

Redesigning Technical Assistance for Global MNCH Impact & Stronger Health Systems

Insight & Ideation Workshop Report DRC March 2019







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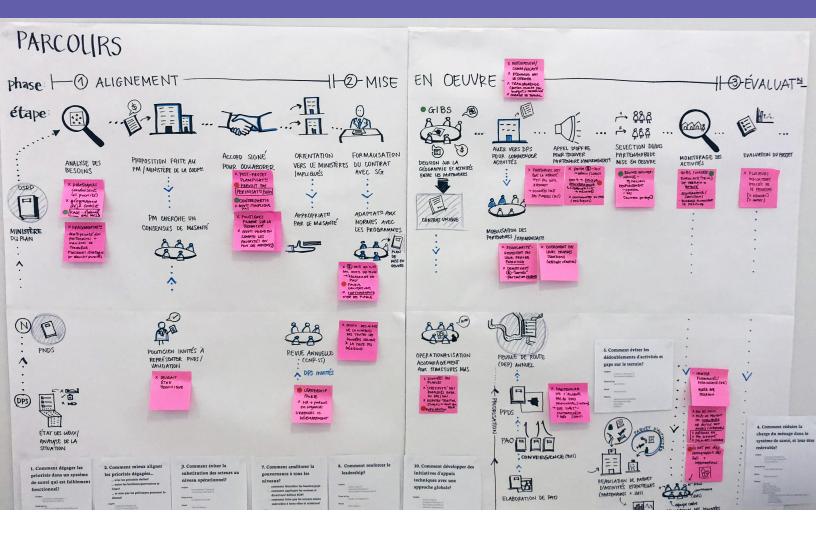






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Acknowledgements

The workshop organizers would like to acknowledge the generous support from the Democratic Republic of Congo (DRC) Ministry of Health (MOH) who supported the mobilization of several experts and actors across the DRC health system, as well as the data collection prior to the work-shop. Additionally, the deepest appreciation is extended to USAID's Maternal and Child Survival Program staff in Kinshasa who assisted this workshop specifically: Léon Katambay, Papy Luntadila Diazola, and Fifi Kabwiku for their dedication and logistical support. Their efforts ensured not only the materialization of this workshop, but also that participants were able to gain the most from this experience. The workshop organizers would also like to express gratitude to Dr. Jean Fidele Ilunga and Secrétaire Général, Sylvain Yuma Ramazani, from the MOH for their continued lead-ership and support.

Finally, many thanks to Nosa Orobaton and Tracy Jonson, from the Bill & Melinda Gates Foundation, for their vision to initiate this exploratory journey that has resulted in invaluable learning and knowledge sharing.

Executive Summary

Workshop Goal and Objectives: The Redesigning Technical Assistance for Maternal, Newborn, Child Health and Health Systems Strenghtening Project (Project) organized an insight and ideation workshop in Kinshasa, Democratic Republic of Congo (DRC) from March 19–20, 2019 to generate, develop and communicating new ideas. The workshop aimed to develop a synergistic understand-ing of the current technical assistance (TA) challenges and opportunities faced by various actors in the DRC health system, and foster a collective ownership of the redesign process.

Workshop Preparation: In preparation for the workshop, the Design Team conducted interviews with DRC stakeholders with the health sphere to gather their perspectives on the TA landscape in the country and its various actors. The interviews culminated in a collection of insights on technical TA that promoted further discussion among stakeholders and resulted in co-created solutions during the workshop.

Workshop Structure: The two-day workshop was well-attended by a diverse group of 26 participants from the government, donor agencies, and implementing organizations. On the first day of the workshop, the group shared their perspectives and underlying assumptions of TA, identified opportunity areas for the Project, and collaborated together to come up with solutions. On the second day, the group shared ideas and solutions to inform the scope of the Project moving forward.

Workshop Outputs and Takeaways: Participants shared their perspectives on the health system while having the opportunity to hear different viewpoints from other actors. More importantly, the participants were able to empathize and begin to understand the underlying reasons of specific behaviors from their counterparts. The group produced 90+ ideas derived from the opportunity areas and created four concepts to be further developed into preliminary prototypes of the TA redesign.

Next Steps: Following this workshop, the DRC Project team commenced the Concept & Testing Phase, with the intent to rapidly develop, test and iterate on concepts that explore new strategies for TA through a creative and grounded process.

