Re-imagining Technical Assistance
Conceptualisation, prototypes & tests

Status Document
May 17th 2019

About this document

This document is a status quo documentation of the most recent design phase conducted for the Reimagining TA project in the DRC. It is the continuation of the exploration and the understanding of the context and the development of insights, the ideation and prioritisation.

This particular phase focused on the exploration of opportunity spaces identified in the previous workshop and the conceptualization of initial prototypes and their testing. This took place between May 5th and 12th 2019 with the majority of the co-creation team.

Four early conceptual prototypes were generated at the end of this phase and this document summarizes the process and the next steps for the concept development.

This document is an interrim documentation and not a final product.

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1/ Introduction

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.

The Project Objectives

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

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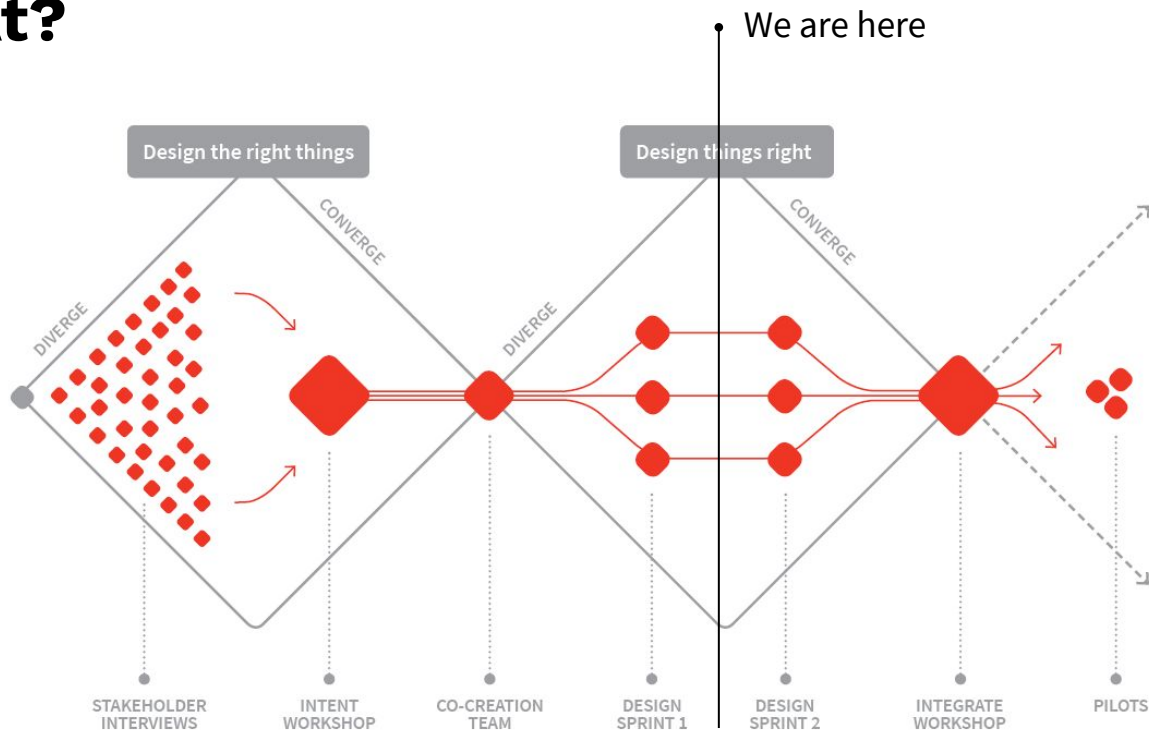
We are leveraging Child Health networks as a window to work in this space. However, the broader ambition is not technical assistance that rests exclusively in Child Health only.

The desired future state is 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.

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Where Are We At?

After a phase of design synthesis and concept preparation towards the design sprint 1 (week of mini-workshops), Sonder and JSI assisted the co-creation team in ideation, prototyping and testing of the four prioritized directions with targeted personas.

The design sprint occurred from May 5th to 12th 2019 in Kinshasa.

We are here

Design the right things

Design things right

CONVERGE

DIVERGE

CONVERGE

DIVERGE

STAKEHOLDER INTERVIEWS

INTENT WORKSHOP

CO-CREATION TEAM

DESIGN SPRINT 1

DESIGN SPRINT 2

INTEGRATE WORKSHOP

PILOTS

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Tools Used / Overview

For the design sprint several tools were used to aid ideation and concept development. These are summarized below and in detail on the next slides.

Design Principles
Design Principles are attributes, qualities or explicit objectives describing the fundamental values of the experience of a product or service. They are defined to help the team create a consistent and meaningful experience for its users/consumers. (UXThink) *(Slide 8)*

Personas
Personas is a tool used to represent user types during the concept process. These are fictional archetypes of real users based on behavioural observations (from the research phase) who could use a service or product in a similar manner.

The personas helped the team keep the different types of people and their needs in the technical assistance ecosystem in mind.
(Slide 9 + see annex 1)

Journey Map
A Journey Map identifies and visually organises each encounter that a user has (or could have) with a specific service. These interactions are generally called points of contact (delight points) or negative (pain points). *(See annex 2 and slide 10)*

Tools Used / Design Principles

Over the course of the first workshop, the participants defined their future vision for technical assistance, in other words the 9 design principles that TA should follow. They became the co-creation team's guide during this phase and keep the project coherent throughout its lifetime.

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.

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.

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.

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.

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.

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.
TA will move away from sustaining parallel systems and be more complementary.

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.

Coordinated
TA is organized in a way that minimizes doubling of activities and scattering of funds.

Tools Used / Persona Example

Implementing Partner

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

A few words about me...

"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 clinical body but also the perception they have of themselves."

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."
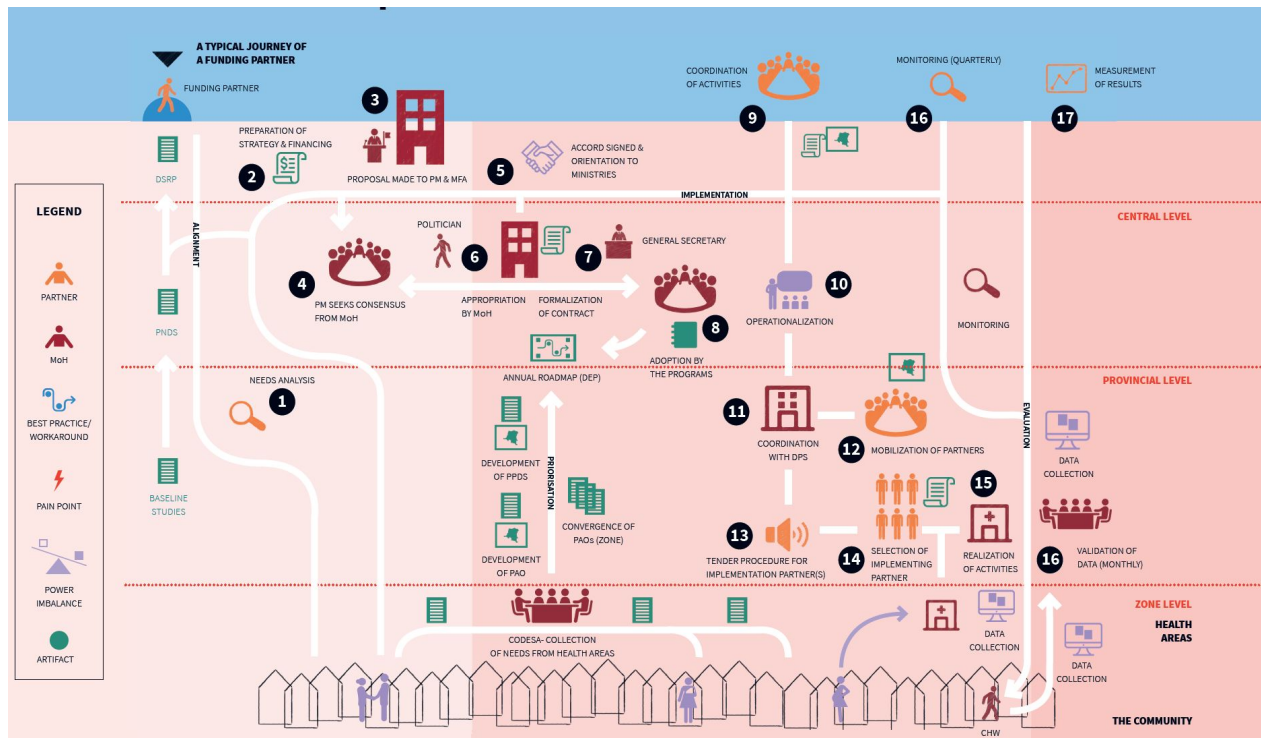
What inspires me...

"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 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..."

