *How can we avoid doubling of activities and gaps on the ground? (created 12 ideas)*
- *How can we make the positive impact long lasting and/or sustainable? (created 9 ideas)*
- *How can we improve governance at all levels? (created 6 ideas)*
- *How can we reinforce leadership? (created 3 ideas)*
- *How can we create a healthcare system that is responsible (for itself)? (created 3 ideas)*
- *How can we develop technical assistance that has an integrated approach? (created 0 ideas)*

Participants created the most ideas for opportunity areas 1, 3, 4, and 5 (highlighted above).

What were the emerging ideas for change?

During the workshop 90 ideas were created in line with the future vision in mind (see next section), the below themes emerged. Participants then clustered the main ideas (highlighted below) and voted on them based on feasibility, impact and affinity, which resulted in the selection of 4 ideas to develop into concepts.



- **Dialogue with community representatives**
- **Rapid surveys followed by participatory analysis**
- Regular analysis and monitoring in communities
- Standardized and detailed Canvas
- Alignment with action plan (PAO)
- Obligatory feedback



- Action on prioritised problems /alignment on real priorities
- Round-table for mobilization of funds
- Alignment of partners with the State's priorities
- Single Planning Process
- High impact interventions with low cost



- Strengthen decentralization (DPS)
- **Respect agreements**
- To each one their role
- **Joint planning**



- **Mutualising; Universal coverage; Risk Sharing**
- Community financing of health care through income generating activities
- Streamlining prescriptions
- Flat-rate pricing
- Identifying the major problems



- **Single contract and accountability with framework for dialogue between partners**
- **Streamlining at the health area level**
- Streamlining structural approaches (health area level)
- **Map of Interventions**



- **Skill Transfer**
- The state takes over
- Empowerment of local beneficiaries
- Dynamic projects: corrective measures along entire process
- Progressive power of central gov



- Identification of problems
- Coordination of interventions and actors
- Compliance to legal texts
- Fostering teamwork
- Governance
- Holding actors accountable



- Strengthening leadership
- Technical skills and management
- Skills, respect regulations, institutional capacity building



- Analysis of needs
- Bottlenecks and reliable solutions
- Ownership

The Future Vision

What is the new 'vision' and 'values' of users in the re-imagined model?

What are the concepts that can bring this new model and vision to life?

What is the new ‘vision’ and ‘values’ of users in the re-imagined model?

During the workshop, the future vision for how technical assistance should be was described by participants as follows:



Country-driven

- TA will be generated, owned and delivered from within the DRC.
- TA will be essentially government led, in partnership with donors.
- TA is not exercised without the awareness and consent of MoH.



Coordinated

- TA is organized in a way that minimizes doubling of activities and scattering of funds.
- TA will move away from sustaining parallel systems and be more complementary.



Accountable

- TA is accountable to the beneficiaries and primary investors.
- TA is evaluated in reference to the impact on the maternal and infant mortality rate.
- TA funding is impactful at the community level.



Transparent

- TA is responsive to requests by the province, zone or its facilities.
- TA is transparent across all structure levels and actors. TA has standards that are practiced by all actors and if not, is enforced.



Efficient

- TA is organized in a fashion that it performs better and thus feels more rewarding to its actors.
- TA is conducted on the basis of good governance and is efficient as it decentralizes power and enables each actor to take responsibility and ownership.



Sustainable

- TA provides sustainable solutions that have long term impact, esp. on the community and MoH structures.
- TA will plan for the ‘relay’ between actors post-initiative at its conception.
- TA will focus on development, not only on urgent matters.



Respectful

- TA occurs through a two-way dialogue rather than a one-way, hierarchical transaction.
- TA is effected in partnership on the basis of trust, conviviality.
- TA is not imposed but is inclusive, elaborating initiatives with the community from the outset.



Needs-based

- TA is based on real unearthed needs and gaps.
- TA is based on community needs, not just facility level needs.
- TA will provide reliable data to facilitate prioritization.



Aligned

- TA is always aligned with national priorities (PNDS) and local plans (PAOs).
- TA is not driven by partners’ political agendas.
- TA is less political and more based on technical expertise.

What are the concepts that can bring this new model and vision to life?

During the workshop, the following 4 concepts were further developed from ideas by thinking through the following aspects:

- *What is the problem you are trying to solve?*
- *Who is it a problem for?*
- *What are the steps/ process involved for change?*
- *What behaviors require changing?*
- *What is the desired outcome?*
- *What barriers exist and how can they be mitigated?*
- *What are the main design principles/ values of this concept?*
- *Where does it lie with respect to the desired future vision of TA?*

Please note that the following concepts are in their original format as developed by participants and require further reframing and development, which is the focus of the next phase (Concepting and Prototyping).