Background

Why the Redesigning Technical Assistance for Maternal, Newborn, Child Health and Health System Strengthening (MNCH/HSS) Project?

From 1990 to 2015, the global under-five mortality rate dropped from 12.7 million to 5.9 million on an annual basis. Although this was a substantial progress in the reduction of child mortality, discernible differences in the equity of this progress between and within countries have become more apparent. According to the study report, Mapping Global Leadership in Child Health, "Nine out of 10 deaths of children under five years of age occur in low and lower/middle-income countries, and children from the poorest households in those countries are 1.9 times more likely to die than children from the richest households." Notably, sub-Saharan Africa continues to have the highest under-five mortality rate in the world. Within this region, 60% of child mortality occurs in the post-neonatal period although largely preventable.¹

In order to tackle lingering causes of poor child health; it is critical to leverage all functions of the global health architecture to serve countries and ultimately reach the most vulnerable populations. Technical Assistance (TA) is an effective intervention within the current global health system. TA is a key investment by governments and development partners to achieve health and wellbeing. As a result, the need and scope for TA in child health has expanded in low and middle–income countries. Partners at global and country levels provide technical and financial assistance, but despite efforts to coordinate, TA is not aligned consistently with national priorities or across various partners. In order to achieve the United Nation's Sustainable Development Goal 3 (SDG 3) for 2030 focused on good health and well-being, countries are required to develop targeted, sustainable, and coordinated TA plans. Improving the design of TA needs to address current issues while creating shared expectations and accountability among stakeholders.

Vision for Child Health, Targets and Gaps

As the Democratic Republic of the Congo (DRC) strives to achieve specific targets of SDG 3, eliminating deaths due to preventable causes and improving the well-being of mothers, newborns, children, and adolescents, it is focusing on high-impact interventions that target killer diseases of children. To gain an understanding of national priorities and targets for child health, the global Child Health Task Force² (CHTF) conducted a rapid desk review³ to synthesize strategic documents for child health in the DRC. The DRC government and implementing partners have set targets and defined priorities for children in the Plan National de Development Sanitaire (PNDS) 2016-2020.

¹ Mary E. Taylor, Renata Schumacher, and Nicole Davis, Mapping Global Leadership in Child Health, 4-5

² https://www.childhealthtaskforce.org/

³ Revue Documentaire et Synthetique de la Sante de l'Enfant en RDC pas rapport a la Vision 2030

In accordance to the PNDS 2016-2020, priority areas and targets include:

- Implementation of high-impact reproductive, maternal, neonatal, child, and adolescent health (RMNCAH) interventions in 14 (most underserved or high burden) of 26 provinces in the country, such as emergency obstetric and neonatal care, integrated management of childhood illnesses (IMCI), skilled attendance at childbirth, antenatal care, immunization plus, family planning, and insecticide-treated mosquito nets;
- Implementation of specific interventions for providing sexual and reproductive health services to adolescents;
- An increase in the coverage and delivery of quality nutrition services;
- An increase in access to safe drinking water and use of appropriate sanitation;
- An increase in contracting with financial and technical agencies to adequately finance health services;
- An increase in involvement of communities in the implementation of health services.

The rapid desk review revealed that future TA approaches will need to resolve the following issues:

- Organizational capacity gaps (leading to low national coverage of interventions, low integration and coordination of health services at the operational level, weak management of service delivery systems, low involvement of the private sector, low accountability towards beneficiaries, low rates of effective referral for clinical services between the health center and the general referral hospital);
- Deficits in human resources (under qualification of health personnel, poor distribution of health workers, inappropriate formal medical training for health needs);
- Shortages of material resources and drugs (low availability of required emergency materials and drugs); and
- Low functionality, quality, and use of health services; and
- Insufficient financing of the health system.