Tools Used / TA Journey

A TYPICAL JOURNEY OF A FUNDING PARTNER

FUNDING PARTNER

LEGEND

PARTNER

MoH

BEST PRACTICE/ WORKAROUND

PAIN POINT

POWER IMBALANCE

ARTIFACT

DSRP

PNDS

BASELINE STUDIES

ALIGNMENT

PREPARATION OF STRATEGY & FINANCING — 2

3 — PROPOSAL MADE TO PM & MFA

5 — ACCORD SIGNED & ORIENTATION TO MINISTRIES

IMPLEMENTATION

CENTRAL LEVEL

NEEDS ANALYSIS — 1

4 — PM SEEKS CONSENSUS FROM MoH

POLITICIAN

6 — APPROPRIATION BY MoH

FORMALIZATION OF CONTRACT — 7

GENERAL SECRETARY

ADOPTION BY THE PROGRAMS — 8

ANNUAL ROADMAP (DEP)

10 — OPERATIONALIZATION

COORDINATION OF ACTIVITIES — 9

MONITORING (QUARTERLY) — 16

MEASUREMENT OF RESULTS — 17

MONITORING

PROVINCIAL LEVEL

DEVELOPMENT OF PPDS

PRIORISATION

CONVERGENCE OF PAOs (ZONE)

DEVELOPMENT OF PAO

11 — COORDINATION WITH DPS

12 — MOBILIZATION OF PARTNERS

EVALUATION

DATA COLLECTION

13 — TENDER PROCEDURE FOR IMPLEMENTATION PARTNER(S)

14 — SELECTION OF IMPLEMENTING PARTNER

15 — REALIZATION OF ACTIVITIES

16 — VALIDATION OF DATA (MONTHLY)

CODESA- COLLECTION OF NEEDS FROM HEALTH AREAS

DATA COLLECTION

DATA COLLECTION

ZONE LEVEL

HEALTH AREAS

CHW

THE COMMUNITY

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.

2/ Defining Technical Assistance

Defining technical assistance / Overview

We asked the co-creation team to define "technical assistance" by asking them to complete the following sentences:

- Technical assistance is…
- Technical assistance isn't…

The co-creation team defined "technical assistance: as *the technical and material aspects, but also the financial*. They had a converging vision on the different roles, emphasizing the importance of the driving role of the State (internal actors) and the accompanying roles of the external actors (partners) that fulfill the gaps (needs not covered by the State).

First exercise to define TA: (left) first day and last day (right).

Technical Assistance Is...

In the field and during the workshops we accumulated a number of definitions from our participants.

Here are some of the quotes:

"A complementary supply to what we already do by someone else or an organisation."

"Giving a desired expertise; facilitating automation; answering to felt needs."

"Where the country is limited, we can help. If I have ideas and someone else has ideas, they can add and we walk together. What we consider technical assistance as francophones is this support of resources so that the ideas that we've created together move forward."

"It's also that motivation in the francophone understanding. Let's take the example of a person that needs to complete the sanitary information each week. The motivation for that person, it's the credit needed to communicate via phone, it's the transport. If he doesn't have the resources… he can have all the will to work in the word, without motivation he can't do his work properly."

"Technical assistance has to be general ("globale" in French); it's the resources that are in different disciplines. The computers, the fuel, the supplies… it's important to take the fragility of the country into account. We've elaborated plans with national and international expertise., but the execution is compromised by the lack of funding that the State can't complete. The idea is to bring the financial, logistic and other resources that the country can't find."

"The sharing of knowledge and skills (transferring); helping to implement, extension and execution of activities."

"A support, an aid that can be technical, financial, through training or logistics that is given to countries according to their needs."

"Bringing aid through the transferring of capacity or funds."

Technical Assistance Is Not....

In the field and during the workshops we accumulated a number of definitions from our participants.

Here are some of the quotes:

"An imposition; an ascendance ; a task substitution."

"There is even a secretary for the management, for instance, that is a foreigner although there are the skills in the country to do the work."

"Working instead of someone else… imposing. Trust comes from two parties through respect. You bring me something through your technical assistance but you do not want to align with what I've done. You tell me you bring new ideas that you do not want to share and that you want to be priority even though they are not mine."

"The doubling of human resources."

"Paying of salaries: technical assistance is not there to pay people's salaries."

Technical Assistance Definition / Synthesis

Defining technical assistance occurred throughout the week. On the last day, we agreed on the following:

"Technical assistance is empowering local teams to fulfill their roles fully. This empowerment is simultaneously technical, material as well as financial."

Key Aspects:
➔ Technical: knowledge, know-how.
➔ Material: equipment, input and supplies.
➔ Financial : transport, bonuses, the financing of activities.

"MCSP did not pay for our office's internet. Now they are turning it off. I am the catalyst for the group. I don't have internet for the office, even though I am suppose to be receiving and sharing the information. That is why financial assistance is necessary."
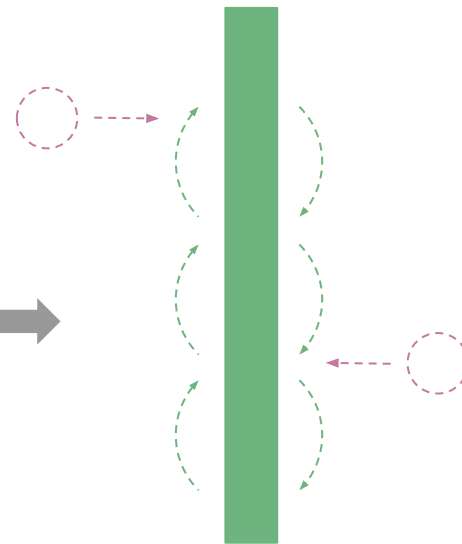
Evolution of Technical Assistance

national

provincial

zone

community
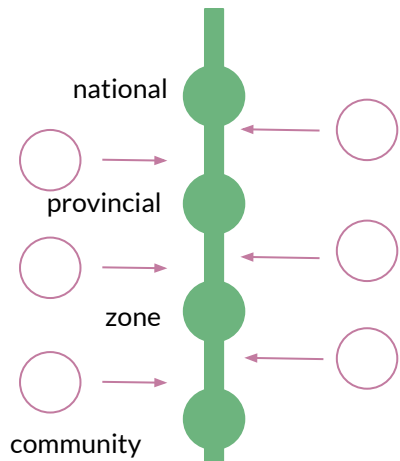
In this diagram representing the current state of technical assistance, the State (in green) is unable to cover all needs. It needs support from external actors (partners) and resources to fill the gaps (needs not covered by the state).
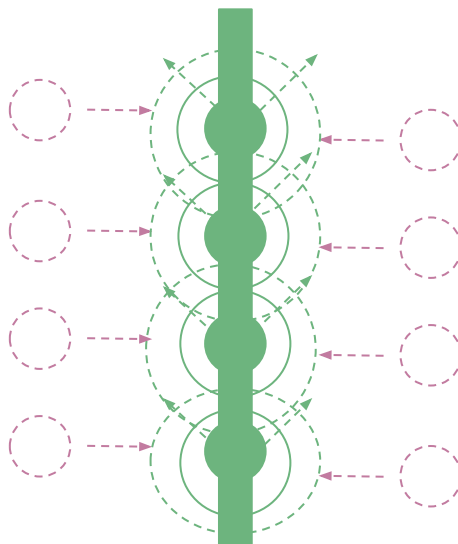
This diagram shows how, in the future, the State structure gets stronger and gradually the internal actors gain strength and cover more ground. Here the external actors help reinforce the structure to be better skilled and autonomous. The structure is ascending, descending and resilient.

Technical assistance is stronger, covers all needs, gains autonomy and requires external actors at specific points only. TA embodies its definition: "the empowerment of local teams to play their role fully. This empowerment is simultaneously technical, material as well as financial."

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3/ Opportunity Spaces and Concepts

Opportunity Spaces

The main aim of the design sprint week with the min workshops was to prototype and develop initial concepts for the opportunity spaces that had been developed at the earlier workshop and prioritized by the co-creation team. The following slides will give an overview of the opportunity spaces and the initial concepts that were developed within the. The pink sentences in the document are notes, reflections, and suggestions by the design team to take into consideration as the design process continues.

Involving All Actors

How might TA ensure its impact is positive, long lasting and sustainable?

Mapping Initiatives

How might TA be coordinated to reduce the duplication of activities, responsibilities and gaps on the ground?

Sharing Risks

How might TA be more accountable to households and reduce the burden on them to access care?

Putting Community First

How might TA priorities be surfaced when the health system lacks efficiency, transparency and inclusion of the community?

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Concepting process conducted with co-creation team

Step 1
Reframe
Develop early concepts

Step 2
Prototype
Create possible tangible solutions

Step 3
Test
Take prototype fo target population and collect learnings

Step 4
Iterate
Integrate the learnings to iterate the prototype.

Reframe and develop the concepts:
The goal of this step was to deepen the initial concept ideas and to define hypotheses in groups. Reframing is an important moment for challenging existing assumptions. The co-creation group in this phase was able to bring its expertise, the knowledge gained from past experiences in order to reframe while thinking about the future, by adding improvements.