Concept 1:

The Community First

HMW 1: How might we unearth the priorities in a weak/dysfunctional health system?

Engaging the population from the ground up to unearth the deepest needs of all the people at all levels. Promote community dynamics by taking all actors, starting in the villages -the Community Units (CAC, CODESA, COCODEV) and community healthcare workers (CHWs).

This movement would not be constrained only to health but would involve other sectors that have an impact on health, such as agriculture and education.

PROBLEM AREA

The community is often not engaged in the conception, elaboration nor the implementation of the projects.

DESIRED OUTCOME

The community feels empowered and responsible as it has a clear role in the project, it engages in its success.

DESIGN PRINCIPLES

Community-inclusive / Multisectorial /Accountable

TARGET & INFLUENCERS

- The main target group is the community, the beneficiaries.
- The other influencers: health zone committee, different health committees, village leaders, MoH, NGOs.

BARRIERS

- Ethnic conflicts
- Natural catastrophes
- Insufficient funding/resources
- Communication of added value of this new concept to actors.

FUTURE VISION

Short-term feasibility

BEHAVIORS TO CHANGE

The health zone management team (ECZ)will bring together the different health committees, ensuring regularity and constant contact across these downstream healthcare actors.

“In Kinshasa, only 5 zones have integrated community dynamics.”

“In rural areas it is easier to do these activities using the village chief as the pillar, imagine for example in Kinshasa, if everything has to be done around the mayor or the head of district, that’s a little more complicated.”

Concept 2:

Risk Sharing

HMW 4: How might we reduce the burden of households in the health system?

This risk-sharing program would be based on regular contributions by members, allowing those that need care to be able to afford it.

It should be a transparent system based on equity led by a committee. The contributions should be minimal and can be annual or monthly, adapted according to the context.

The State would provide funding, technical support and medical advisors. Partners would support by covering administrative costs and technical assistance. The following steps would be necessary:

- Evaluation of problem and costs.
- Sensitization of members.
- Identification and sensitization of HCPs
- Mobilization of resources
- Access to care services

PROBLEM AREA

- The financing of healthcare system is based on households that are already poor.
- Households have no access to healthcare services and display reactive health-seeking behaviors.
- Beneficiaries are not involved in the formulation nor implementation process.

DESIRED OUTCOME

More households can afford to access healthcare services. Households move from reactive to preventive health-seeking behaviors.

DESIGN PRINCIPLES

Transparent / Solidarity / Convivial / Simplified (Process)

TARGET & INFLUENCERS

- The main target group are the local communities.
- The activity would be led by the community with support from the State and financial and technical partners.

BARRIERS

- Poverty of members.
- Lack of monitoring/ management.
- Studies need to be done to determine contributions/ member and cost of services.
- Continued adherence.

FUTURE VISION

Mid to long-term feasibility

BEHAVIORS TO CHANGE

There is a strong need to sensitive the community on mutualist culture. .

“The behavior that needs to change is the lack of mutualist culture, certain people that contribute but do not fall sick demand to be reimbursed.”

Concept 3:

A Dynamic Map of Interventions

HMW 5: How can we avoid doubling of activities and gaps on the ground?

A dynamic and complete map aiming to resolve the 3 important problem areas mentioned.

It is key to establish a dialogue at all levels with all stakeholders involved in the process.

PROBLEM AREA

- Doubling of interventions.
- Scattering of fund.s
- Disparities at the household level.

DESIRED OUTCOME

- MoH-led.
- Community-level structures are really engaged and are involved from the outset.
- The MoH knows where to orient actors to see results / impact.
- Equitable distribution of resources.

DESIGN PRINCIPLES

Dynamic / Bottom-up / Transparent / Strategic

TARGET & INFLUENCERS

- The main target group is the State.
- Other actors involved would be international (donors et NGOs) and local (MoH, NGOs in the health space, the community).

BARRIERS

- Political environment
- Economic/fiscal environment
- DRC’s vast geography and insecurity

FUTURE VISION

Mid-term feasibility

BEHAVIORS TO CHANGE

- MoH cannot easily identify where resources are needed.
- Orientation of actors is not very strategic.
- Distribution of resources is not equitable.

“We know where there are no resources and where there is too much stock.”