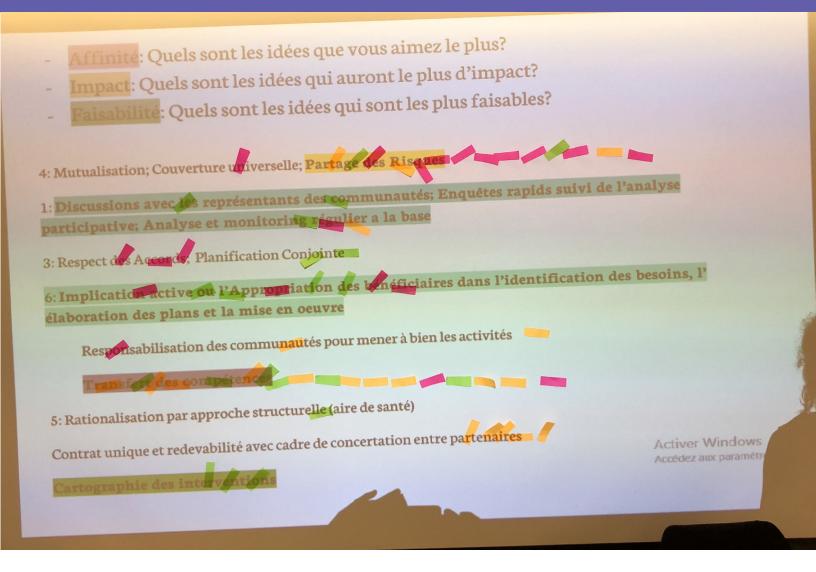
Why Human-Centered Design?

With any system change process, the role of design is to broker change, align intent and tap into the latent motivators that drive decision-making and experience pathways. The human-centered design (HCD) approach can be extremely impactful, particularly with system change, as it provides a deeper, richer understanding of the behavioral determinants affecting people's capability to confidently and willingly affect change.

HCD's approach to problem solving is to listen to the people operating and experiencing in a particular context as they hold the greatest motivation, expertise and insight to change it. In <u>Pedagogy</u> <u>of the Oppressed</u>, Paulo Freire writes, "One cannot expect positive results from an educational or political action program which fails to respect the particular view of the world held by the people." Consequently, the HCD design places emphasis on a co-design process, meaning design occurs with the people it is designing for. Co-design is well suited for complex system design such as the health system in DRC, as it is requires balancing the experiences of different actors adaptively and openly while remaining true to a disciplined process.

About the Redesigning TA for MNCH/HSS Initiative

Through the JSI Research & Training Institute, Inc. (JSI) and with support from the Bill & Melinda Gates Foundation; the Child Health Task Force (CHTF) partnered with Sonder Collective to support the DRC and Nigeria Ministries of Health in the redesign of their current TA models using the HCD approach. The HCD approach focuses on the needs and motivations of the end users receiving the TA, such as the MOH at national and subnational levels. The intent is to enable countries to better implement evidence-based, integrated MNCH interventions. Therefore, the new co-created vision for TA intends to emphasize on strengthening local capabilities, coordinating partner efforts, and ensuring country-driven objectives.



The overall objective of this initiative is to improve service delivery for mothers and children, through a redesigned model of TA with the greater goal of achieving the 2030 vision of maternal and child mortality reductions in Nigeria and DRC by 2019. Detailed objectives of the redesign included the following:

- Deep understanding of barriers and challenges with current TA delivery;
- Exploration of diverse opportunities for future TA delivery;
- Co-designed set of prototypes for future TA delivery; and
- Documented roadmap for the implementation of future TA delivery.

Workshop Goals and Objectives

Goal:

This collaborative workshop aimed to develop a shared understanding of user experiences to springboard into ideas and prototypes for the TA redesign in DRC through the following:

Objectives:

- Familiarize participants with the Project objectives and the HCD methodology and terminology;
- Immerse participants in findings and insights to help stakeholders become more aware of perspectives of TA and needs for improvement;
- Prioritize opportunity areas to focus on for the remainder of the Project;
- Share ideas and solutions for each opportunity area; and
- Develop concepts from selected ideas and prioritize them for the next stage of the Project.

Target Audience

In order to capture as many perspectives as possible and create ownership of the redesign process, key stakeholders from the MOH at national, provincial and zone levels (9 civil servants, 31 healthcare providers), international donors (7), international and local implementing partners (7) and civil society actors (1) were involved in the redesign Research Phase prior to the workshop. This very same group of individuals was also our target audience for the workshop. In a complex system, it is important to ensure all voices are heard so that the output is inclusive, balanced and addresses the needs of those that are part of the system.