Build the prototype:
The goal was to create something tangible to convey the concept to be tested (based on the central hypothesis). We aren't seeking perfection, but making a prototype sufficiently useful and tangible in order to communicate and understand the concept.

Prepare the questions to ask the end-users of the concept: The goal was to put the prototype in their hands or do a roleplay to help understand the concept. During the test, we asked them to elaborate on their thoughts. The questions aimed to validate the basic hypothesis.

Following the test, the team shared the learnings and analyzed the results of the test.
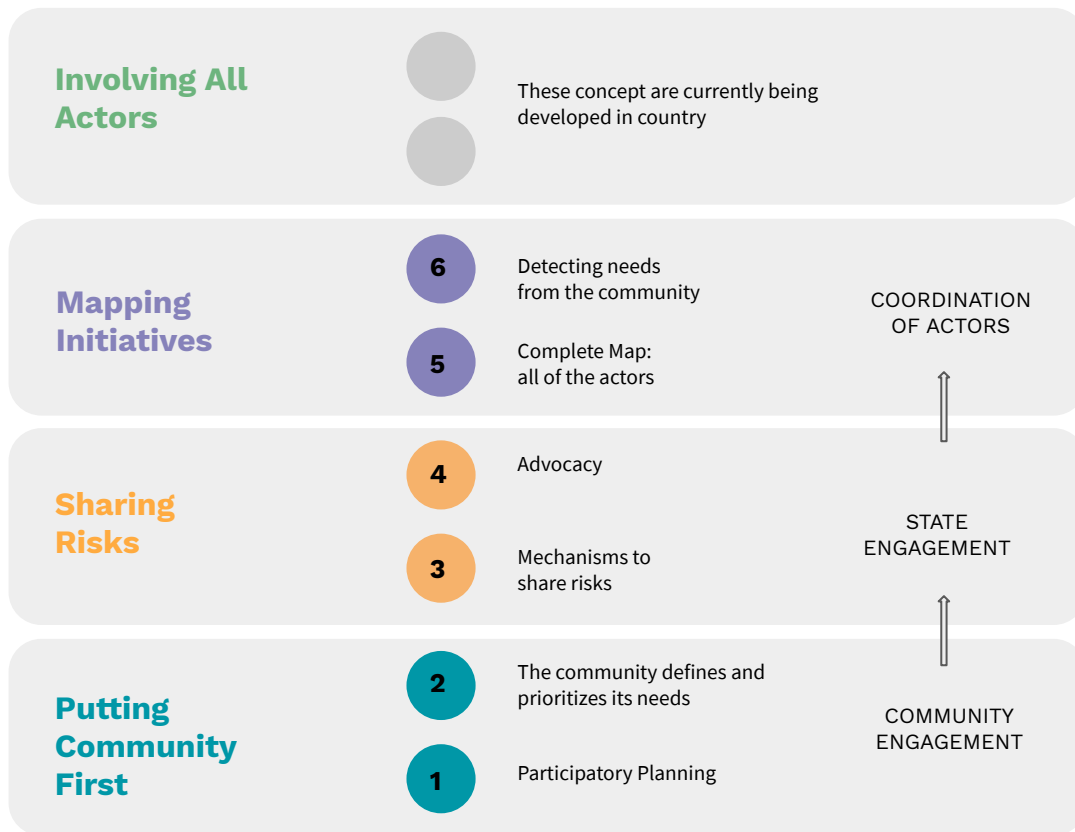
Iterate:
The goal was to use the learnings and feedback to integrate and modify the concept, to then quickly prepare another version of the improved prototype to test the concept again until new results are achieved. It is recurrent to do many iterations before obtaining the desired result.

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Early Concepts / Overview

During the week of the design sprint with the mini-workshops, the co-creation team created 2 concepts for each opportunity area prioritized in the March 2019 workshop. As you can see with the numbers 1-6 on the right, 6 initial concepts were created. The top most opportunity space was not addressed due to time constraints but the co-creation team has been working on developing concepts after the workshop.

Each concept focuses on different underlying issues and important barriers to TA. These concepts build on each other in a bottom-up manner, which depicts a paradigm shift to the top-down approach TA uses currently.

Involving All Actors

These concept are currently being developed in country

Mapping Initiatives

6 — Detecting needs from the community

5 — Complete Map: all of the actors

COORDINATION OF ACTORS

Sharing Risks

4 — Advocacy

3 — Mechanisms to share risks

STATE ENGAGEMENT

Putting Community First

2 — The community defines and prioritizes its needs

1 — Participatory Planning

COMMUNITY ENGAGEMENT

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Opportunity Space
Putting
Community First

Putting Community First / Overview

How might TA priorities be surfaced when the health system lacks efficiency, transparency and inclusion of the community ?

DESCRIPTION
The new community dynamic involves all the actors, starting with the villages, the CACs, the RECOs, the CODESA and the manager called the COCODEV. All these committees work around the village chief who is not exclusively a health-specialist. We start with people from the bottom to ensure we grasp the needs on all levels.

This concept is not restricted to the context of health; other sectors have an impact on health, such as agriculture and education.

THE PROBLEM
The community is rarely involved in the design, development and implementation of projects.

EXPECTED RESULT
The community feels empowered and beholden and as such gets involved in the success of the project.

QUALITIES
Responsible / Multisectorial / Accountable

TARGET AND INFLUENCERS
- Beneficiary Community
- Village Chiefs
- Zone management team (ECZ), various health committees, MSP
- NGOs

BARRIERS
- Ethnic (conflicts)
- Natural catastrophes
- Insufficient resources
- The actors' misunderstanding of the concept's goal and value.

FUTURE VISION
Short term feasibility

NECESSARY BEHAVIOR CHANGE
ECZ will federate the various health committees by keeping in touch with them.

"In Kinshasa for example, there are only 5 health zones that have integrated community dynamics."

"The community dynamic is still a new concept that is not very operational. The actors must first understand the why and the added value of this new concept."

"In rural areas it is easier to have everything turn around the village chief; imagine for example in Kinshasa if everything had to turn around the bourgmestre or the head of district, it would a lot more complicated."

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Putting Community First / Step 1 Reframe

Team 2
People involved: Jean Fidèle, Elysé, Wivine, Célestin.

Problem focus
Inability to identify health problems.

Hypothesis to be concepted with
- The members of the community do not have the ability to identify the health problems in the their context and prioritise them in a consensual manner.
- A better community engagement would lead to better results.

"What we would like technical assistance to help the community; to be able to identify its own problems, to claim its rights and to know that it is also indebted to all of this. It should be led by the community to reflect on its problems and identify possible solutions: what do we need help with, if so what type, where to find it."

Team 1
People involved: Toto, Papy, Nestor, Serge.

Problem focus
Low community engagement in the planning.

Hypothesis to be concepted with
- A better community engagement in the planification would lead to better results.

Putting Community First **Concept 1** / Step 3 Test

The team put forward that there is the intrinsic motivation to change, but demonstrated that, though the community is engaged, it has little knowledge of how community participation is structured.

Takeaways

- There is false information in the community, the State must sensitize households, and it needs to be done door-to-door.

- The State must strengthen RECOs abilities and motivation. Sometimes the vaccines, or even the mosquito nets are not enough to cover the entire population.

- The State must set up training centers for RECOs, that are insufficient.

- Strengthen communication to increase involvement and awareness of women leaders in the community.

- The president of the CODEV has an important role to play. He is central in the communicating chain with the centres de santé.

- The community is confused about current roles and operations. It does not know how the community structure works, the roles involved, etc. *"From what we have just done I have just discovered a lot about community structures that I did not know".*

- There is a need to mentor community leaders to do a good job in the community.

- RECOs are not numerous. Their numbers must be increased as well as the number of people from each neighborhood so that they can raise local problems and bring them to the next level. (Possibility to connect with the concept worked by team 1).

- RECOs are not well treated, they are minimized. There is a lack of motivation and lack of transparency. RECOs must give a portion of the small premium they receive to their superiors. CAs should ensure that RECOs are able to develop community plans.

- The community is unaware it has an important role to play.

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Putting Community First Concept 1 / Step 4 Redesign

PROBLEM	• Act in the community and make the community able to plan and follow activities according to identified needs.
HYPOTHESIS	• Better community involvement in planning leads to better results.
TEST	• Awareness of the existence of community participation bodies. • Knowledge of the quality and quantity of RECO members. • Training / empowerment. • State's role in the hiring of RECOs. • Relationship between the quality of curative services and the participation of members in activities.
APPLICATION OF NEW DESIGN	• Make the community capable of planning and ensuring the follow-up of activities according to its identified needs.