Concept 4:

Engaging the Actors

HMW 6: *How might we make positive impact long lasting and/or sustainable?*

1. Principal actors are contacted to discuss the main problem and determine the next steps.
2. An analysis of the situation is conducted with actors and the priorities are determined to resolve the problem. Defining contributions of each stakeholder and implementation mechanism.
3. Operationalization of the project with the participation of partners
4. Monitoring and supervision of activities with the participation of partners and transfer of competences.
5. End of TA, continued assistance by State and continued activities on the ground by local actors.

PROBLEM AREA

- Little to no planning or preparation for relay takeover.
- Actors that could take relay may not have competences to take over initiative.

DESIRED OUTCOME

Ownership of intervention by stakeholders from its conception.

DESIGN PRINCIPLES

Ownership / Relayed / Planned / Competent

TARGET & INFLUENCERS

Actors at all levels -national & intermediary level & operational levels, HCPs, CHWs & local development committees.

BARRIERS

- Profile of trainers
- Profile of participants
- Lack of motivation
- Conflict of agendas
- Lack to weak leadership

FUTURE VISION

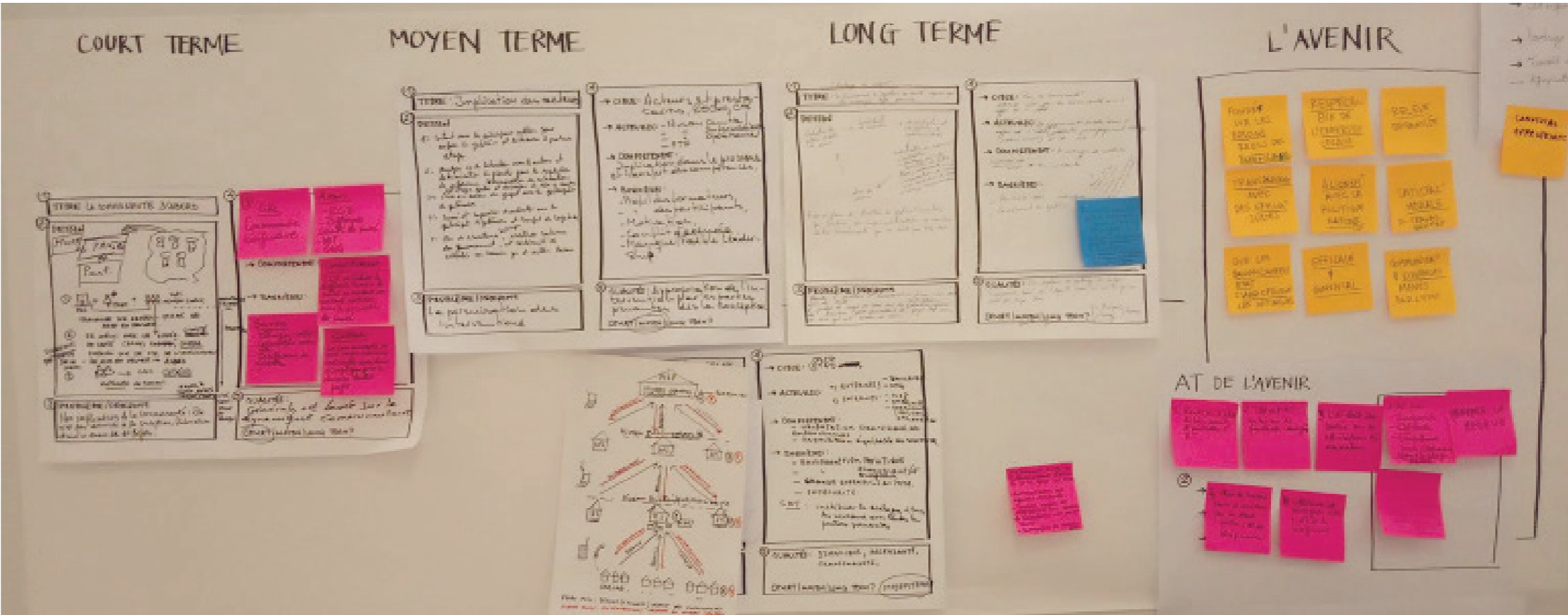
Mid-term feasibility

BEHAVIORS TO CHANGE

- No or little involvement of local actors in the process.
- No transfer of competences to other actors that take over for partners.

How are the concepts aligned with the future vision?

The keywords used to envision the future were used as the guiding design principles while ideating and should remain evaluating criteria in the development of the concepts in the next phase (Concepting & Testing).