Methodology

Preparation and Research

Prior to the workshop, the Research Team, comprised of a designer, an anthropologist and a pediatrician, met with stakeholders from the entire DRC health ecosystem including donors, implementing partners and civil servants at all levels of the health system (including the central and provincial levels) to explore perspectives on TA. After the Research Team conducted interviews and facilitated activities to gather information (see Annex 4), the Research Team analyzed feedback on the system and TA from various perspectives. This led to the creation of the TA journey in DRC (see Annex 5), a visual that incorporated insights emphasizing the underlying dynamics of the system and opportunity areas to co-create solutions together during the two-day workshop. Insights are actionable 'truths' or poignant perspectives about the system that help understand it holistically while considering key barriers and facilitators to ideate creative solutions.

Contents of Workshop

DAY 1

The first day of the workshop had three objectives:

- Share findings, insights and underlying assumptions of TA to create awareness of others perspectives,
- 2 Prioritize opportunity areas to define scope and focus for the rest of the Project,
- **3** Attempt to complete a first round of ideation and solution creation.

Following general introductions, an overview of the Project and objectives were presented. Thereafter, the HCD methodology, strategy, and tools were shared and used to facilitate the rest of the workshop.

Activity 1: Overarching System and Enactment: The facilitators presented participants with a summary of insights and a visual depiction of the TA journey. The insights were accompanied by case studies that participants were invited to perform to help empathize with the other actors in the system. This step permitted participants to gain awareness of the underlying reasons behind their behaviors and understand why particular aspects of TA did not work.

Activity 2: Ideation: Participants proposed ideas in response to the opportunity areas presented during Activity 1 mentioned above. Then, participants mapped out opportunity areas corresponding to actors' frustrations, barriers and facilitators along the TA journey. The opportunity areas included:

- How might we unearth the priorities in a weak/dysfunctional health system?
- **2** How can the system actors better align themselves to the priorities?
- **3** How can we avoid turnover of actors at the operational level?
- **4** How can we reduce the burden of households in the health system?
- **5** How can we avoid duplication of activities and gaps on the ground?
- **6** How can we make the positive impact long lasting and sustainable?
- **7** How can we improve governance at all levels?
- 8 How can we reinforce leadership?
- **9** How can we create a healthcare system that is self-sufficient and responsible?
- U How can we develop TA with an integrated approach?

DAY 2

On the second day of the workshop, participants developed and shared ideas and solutions with a focus on each prioritized opportunity area. They then voted on the concepts for the next phase of the Project (prototyping).

Activity 1: Future State: Participants shared keywords to describe an ideal vision for the future and to consider when ideating. Some of the keywords included:

- Sustainable (relayed)
- Respectful
- Convivial
- Transparent

Aligned (with DRC's politics)

Founded on real needs

Essentially local (lead)

Inclusive (of beneficiaries)

Efficient

Activity 2: Ideation: With the future state in mind, a new round of ideation followed. This round purposefully followed the future state exercise to help participants mentally align their ideas with their vision for the future.

Activity 3: Co-creation Concepts: Co-creation means to create an enabling environment for a diverse group of people, to actively shape and create new ideas and solutions, and make important decisions together. The purpose of co-creation is to increase ownership and joint decision-making.

After clustering similar ideas and voting for the ones they found the most impactful, feasible, or had the most affinity towards; the participants co-created concepts. Concepts are further developed ideas. They describe the steps that are necessary to realize ideas, including actors, roles and mitigating potential barriers resisting change.

Co-Creation Team: The Co-Creation Team (see Table 1) is a cross-sectional and multi-disciplinary group that drove the design process during the workshop. It is the operational level group that drives the process and is maintained throughout the life of the project. It typically includes members who are senior enough to make decisions but available enough to not prevent the team from meeting regularly. The Core Design Team, in this context, was comprised of individuals who understand today's reality but who also have an eye towards the future.

The project Co-Creation Team was formed during this workshop. It is comprised of key stakeholders, donors, international and local implementing partners and central and provincial actors from the Ministry of Health.

Name	Organization
Ilunga Jean-Fidèle	PNIRA, MOH
Kapanga Kule Serge	University of Kinshasa
Kini Brigitte	OMS/WHO
Kalenga-Tshiala Béatrice	PRONANUT (MoH)
Lumtadila Papy	MCSP
Ngoie Bernard	PNLCHOLMD, MOH
Kabutakapua Ilunga Gustave	Province (DPS) Kasai
Nsanie Lucie	PNSR, MOH
Madinda Luc	Cooperation Bilaterale. MOH
Mukinay Tumb Tumb Nestor	CNOS/OSC

Table 1: Members of the Co-Creation Team

Workshop Outputs and Takeaways

An important result of this workshop was creating the opportunity for participants – – partners, civil servants, donors, and health care providers – to hear the different perspectives within the system and agree, together, that this system is vulnerable and not working, as it should. Feeling heard and gaining empathy were other important outputs for the HCD approach. Furthermore, participants felt empowered that they had a role in the plan for change and were provided a platform to enact change with others that were equally motivated.