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Putting Community First Concept 1 / Takeaways

In order to test the hypotheses and prototypes we conducted two test sessions with different users:
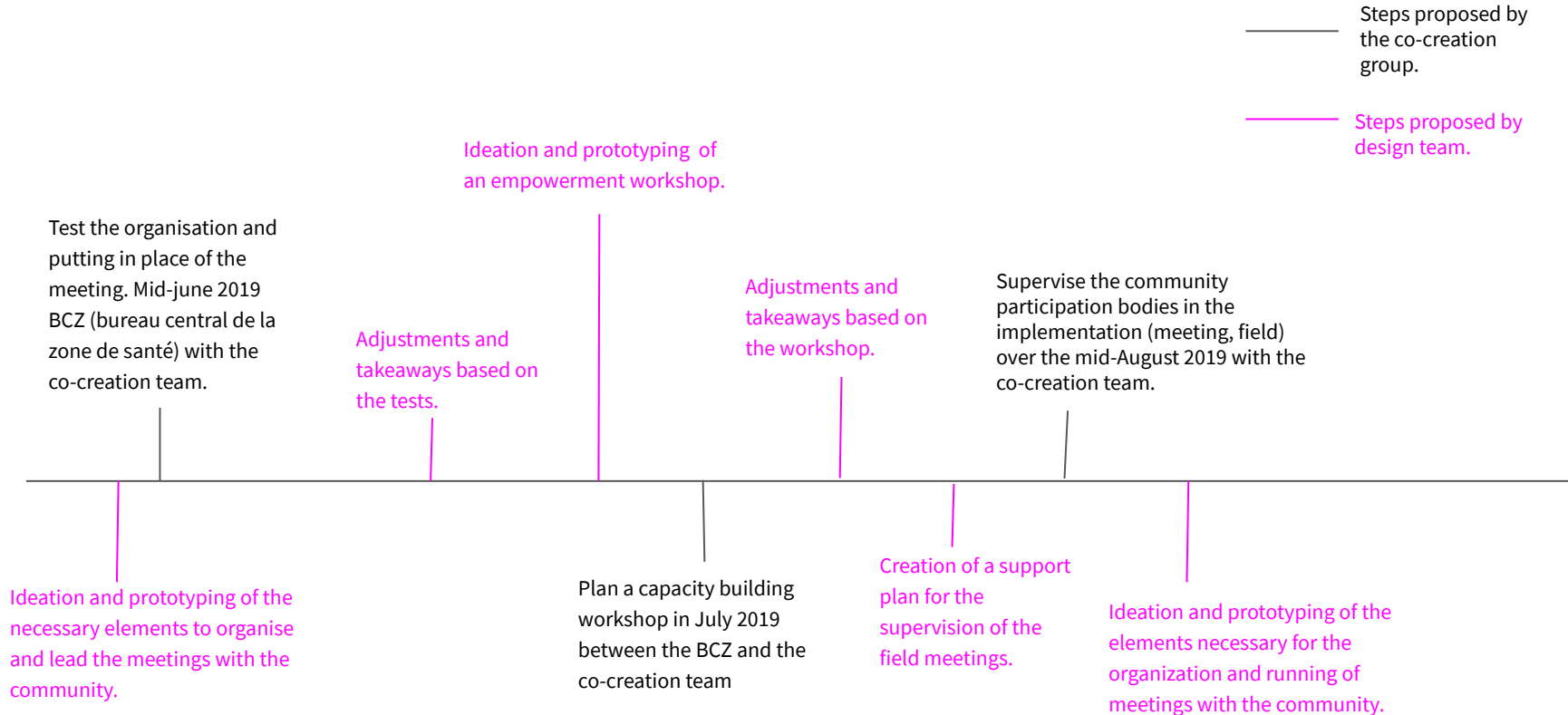
TEST 1 In field with people from the community of different profiles (Pastor, student, community leader, nurse leader, zone management team, etc.)

TEST 2 In field with mothers of children under 5 in a community. The co-creation team traveled to Mont Ngafula 1 to work with users.

The two groups were asked to validate the concepts and gather as much data as possible about their concepts and the associated hypotheses.

Putting Community First Concept 1 / Next Steps

Steps proposed by the co-creation group.

Steps proposed by design team.

Ideation and prototyping of an empowerment workshop.

Test the organisation and putting in place of the meeting. Mid-june 2019 BCZ (bureau central de la zone de santé) with the co-creation team.

Adjustments and takeaways based on the tests.

Adjustments and takeaways based on the workshop.

Supervise the community participation bodies in the implementation (meeting, field) over the mid-August 2019 with the co-creation team.

Ideation and prototyping of the necessary elements to organise and lead the meetings with the community.

Plan a capacity building workshop in July 2019 between the BCZ and the co-creation team

Creation of a support plan for the supervision of the field meetings.

Ideation and prototyping of the elements necessary for the organization and running of meetings with the community.

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Putting Community First Concept 2 / Test and Takeaways

Concept 2 /
The team worked on a participatory session that allowed the community to get to know each other better, to share health-related issues, to become aware and to be more in charge.
"Taking care of yourself does not necessarily mean being self-sufficient; it means the community is able to know what it needs, what it can do, what its limits are and where to go ask for help."
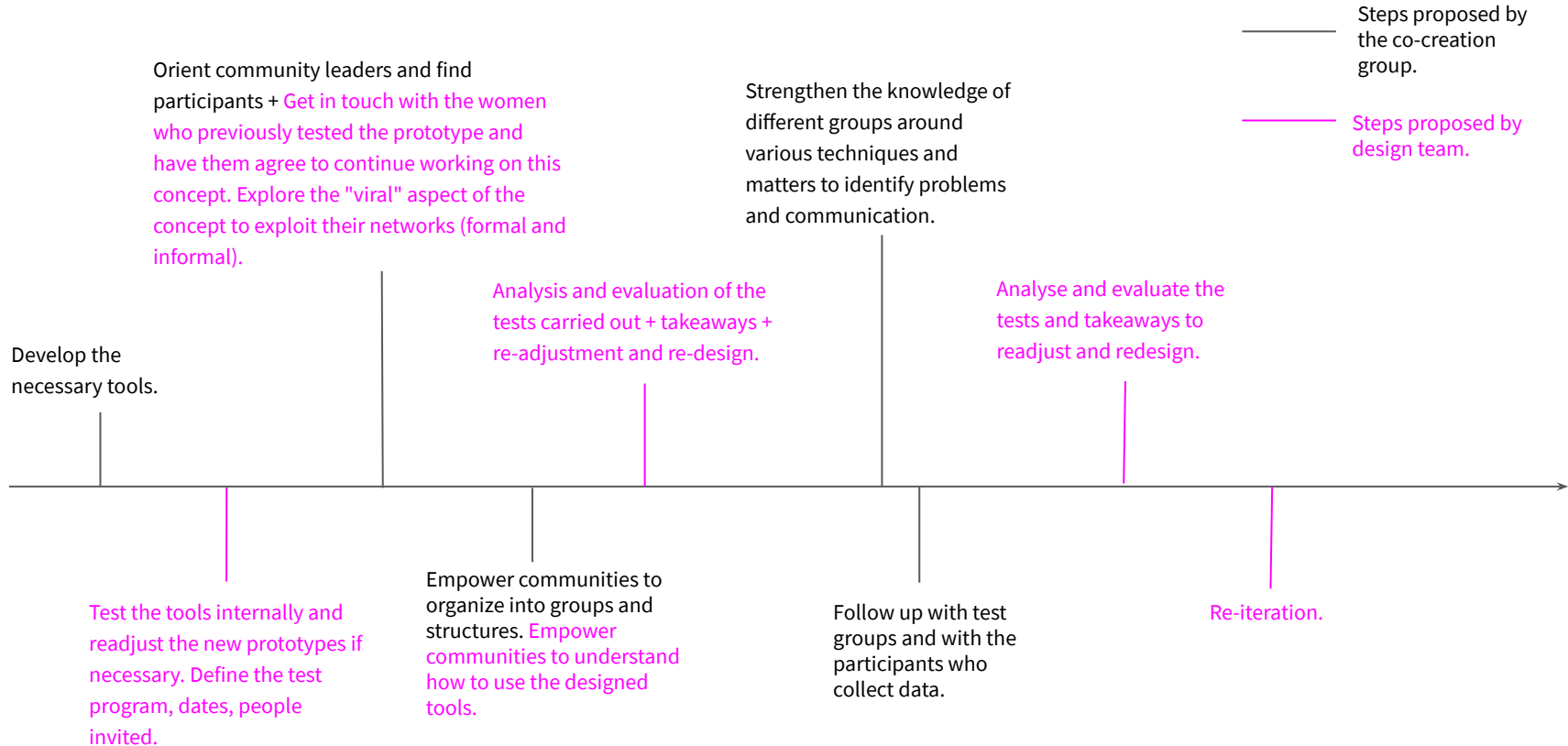
Takeaway /
- The takeaways from the test confirmed that the community lacks spaces and moments to meet and address specific health themes.

- The test reinforced the importance of creating the necessary skills in the community to make them be truly effective and able to participate.
"You have to give the community a voice so that they can talk, and then create the capacity for them to make themselves heard."

- Lack of knowledge is a predominant barrier in communities. Apart from ignorance there is also negligence and the need for community support for creating lasting social change.
"If an individual changes his behavior and does not have the support of others around him, he eventually falls back."