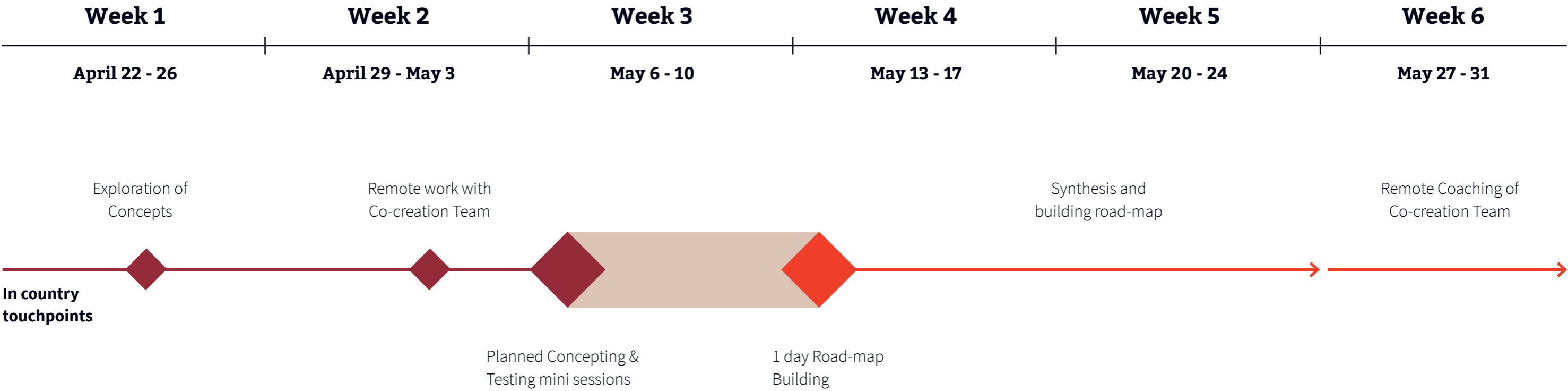
Concepts were mapped according to their feasibility (from left to right: short -term, mid-term to long term), to start creating a roadmap to the future vision.

The Next Steps

What are the next steps in the process?

How will we use these outputs to further develop the selected concepts?

What are the next steps?



Now is the moment where we move ahead to the concepting and testing phase where the 4 concepts selected during the ideation workshop will be further developed.

As planned, this phase will primarily be conducted in mini-sessions rather than a big workshop in order to allow for deeper collaboration in small groups. To prepare us for these on-site sessions, remote

exercises with the co-creation team will be conducted in order to better define the parameters to test for each concept, as well as recruit end-users. It should be noted that some of the concepts will first need to be re-framed to ensure focus is on re-imagining TA.

The success of the project relies on the motivation and continuity of the Co-Creation Team throughout the process. The team is a cross-sectional

and multi-disciplinary group, put together to drive the design process and create ownership within DRC. Maintaining a diverse membership in the Core Design Team makes moving quickly easier and ensures that many different stakeholders are represented every step of the way. Members should have one foot in today's reality and feel empowered to have the other in the ideal future whilst designing their new TA model.

How will this document be used in the next steps?

Each of the outputs presented in this document will serve as tools in the concepting and prototyping phase, as follows:

The Insights provide a backbone to the underlying dynamics and explain why the system functions the way it does. They are accompanied by **provocations**, or thought-starters to ideate creatively and find solutions addressing the context more holistically as well as its less visible forces. We will be referring back to the **insights topics** as they apply to each concept to help us further develop the cultural and structural aspects in the most relevant direction.

The Personas help remind us who we are designing for and remain accountable to developing the concepts in a manner that responds to their needs, frustrations and desires. To prepare for the mini-workshops, we will step back into the shoes of the target users and influencers, also taking into consideration the dynamics between them in order to design better ways for them to interact within each concept.

The Journey will help us identify which steps in the TA process each concept focuses on and contextualises what else is happening simultaneously (i.e. the main challenges, connection to other steps in the process). As the **HMW questions** are linked to particular challenges experienced during the TA process, it also provides a quick reference and allows one to trace back to the core problem and can help when reframing concepts, choosing directions or making links between them.

The Future Vision & Design Principles are overarching design rules and values that will guide the design and prototyping phase. Each concept will embody at least one of these values and at each iteration, the team can look back and verify that the concepts are aligned with their collective vision of TA. It should be said that these principles are adaptive and the vision should progress with each round of learning through testing with end-users, enabling the Co-creation team to develop the vision as needed.