Ideas:

The participants produced over 90 ideas in response to the ten opportunity areas the research team identified. The participants developed the following four concepts based on their prioritized opportunity areas:

• **"Risk sharing"** tackling the weight of health costs on families and the difficulties of creating long term development strategies;

2 "Involving the beneficiaries" solving problems related to the prioritization of the true needs of the DRC population;

3 "Transfer of competencies" addressing the lack of "sustainability" once the project ends; and

4 "Transfer of competencies" addressing the lack of "sustainability" once the project ends; and

Concepts currently include a high-level description of the actors and the steps involved in realizing their short, mid or long-term visions. These will be further developed in the next phase of the redesign.

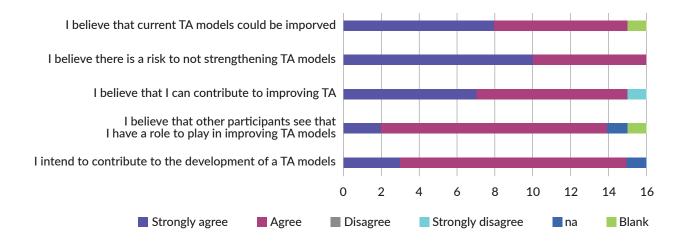
Post-workshop Assessment

Before closing the workshop, the JSI documentation team provided participants with an optional, post-workshop assessment to determine what worked well and what aspects of the approach could be improved. The assessment also sought out to explore stakeholders' opinions on current TA approaches and effective TA models. The team received 16 out of 26 completed assessments.

Positive feedback

Results from the post-workshop assessment found that most participants expected the workshop would generate a more effective TA model. Participants mentioned that the group work enabled them to absorb new ideas and influenced their thinking related to TA. When asked which aspects of the workshop were most useful, most participants mentioned that while all sessions were useful, they most appreciated the idea card session (see Figure 1).

Figure 1: After attending the workshop,



Opportunities for Improvement

Participants suggested the final synthesis and next steps session could be improved by clarifying what would follow at the conclusion of the workshop. Participants also suggested that resources could be made available in advance of the workshop to allow them to become familiar with the content. There were also suggestions to have more time to enable further development of concepts. Finally, one participant suggested that future workshops could include learnings from other countries.

Stakeholder Understanding of Current TA Approaches

Figure 2 displays some of the workshop participants' understanding of current TA approaches and their opinions of how to improve it to be more effective. The documentation team asked participants questions about the status of TA models, their role in contributing to their improvement and ultimately, their intent to contribute to improve the TA model. The findings were not representative of the workshop participants or the broader TA community and were simply to provide an illustrative understanding of the context. Approximately half of the participants who responded strongly agreed that current TA models could be improved and 10 out of 12 respondents strongly agreed that there was a risk in not strengthening TA models. However, when asked if participants felt they could contribute to improving TA models, only seven out of 16 strongly agreed that they played a role and only 2 strongly agreed that other participants expected them to play a role in improving TA models. Finally, only 3 participants strongly agreed that they intended to contribute to the development of a TA model.

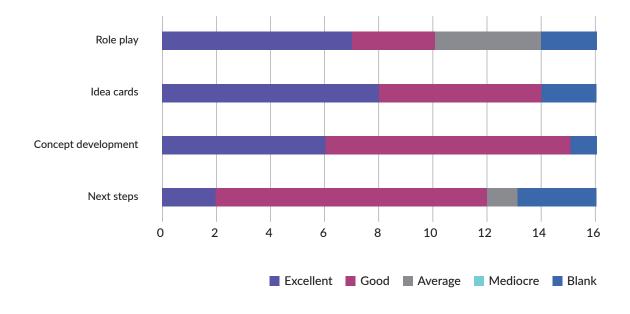


Figure 2:Participant rating of the worshop sessions

Involvement of Key Stakeholders in the Development of New TA Models

The assessment asked participants to reflect on the key stakeholders attending the workshop and to recommend any new stakeholders be included in subsequent workshops. Participants recommended that it would be helpful to have representation from religious groups, women's networks, pharmacists and organizations that work with vulnerable groups such as the handicapped. A couple of participants requested that there be greater representation from the Provincial Health Divisions and communities. One participant recommended that researchers such as anthropologists and/ or other disciplines be included.