- It is essential that each participant become a vector and receiver of information in his family and entourage. The action of social change must target people who have influence over others.
"If a person hears people they esteem speak of something (pastor, grandmother ...) it can easily change.

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Putting Community First Concept 2 / Redesign

PROBLEM	• Identification of community problems
HYPOTHESIS	• An empowered community can organize and consensually identify health problems. • An organized community becomes able to integrate the system.
TEST	• Prototypes tested with community members and mothers.
APPLICATION OF THE NEW DESIGN	• Develop the necessary tools to collect information at two levels, first so that each participant can collect data in their entourage, and second so that during the meeting they can regroup and prioritize all the information. • Adapt tools to the community's language. • Orient community leaders. • Empower the community to organize into structured groups. • Strengthen the knowledge of different groups into different priority areas of health. • Follow community activities.

Putting Community First Concept 2 / Next Steps

Steps proposed by the co-creation group.

Steps proposed by design team.

Orient community leaders and find participants + Get in touch with the women who previously tested the prototype and have them agree to continue working on this concept. Explore the "viral" aspect of the concept to exploit their networks (formal and informal).

Strengthen the knowledge of different groups around various techniques and matters to identify problems and communication.

Develop the necessary tools.

Analysis and evaluation of the tests carried out + takeaways + re-adjustment and re-design.

Analyse and evaluate the tests and takeaways to readjust and redesign.

Test the tools internally and readjust the new prototypes if necessary. Define the test program, dates, people invited.

Empower communities to organize into groups and structures. Empower communities to understand how to use the designed tools.

Follow up with test groups and with the participants who collect data.

Re-iteration.

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Opportunity Space
Sharing Risks

Sharing Risks

How might TA be more accountable to households and reduce the burden on them to access care?

DESCRIPTION
Risk sharing is based on the regular payment of membership fees to cover for the care of those in need.

The communities create mutuals with the support of the State and partners who can subsidize for the administrative costs and provide technical support through a medical adviser.

THE PROBLEM
Financing the health system relies on poor households, and accessibility to the health system is mainly financial.

EXPECTED RESULTS
More people in the community access health services and the beneficiaries change their behavior towards prevention.

QUALITY
Transparent / Equity-based with a committee that does not cost too much

TARGET AND INFLUENCERS
- local communities lead the activities
- with the support of the State (subsidies, technical support and medical advice) and TFPs (financial and technical partners)

BARRIERS
- The poverty of its members
- Management

FUTURE VISION
Medium and long term feasibility

BEHAVIOR CHANGE
The lack of mutualist culture: some people who contribute and do not get sick request a refund. There is a need to sensitize the community.

> *"By putting everyone together, it can be a mutual, a health insurance or any other form of risk sharing and everyone contributes regularly and the money is used to treat the ones who needs the care most."*
>
> *"The contribution can be monthly or annual depending on the context; there are also studies to be done to determine the amount to contribute based on the number of members and the cost of care."*

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Sharing Risks / Reframe

Summary / To reframe, the co-creation group divided into two groups. Each group reframed the concept around TA my proposing different problems and hypothesis to test with users.

CONCEPT 3

Problem
Insufficient mechanisms to share risks. What role could the State/partners play in the creation of these insurance policies (at what point in the TA journey)? What models could work to cover more than the target populations? How to engage the State and consequently increase health service accessibility?

Hypothesis
- Des mécanismes de partage amènent à l'équité dans l'accès aux services de santé à tous les ménages.
- Les mécanismes de partage renforcent la solidarité des communautés.

CONCEPT 4

Problem
Low State engagement in health spendings.

Hypothesis
- A strong engagement of the State through subsidies would improve financial accessibility to health services.
- Services will be used by the beneficiaries.

"There is a line in the budget for health but it never gets paid. The spendings of the State are very low, and the law says the State has to finance the insurance but does not."

"The problem started in the 1980s when the World Bank put in place reforms that encouraged the State from subsidising social services like health and educations…"

Sharing Risks **Concept 3** / Prototyping

CONCEPT 3

The actors in the prototype are: The State has the normative role, regulation and subsidy of mutual funds, it sets up standards and the fundamental principles of health mutual funds. The state should subsidize mutuals but it does not. The implementing partners who support the State in the implementation of mutual funds. They also advocate and fundraise and are in contact with the State to see where to locate the mutuals according to the needs expressed. The health zones are part of the state, and are made up of medical structures and training.

The state does not support health insurance, so we want to create mutual fund whose role is to raise awareness; eventually the members will take charge of their collective fund.

1. Mutual fund help members with the support of partners and the ministry.
2. The Mutual Executive Committee's role is to mobilize the funds of its members and identify a center that will provide quality health care.
3. Households have the role of contributing and participating in meetings.
4. There needs to be advocacy (Concept 2A) for the State to subsidize the already functioning and operational mutual funds. If the state subsidizes, the difficulties of accessibility to care will be lightened for the poorest people.

Sharing Risks **Concept 3** / Test and Redesign

TAKEAWAYS
The Mutualization of care is based on the organizing role of the state and the empowerment of mutual fund structures. The empowerment of mutual structures through their ability to define of needs + gaps + priorities improves their functionality.

NEW HYPOTHESIS
Under the watchful eye of the state, capacity structures contribute to equity in the care and solidarity of its members. The co-creation of a multisectorial platform would make it possible to increase free healthcare by finding the complementarity of each individual.

RISKS

"The DRC's problem is the financing of health care. We have a fragmented approach, but with a common basket of funds, we can collect the funds and allocate them where there is the most need."

"Us, Congolese, need to stop thinking that the partners will come to finance our healthcare. Partners are additional funds, nothing more, they have problems at home, they make sacrifices to give."

"We can not talk about health care without taking into account community dynamics. Or else we go around in circles."

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Sharing Risks Concept 3 / Test and Redesign

OTHER MODELS AND IDEAS

- We need a mutual fund adapted to community dynamics.
- Women's capacity to save on their income needs to be strengthened.
- Payment in kind could be favored and normalised for the poorest.
- The programming level of the mutual funds should think about a flat rate. Such a drug fund could help health facilities access quality drugs.
- Exemption of drugs upon entry.
- At the community level, there needs greater awareness of mutual funds.
- Retention in the form of a tax on beer for example so that these funds allow the population to access health care.
- For certain professional categories (in the private sector), payment may be required in exchange for a mutual insurance card. In Rwanda, for example, a driver must have a mutual card to access the airport. A bit like a yellow card to travel.

"We had asked the Bourgmestre of Mont Ngafula to disburse a certain portion of taxes collected at the community level to support the mutual fund. We based the mutual's income on communal budgeting because the bourgmestre was not transparent."

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Sharing Risks **Concept 4** / Prototyping

PROTOTYPE
An advocacy platform made up of multi-sectoral lobby groups towards decision-makers (presidency, prime minister, government, parliament, private sector). It is meant to empower and restructure pressure groups.

Image of Concept 4
"We want to aim for the no cost for the most vulnerable groups (mothers and children under 5). For that, we need a platform made up of groups that can put pressure on the government because they do not have a link to the upper hierarchy. With the help of civil society, groups of young people, groups of women, and groups of the société savante, this plaidoyer goes towards the authorities that make the decisions: the presidency, the government, the parlement, the governors, the private sector."
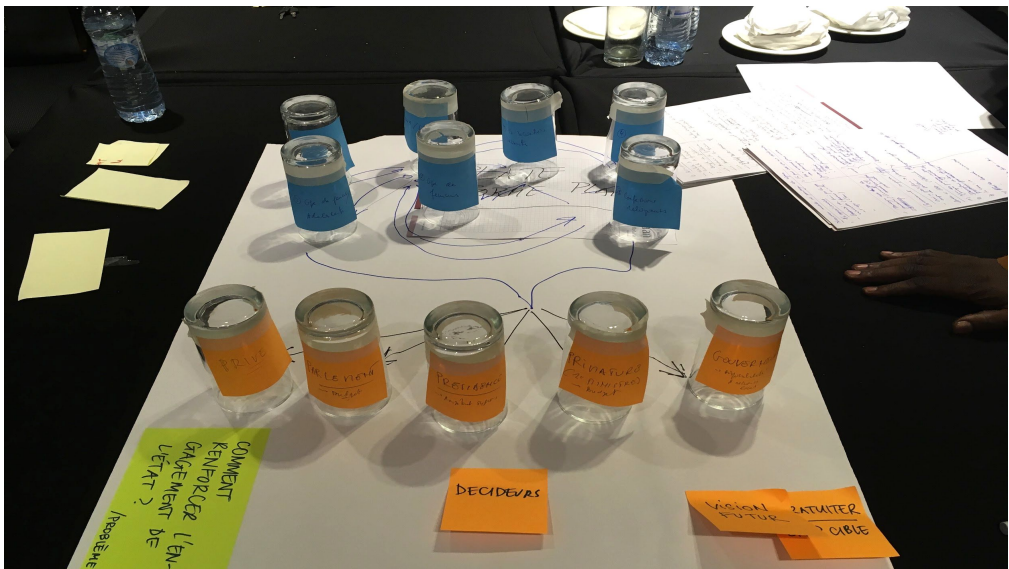
Sharing Risks **Concept 4** / Test and Redesign

LEARNINGS

- An accepted non-State affiliated organization must control the structure and coordinate and mobilize the platform.
- An accepted and celebrated leader by all components needs to be responsible for group decisions.
- Lobbying and advocacy must be done using interpersonal relationships: targeting those who are in favor of actions in the decision-makers' circles.
- Meetings need to be held with the ministry to review the situation.
- Needs must be identified to guide communication with decision makers.
- If we accept that the structure is driven by civil society, it will have more weight and impact.
- We need to develop a draft of the structure, to gather the opinions of the target decision-makers (in each institution, in relation to their responsibilities) and eventually get their buy-in. We should aim to co-create with these stakeholders for them to take ownership of actions.
- There must be a co-creation team (supported by a partner) with a strong vision and clear objectives.
- Think about expanding the pressure group into other areas (integrate education, gender, social affairs). (This important point refers to the transversal opportunity HMW10: How to develop technical support initiatives with a global approach?)
- We must also strengthen the skills of the lobby for more efficiency.