Recommendations

Based on experience from the workshop facilitators and participants, the following recommendations are proposed to meet the workshop and Project objectives:

Engagement of stakeholders

- Provide the Secretary General with frequent updates on plans and intent throughout the redesign process which involves sharing a technical note with the Secretary General at each new phase of the process followed by frequent communication with his office,
- Increase engagement with the Groupe Inter-Bailleurs en Santé (GIBS),
- Expand reach to the social sector specifically churches and different levels of the health system,
- Further adapt the HCD approach and activities to the local context as it was well received and the role-playing in Lingala was a success.

Workshop structure

- Continue using and/or increasing the use of activities that call for the engagement of the participants,
- Allow for more time to complete the sessions and provide insights to participants in advance,
- Explicitly explain the next steps at the conclusion of the activity so that participants have a clear understanding of what will follow.

Next steps

Following this workshop, the Project will begin developing the Concept & Testing phase. This phase is intended to rapidly develop, test and iterate on concepts that explore new strategies for TA through a creative and grounded process. During this phase, the Project will further develop the concepts created during the workshop, prepare and facilitate a series of 'co-creation and proto-typing' sessions during the week of May 6, 2019; fully engage the Co-Creation Team and other end users wherever necessary through divergent, experimental thinking. Additional next steps include:

- Develop user test guides (e.g. visual storyboards or interactive role-plays and observation) to test with system actors from different user cohorts. Synthesize feedback and determine user suggestions for refinements, then apply those refinements in real-time for the prototypes.
- Collaborate with the Core Design Team to prioritize the key concepts and launch 4-5 x 1 day prototyping design sprints. Each sprint would include a concept development, a round of prototyping, an in-situ testing period with users, and an opportunity to revise the prototypes further. The number of prototypes will naturally decrease and the fidelity of prototypes will increase as the sprints progress.
- Develop and apply a monitoring framework that tracks the design journey of each prototype, its successes and failures, and its iterations.
- Review the content from the prototyping sprints and shortlist 2-3 refined options for detailing the implementation implications.

These next steps involve further development, validation and testing with end users and relevant actors of initial concepts produced during the workshop. Participation will be a fundamental part of the process to develop the concepts into scenarios and/or low-fi prototypes in the months to come. The Sonder Collective will assist the Project in the creation of a roadmap for their future implementation.

Annex 1: List of workshop participants

Liste de participation finale, Atelier Insight & Ideation RDC, mars 2019				
		Organization	Title	
1	Dr. Nsanie Lucie	PNSR, MOH	Directeur adjoint	
2	Dr. Kabwe Michael	DSSP / SNIS	Chef de	
3	celluleThotho Lumbu Mbali	DGOGSS	Experten Santé Publique	
4	Gustave Kabutakapua	DPS / KASAI Central	Chef de Bureau Gestion	
5	Papy Lumtadila	Programme mère et survieenfant	en Santé Maternelle Conseiller et infantile	
6	Dr Catherine Akele	Vaisseaux Kalembe-Lembe	Directeur	
7	NestorMukinay Tumb	CNOS / OSC	Président national	
8	Mulohwe Michel	UE	Projetdu Gestionnaire	
9	Béatrice Tshiala	PRONANUT	Directeur Adjoint	
10	Dr. Senga Lwanba John	SOPECOD	Président National	
11	Dr. Kanza Nsimba Maurice	MAA	Point Focal National	
12	Dr. Bakary Sambou	OMS	Responsable du programme de lutte contre le paludisme	
13	Kapanga Kule	UNIKIN / Socio-anthropologue	Point Focale	
14	Dr. Lose Marie Josee	HPGRK	Pédiatre	
15	Dr. Kini Brigitte	OMS	RMNCAH	
16	Dr. Bernard Ngoie	MSP / SG	Expert	
17	Dr. Narcisse Embeke	PROSANI-USAID	Directeur	
18	Dr. Kalune Alex	ZS MONT-NGAFULA 1	MCZ	
19	Dr. Polycarpe Lubuku	SANRU	Gestionnaire Adjoint de programme / ASSP	
20	Elysé Zambite	USAID	МСН	
21	Dr. Jean Fidèle Ilunga	PNIRA / PCIMNE	Directeur du	
22	Dr. Adeland Lofungola	DPS Tshopo	CB SP	
23	Dr. Marie-Jeanne Bokoko	PSAT / AMC (Canada)	Expert en Santé Publique	
24	Dr. Pierre Tayele	ASSK	Coordinateur Santé Publique	
25	Luc Mdinda Tshongu,	COOPINTERNATIONALE	Directeur	
26	AdrienNsiala	SANRU	stratégique conseiller national	