"Recently we convened the parliament's socio-economic and financial commission to advocate for health, and for the first time, the government disbursed US $ 740,000 for EPI (Expanded Program on Immunization). The lobby group will need to be structured with clear roles and responsibilities for each part of the group to facilitate meetings."

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Sharing Risks **Concept 4** / Test and Redesign

RISKS

Leadership
"For these groups the problem is always at a leadership level. Everyone wants to take control."

Existing plan
"At the national level there is already something like this that is sprouting. There has been a lot of effort being put in a big montage but organizational details, like the lack of water at meetings, have made its realisation difficult."

Financing and Logistics
"The problem is funding. If there is a biannual meeting for example, you have to rent the room for people to come."

Politics vs. Technical
"The structure must not be state. The idea of the teachers' mutual changed, for example, when it was presented to the minister who appointed the board of directors and others. It became politicized."

NEW HYPOTHESIS
Advocacy groups get a strong commitment from the State.

QUESTIONS FOR THE NEXT ITERATION /
- How can the risks be mitigated?
- HMW8: How to strengthen leadership?
- What organizational details can prevent activities from happening?
- What are the reasons why activities have not been carried out in the past?
- What can we learn from these experiences?
- What resources are at your disposal?
- What resources would be nice to have?
- Who should drive it?
- Which system could work?

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Sharing Risks Concept 4 / Next steps

The two groups need to think about the next steps based on the new hypothesis and then create a timeline with all the necessary steps.

(The team can use the timelines suggested for concept 1, as inspiration).

ACTIVITIES	PERIOD	RESPONSABLE

Opportunity Space
Mapping
Initiatives

Mapping Initiatives

How might TA be coordinated to reduce the duplication of activities, responsibilities and gaps on the ground?

DESCRIPTION
Stakeholders are able to plan and coordinate better once activities are mapped, exposing gaps and possible duplications of efforts.

THE PROBLEM
The doubling of interventions.
The "saupoudrage" of fonds (uneven coverage in the aires de santé) and the disparities between neighbours.

EXPECTED RESULT
Strategic orientation of the stakeholders.
Equitable distribution of resources.

QUALITIES
Dynamic / Ascending / Transparent

TARGET AND INFLUENCERS
- State conducts activities
- external (donors and NGOs) and internal (MSP, NGO health, community)
- Community structures and actors must be involved right from the start

BARRIERS
- Political Environment
- Economic Environment and Budget
- Size of country
- Insecurity

FUTURE VISION
Medium term feasibility

BEHAVIOR CHANGER
Create dialogue at all levels with all stakeholders.

"We know where to point stakeholders to get the results for the equitable distribution of resources. We know where there are resources and where there is overstocking. "

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Mapping Initiatives / Reframe

The teams used the strategic card game to reframe the concept (see Appendix 3). They decided to work on 2 map aspects:

- Internal level
- Community level

Their proposals are complementary and form part of a single card. The three key players in the map are MSP, Partners and Providers.

PROBLEM
Absence of a dynamic cartography.

HYPOTHESIS /
Mapping must indicate where there are needs and in the long run it should help reduce duplication, disparities and dusting.

HYPOTHESIS CONCEPT 5
- A map that adapts to different political levels will be useful at a national and at an operational level.

HYPOTHESIS CONCEPT 6
- The existence of a map will lead to a judicious distribution of resources.

"Projects are always oriented to places where previous actions have already taken place to insure better results. There is a lack of trust between actors and a neglect of local resources."
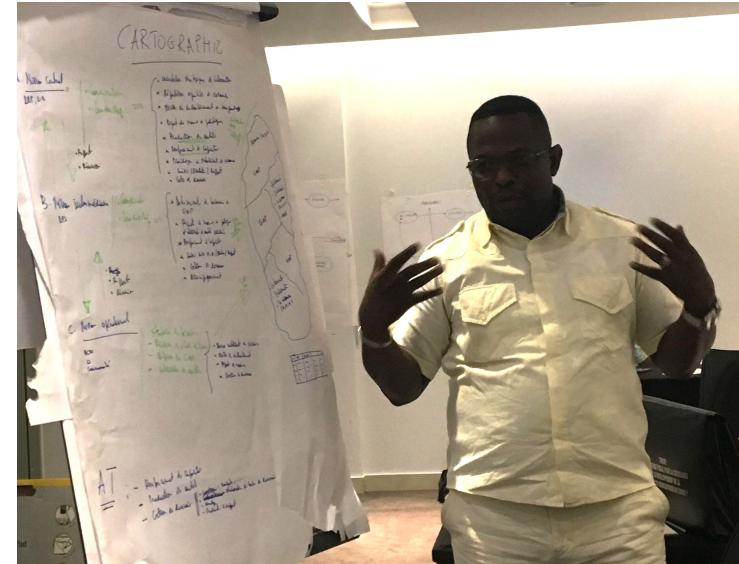
Mapping Initiatives **Concept 5** / Prototyping

For the first map concept, the group proposed three levels of intervention:

- The central level to coordinate and lead: it is at this level that tools are produced and data is managed. They will provide strategic direction, equitably allocate resources and avoid duplication and scattering. It could be linked with the CNP (National Steering Committee).
- The intermediate level: it is here, through a provincial committee ,that needs are managed and made visible.
- The operational level: at this level needs are reported and identified. The map here would certainly be on paper and adapted to the zones de santé abilities.

Technical assistance is provided for capacity building to build databases, purchase materials, analyze data.

Health policies determine the mechanism by which information circulate upwards.

Mapping Initiatives **Concept 6** / Prototyping

Description
The first concept is a map that lives in the community and helps decision-makers in their decision making. For this a canvas can be set up. The map will be defined at the national level and coordinated by a database manager. At the level of the zone de santé, data will be collected thanks to zone doctors who will transmit it to the central level. The group worked on the map at the community level.

The map will display 3 types of activities: promotional, curative and awareness activities. In addition it will give a global view of the coverage established and of the intervention and the intervener, ie the Who/What/Where. It will show the indicators of resources and results. At the format level the data will be divided between map visualizations and others by tables.

The card can also be used for advocacy purposes (linked to Concept 4).

Steps to implement the map
- First, the normative level decides on the map's use for decision-makers, then sets up a canvas for the information to be collected on the map.
- Second, they focus on database managers.
- Third, train the people on the ground to collect data.
- Forth, give the resources.
- And finally, start using the data in the zone de santé. When a partner arrives the area can easily orient them according to these data sets.

Elements to be integrated into the map
- Demographics: number of children under five, newborns, pregnant women and children of childbearing age.
- Indicators of child health: specific rate per illness; matrix of basic data.

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Mapping Initiatives / Next Steps

While it became very clear that the two prototypes were going in similar directions, because of timing, none of the prototypes could be tested. However, the teams listed the important points to continue the work:
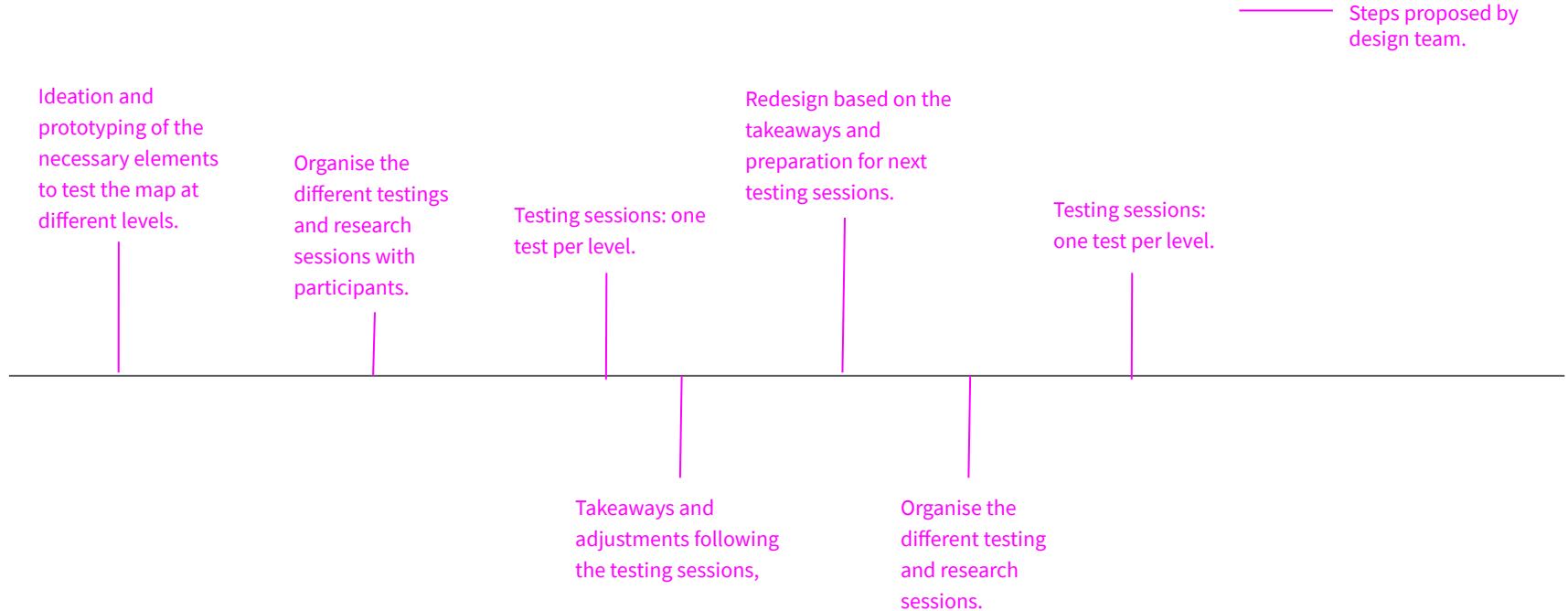
TAKEAWAY /
- Have a map at all levels of the system.
- The need for good coordination and effective leadership.
- The need to develop the tools.
- Investing in capacity building.
- Ensure communication and feedback between the different levels of the system.

ADVICE FOR PROTOTYPE PHASE /
- To test and communicate your hypothesis, find the map format that is the most true to your idea.
- Visualise the other important aspects of this map. Find a way to visualise the lack and surplus of resources.
- Prepare a guide to test it with the target population.
- If time permits, test it with another team.

Mapping Initiatives / Next steps

Steps proposed by design team.

Ideation and prototyping of the necessary elements to test the map at different levels.

Organise the different testings and research sessions with participants.

Testing sessions: one test per level.

Redesign based on the takeaways and preparation for next testing sessions.

Testing sessions: one test per level.

Takeaways and adjustments following the testing sessions,

Organise the different testing and research sessions.

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Opportunity Space
Involving All Actors

Involving All Actors

How might TA ensure its impact is positive, long lasting and sustainable?

DESCRIPTION
1. Contact with key stakeholders to outline the problem and determine next steps.

2. Analysis of the situation with stakeholders to determine priorities to solve problems. Outline the contributions of each party and mechanism of implementation.

3. Implementation of the project with the participation of partners.

4. Monitoring and supervision of activities with the participation of partners and transferring of skills.

5. End of technical assistance, ongoing government assistance and continuity of field activities by local actors.

THE PROBLEM
Sustainability of interventions - TA results are temporal.
Lack of skills transfer during TA.
Lack of system and relay planning between actors (partners, MSP, community).
The state does not take enough responsibility.

EXPECTED RESULT
Ownership of the intervention by stakeholders from the design stage.

QUALITIES
Appropriate / Planned / Competent / Sustainable

TARGET AND INFLUENCERS
Actors at all levels:
- MSP - National, Intermediate and Operational, Providers, RECO
- Local development committees
- PTF

BARRIERS
- Trainer Profiles
- Participant Profiles
- Motivation
- Calendar conflict
- Lack / weak leadership

FUTURE VISION
Medium Term feasibility

BEHAVIOR CHANGE
Non-Involvement of the actors from the start and the lack of skills to continue the activities.

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Involving All Actors / Next Steps

Step 1
Reframe
Develop early concepts

Step 2
Prototype
Create possible tangible solutions

Step 3
Test
Take prototype fo target population and collect learnings

Step 4
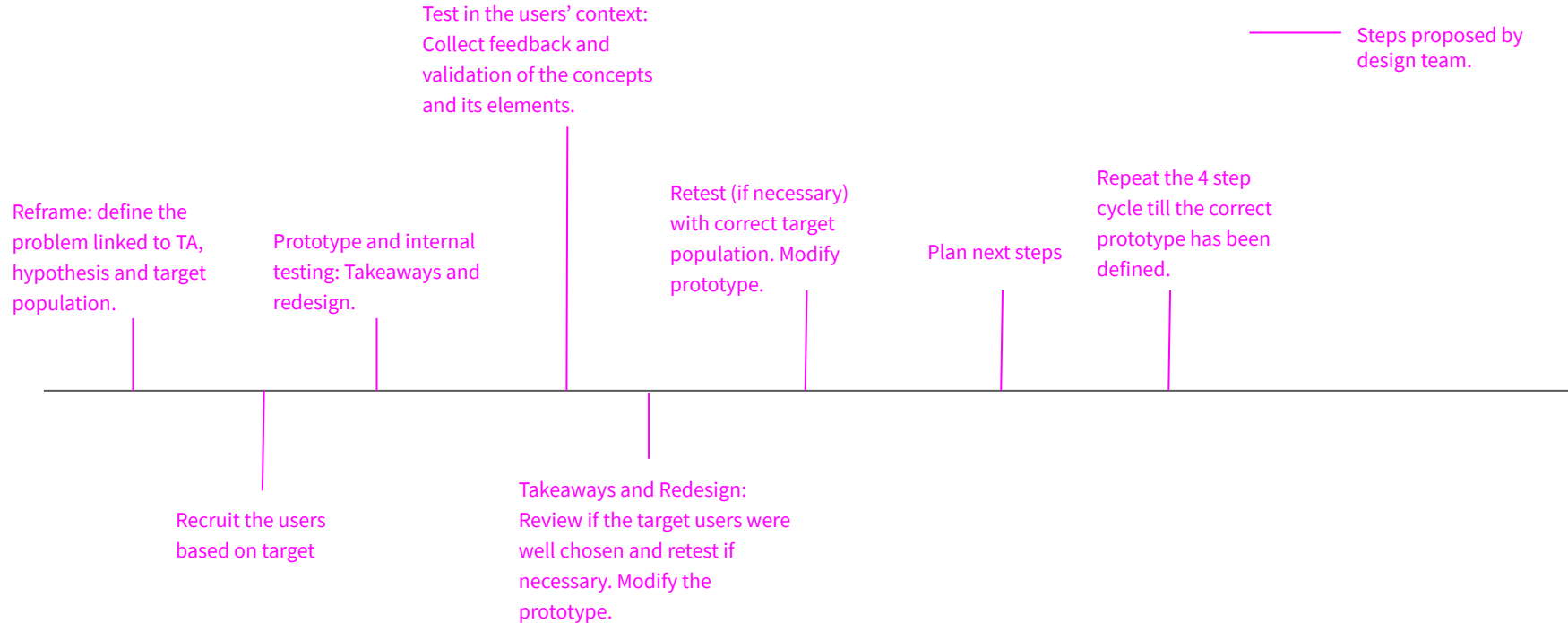**Iterate**
Integrate the learnings to iterate the prototype.

Like for the other concepts, the co-creation team will have to follow the same 1-4 steps that were done for the other concepts. It is important to always start with the reframe of the concept by choosing a problem that is linked to technical assistance.

Involving All Actors / Next Steps

Test in the users' context: Collect feedback and validation of the concepts and its elements.

Steps proposed by design team.

Retest (if necessary) with correct target population. Modify prototype.

Reframe: define the problem linked to TA, hypothesis and target population.

Repeat the 4 step cycle till the correct prototype has been defined.

Prototype and internal testing: Takeaways and redesign.

Plan next steps

Recruit the users based on target

Takeaways and Redesign: Review if the target users were well chosen and retest if necessary. Modify the prototype.

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Involving All Actors / Next Steps

How might TA ensure its impact is positive, long lasting and sustainable?

Advice for the reframe

DESCRIPTION
1. Contact the key stakeholders to outline the problem and determine next steps.
Who does what? How are the problems determined? (think about tools, expertise, roles and how this concept relates to others).

2. Analysis of the situation with stakeholders: determine the priorities for solving problems, identify the contributions of each party and mechanism of implementation.
Is the analysis routine? How can we improve the way we do the analysis?