Annex 2: Workshop Agenda EXPLORATORY PHASE: AGENDA FOR THE INSIGHT & IDEATION WORKSHOP

Co-creation on Technical Assitance

Hotel Plaza, Kinshasa - March 19-20, 2019

Objectives

- Refamiliarize the group with the objectives of the project and the HCD methodology.
- Review the results so that each stakeholder's views on technical assistance and what needs to be improved is known.
- Define the objectives of the project
- Design ideas and / or solutions together with a focus on each priority area of opportunity
- Develop concepts from the selected ideas and prioritize them for the next stage of the project (co-design and test)

Time	Session Name	Session Leader		
Day 1 LA PERSPICACITÉ				
8:30-9:00	Arrival of Participants	None		
9:00	Official Opening			
9:00-9:10	National Anthem			
9:10-9:20	Welcome from the Director of PNIRA, Jean-Fidèle Ilunga	Jean-Fidèle Ilunga, PNIRA		
9:20-9:30	Welcome by JSI representative, Léon Katambay	Léon Katambay, JSI		
9:30-9:40	Opening and Orientation by Secretary General	Yuma Ramazani, Ministère de la Sante		
9:40-10:00	Official Photo	None		
10:00	Introductions			
10:00-10:10	Word of the Foundation Bill Gates, Nosa Orobaton	Nosa Orobaton (video)		
10:10-10:20	State of Place of the Infant Health	Jean-Fidèle Ilunga, PNIRA		
10:20-10:30	Review of the Project of Redesign of the Ass Technical istance	Serge Raharison, JSI		
10:30-10:40	Methods of Research, Co-Creation and Design for the project	Sonder		
10:40-10:50	Discussions, Exchanges, Questions			
10:50-11:05	Coffee break			
11:05	Immersion			
11:05-11:50	Presentation of Insights, profiles and case studies	Sonder		
11:50-2:35	Presentation of technical assistance course	Sonder		
12:35	Developement Challenges	Sonder		
13:05-14:00	Break Lunch			
14:00	Presentation of the Rules of	Sonder		
14:10	Co-creationFirst Co-Creation Iteration	Sonder		
14:10-14:30	Create Ideas / Find Solutions			
14:30-15:00	Plenary Discussion			
15:00-15:15	Questions and Summary			
15:15-15:30	Coffee Break			
15:30	Second Iteration of Co-Creation	Sonder		
15:30-15:50	Creating Ideas / Finding Solutions			
15:50-16:20	Sharing with Participants			
16:20-16:35	Synthesis and Closing of the Day			

Day 2 LA CONCEPTION				
8:30-9:00	Arrival of the Participants			
9:00-9:20	Imagining the Future	Sonder		
9:20-10:05	Design 2 & 3	Sonder		
10:05-10:20	Lunch Break			
10:20-12:00	Prioritization of Ideas	Sonder		
12:00-13:00	Lunch Break			
13:00-15:00	Development concepts	Sonder		
15:00-15:15	Coffee Break			
15:10-15:40	Select and mapconcepts:	Sonder		
15:40-16:00	next Steps and closing	Sonder		
16:00-16 40	Interviews This will be part of an assessment after the close of the workshop. Only selected people will be interviewed.	Leanne Dougherty, JSI Serge Raharison, JSI		

Annex 3: Instructions for Explore Phase EXPLORE PHASE | Individual & Group Session Agenda 1h30-2h

Objectives

- Understand participants' definitions of TA from their perspective
- Allow participants to share their personal experiences with TA and identify the major barriers, facilitators (emotions, pain & delight points) and influencers along the process and offer potential solutions (ie illustrative examples, ideas)
- Discuss participants' current perspective on power and relationship dynamics with other stakeholders during the current TA process and in their ideal scenarios
- Revise mission statement as necessary to reflect their needs, gaps and visions
- Identify similarities across MNCH and other health areas (cover lightly in 1:1 sessions)

Activities:

The following exercises are part of the toolkit and moderators will choose the exercises based on the participants' availability and information needed.