3. Implementation of the project with the participation of partners.

4. Monitor and supervise the activities with the participation of partners and transferring of skills.
When does the transfer begin? How it works? How are we evaluating?

5. End of technical assistance, ongoing government assistance and continuity of field activities by local actors.
Is it still evaluated? By who? How?

THE PROBLEM
TA results are temporary.
Lack of skill transfer during TA.
How can we transfer skills? Whose? What skills? At what moment in the course of TA?
How to plan for sustainability? ex. How can this type of planning be integrated into the first phase of TA?
Lack of system and relay planning between actors (partners, MSP, community).
The state does not take enough responsibility. (relationship with the concept 2A?)
How to make the stakeholders really take their responsibilities? How can we encourage actors to keep their word / promise? (counterpart, accountability, governance)

EXPECTED RESULT
Ownership of the intervention by stakeholders from the design stage.

QUALITIES
Appropriate / Planned / Competent / Sustainable

TARGET AND INFLUENCERS
Actors at all levels:
- National, Intermediate and Operational Providers, RECO
- Local development committees
- PTF
Which actors exactly? What roles do they want to have?

BARRIERS
- Profile of trainers
- Profile of participants
- Motivation
- Calendar conflict
- Lack / weak leadership
How to promote leadership?
How to mitigate these barriers?

BEHAVIOR TO CHANGE
Non-involvement of actors early in the process

and lack of skills to continue activities.
Which actors are not involved?
What skills are needed to sustain activities?

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Involving All Actors / Next Steps

Advice for the prototype /

- To communicate and test the hypothesis, build the prototype in the format that is most faithful to your idea.
- Visualize the important aspects of your concept.
- Prepare the guide for testing it with the target population.
- If you find that the population target was not the right one, it is necessary to rethink that target and repeat the test.

Suggested Tool /

- Use this structure as a basis for writing your guide on paper for the test, step by step.

Hypothesis	Questions to ask (First start with high-level questions and then move to specificities, ask open questions, ie no questions that can be answered by yes / no)	Notes	Observations

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4/ Next Steps

Learnings and Recommendations

Reframing

- In general, the dialogue and the good participation of all the co-creation members made it possible to advance this step quickly .
- The time and role of the facilitator must be defined. The facilitator repeats, helps understanding and aggregates information to help build consensus and define latent issues.

Prototyping

- Splitting the group into two allowed more prototypes to be explored.
- The use of HCD tools (questions, maps, post-its and other elements) facilitated the conversation and participation of everyone.
- The role playing to put everyone in the shoes of the users was very helpful and very well done. This was a strong point for the team.
- The prototyping phase was not fully explored, because, although the prototypes were helpful to reframe understanding, they were not thought out with the test phase in mind. For the next iterations of the project the prototype should be more in-depth and especially be used during testing.
- Prototyping allows:
  - to gain empathy by identification with the end user;
  - explore options;
  - to perform tests;
  - to inspire the other members of the team.

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Learnings and Recommendations *cont.*

Testing

- The testing sessions need to be better prepared. Materials, a meeting plan, paper etc. are needed, and in some cases, the team was not always well prepared to complete the test session.
- Prepare a guide with the key questions you want to ask users, and at the end of the session, have answered as a team. Make sure you keep an audio recording so you can track and share with other stakeholders.
- Overall the test sessions felt short for the participants as well as for the facilitators. A minimum of 2-3 hours would be ideal.
- Being empathetic and building trust from the start is essential.
- Roles should be well-defined. Someone must take responsibility for the time, another for taking notes and the others for the conversation and planned activities.
- The test of the concept and its associated elements made it possible to quickly locate the frustrations and the possible undetected problems until now.

- Being aware of your audience, for example if you plan to work with women or children who are illiterate or shy, or who are not used to such sessions, take the time to explain what you are doing and make sure that they speak more than moderators!
- When a prototype is tested, user comments and feedback provide information that can radically change the original concept. The prototype should be modified after each test.
- It's important to think in 3D, not just stay on words. It is an active interaction between space, users and objects.

Redesign

- The strength of design lies in its principle of "failing fast to succeed even faster." (T. Brown). This error recovery principle is very powerful in terms of rapid design of relevant solutions.

Next Steps for the Co-creation group

After the work week, the following next steps should be assigned and worked on:
- For "Putting Community First" and "Sharing Risks": taking the 4 steps from the new hypotheses.
- The concepts should continue being prototyped.
- The team needs to take "Involving All Actors" through a full cycle.

The co-creation team will now have to meet to organize and schedule for the continuation of the project.

Célestin and Jean Fidèle will organize these new stages.

Meanwhile, Sonder and JSI are working together on planning the follow-up of the project.

Thank you to the entire co-creation team and participants!

The co-creation team:

Bernard Bushabu
Toto Ezombe
Jean Fidèle Ilunga
Brigitte Kini
Papy Lumtadila
Wivine Mbwebwe
Nestor Mukinay Tumb Tumb
Célestin Nsibu
Elysé Zambite

With the active collaboration of:

Serge Kapanga Kule
JSI team
Sonder team.

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5/ Annexes

Annex 1 / Personas

Ministry of Health

Vital, The Determined Engineer
Program Director
Ministry of Health

Rose, The Optimistic Civil Servant
Administrative Staff
Ministry of Health

Partners

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

Pierre, The Disillusioned Donor
Team Lead
Donor based Internationally

Practitioners

Mimi, The Traditional Careerist
Head
Zone level

Petra, The Solidary Tinkerer
Director of Finances
Public Hospital

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Vital
The Determined Engineer

Head of Program
Central Ministry of Health
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 understands 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."

Rose

The Optimistic Civil Servant

Administrative Civil Servant,
Central 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."

Sarah

The Grassroots Believer

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

66 *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 clinical 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..."

Pierre
The Disillusioned Donor

Team Lead, Donor
Based internationally
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, Zaire, 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 ago 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…

"Something like 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."

Mimi

The Traditional Careerist

Head of Zone de Santé
Provincial Level (near Kinshasa)
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…

"When there are projects where partners come and ask me my opinion, then we can manage together and together create ways of working and defining together solutions. That's really great, especially to increase 'la pérennisation' and reduce the multiplication of resources in field."

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."

Petra
The Solitary Tinkerer

Director of Finances of a Hospital
late 40s, accountant

> 66 *I've been working here as an accountant for ten years, including four when I worked in close collaboration with an auditor but he was really part of the team after having worked here for over ten 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, then 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, this hospital worked 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."

Annex 2 / "How Might We" questions

1. **How might TA priorities be surfaced when the health system lacks efficiency, transparency and inclusion of the community ?**
2. How might different actors better align to community-level priorities, and to each other?
3. **How might the substituting of actors from MoH and partners at the operational level be avoided?**
4. **How might TA be more accountable to households and reduce the burden on them to access care?**
5. **How might TA be coordinated to reduce the duplication of activities, responsibilities and gaps on the ground?**
6. How might TA ensure its impact is positive, long lasting and sustainable?
7. How might TA improve governance and transparency between actors at all levels?
8. How might TA better foster, leverage and reinforce strong leadership?
9. How might TA better support the public health system to take responsibility for its own mandate and actions?
10. How might TA take a less vertical and more integrated approach?

Annex 3 / How are the 4 opportunity areas related to each other and to the TA Journey?

Putting Community First

How might TA priorities be surfaced when the health system lacks efficiency, transparency and inclusion of the community ?

TA Journey:
Corresponds to **Step 1**, and later **Step 2, 4, 11 & 16** during the alignment process (HMW2) between internal and external actors using the artefacts created from downstream MoH actors (eg. baseline studies, see slide 80).

Also strongly associated with **transversal HMWs 8 & 9**: leadership, responsibility, empowerment.

Sharing Risks

How might TA be more accountable to households and reduce the burden on them to access care?

TA Journey:
Corresponds to **Step 2, 3, 6 & 15** where internal actors start taking a lead role in TA and empowering community actors to take part in the process.

Transversal HMWs 7, 8, 9 in particular, should be kept in mind during the exploration and development of this concept.

Mapping Initiatives

How might TA be coordinated to reduce the duplication of activities, responsibilities and gaps on the ground?

TA Journey:
Corresponds to **Step 8, 9, 10 & 12** during the alignment, coordination and implementation processes between internal and external actors. This concept provides the artefact/structural component to **facilitate alignment of the priorities unearthed in Concept 1**.

However, there is a need to consider **HMWs 3, 7, 9, 10** to change the cultural aspects currently acting as underlying barriers of TA; governance, accountability, global health perspective. *How can we incentivize actors to use this artefact to align during the AT journey?*

Involving All Actors

How might TA ensure its impact is positive, long lasting and sustainable?

TA Journey:
Corresponds to **Step 2, 16 & 17; the pre and post phases.** As there is no relay system established between actors - it is either not considered/planned up front or the actor does not take up their responsibility as expected. This results in only short-term impact. This concept should **complement Concept 2** in motivating internal actors to claim ownership.

Transversal **HMWs 8 & 9** need to be integrated here: governance, leadership, accountability/responsibility.