- 1. 5min: Intro of objectives, mission statement, participatory design
 - Participatory design is central to our work and relies on their perspectives as actors of the TA system/process
 - Important to mention that participation is voluntary and privacy will be protected; data will be aggregated and quotes anonymized in our report/presentation during insights workshop
 - Materials: eg show slide of 'what is truth?' and key steps to HCD (explore, ideate, test, divergent/convergent triangles)

Warm up exercise

2. 5-10 min: Defining TA - What is technical assistance?*

Card sorting exercise: What is TA to you?
 Instructions: Remove cards that you do not consider TA, the ones that are left, prioritize them from top to bottom – ie cards at the top are the most important aspects of TA, the ones at the bottom are less important). If none of these work for you, write your own ideas on Post-its.

■ Is something missing?

Instructions: *add your own Post-it with a key word and small icon/drawing.* Materials: prepare cards/Post-its with icon & key word from definitions in phase 1 interviews. (add adjectives on Post-its, emotives & nouns)

3. 20 min: Quote exercise

Instructions: place a green dot on the quotes that resonate with you 10 min reading, 10 min sharing Materials: Edit the quotes (less overlap with personas and journey)

4. 60 min: Journeys & Circle of Trust

- **5 min:** Introduce tool, uses of journey/personas
- **15 min:** Our journey

Instructions: React to your group's journey (as a group), what resonates here/doesn't? Mark it directly on page with red/green pen or stickers. Anything/anyone missing? **Variation: 5 min:** Each participant identifies 3 artefacts from their TA experience: Pain point,

delight point, possible solution/ideal scenario (placed on poster paper)

- 15 min: Other stakeholders' journeys (in pairs)*
 Instructions: Answer questions:
 - What were the biggest barriers here?
 - Have you experienced any of these problems? What can you relate to? What has surprised you here?
 - Could you propose any ideas to solve these issues?
- 20 min: provide skeleton, build your own Journey*
 - Instructions:
 - Fill out brief information (role, three words to describe themselves)
 - Why are you doing what you're doing
 - Key factors for success, what doesn't work
 - Materials: A3 printed journeys and templates, blank A3/A4 paper, green and red stickers or felts, roll of blank paper)

5 min: Building Circle of Trust (as a group)
 Instructions: Placing yourself or your team at the center, place actors involved in TA at a relative distance (of trust) to you, map any particular power dynamics.

5. 20 min: Pathway to change Game*

Materials: Prepare cards (previously) for barrier (red lightning bolt), facilitator (green dot), idea (yellow light bulb), and one for each stakeholder type: govt (building), int'l partner (globe), HCP (doctor). Place upside down and mix.

Instructions: We're going to play a game to discuss some of the major barriers and facilitators for TA as well as offer some ideas. When it's your turn, pick up 2 cards and provide your answer on a Post-it. If anyone has something to add, please also put it on a Post-it.

→ output: SEM model with barriers and facilitators for 3 different user typologies (MoH, int'l partners, HCPs)

6. 5 min: Revise mission statement

Retake mission statement and revise with Design Principles/key word arising out of previous exercises.

*Prioritized activities (when limited with time)

Scenario 1: first 1:1 interviews and then group session

- 1:1 interviews, output: Personal Journeys
- Grp session: quotes, sharing own journey (from interview), other journeys, pathway to change game (map barriers, facilitators and ideas for 3 stakeholder typologies).

Materials

- Square blocks of Post-its & rectangular blocks (7.5 cm & 13 cm) 4 colors bright colored: green, pink, blue, yellow (ie GPB for each user typology and yellow for ideas)
- Green and red dot stickers
- A few sets of different (3) colored markers
- Masking tape & invisible tape
- Flipchart paper blocks (2) (buy in Kinshasa on Tuesday)
- A4 and A3 paper (buy in Kinshasa)

Annex 4: Outputs from Research Phase

A map (user journey) of technical assistance in the DRC, a set of insights that emphasize the underlying dynamics of the system as well as opportunity areas for stakeholders to co-create solutions together during a two-day workshop.

Insights Résumé

Selon l'anthropologue, Marcel Mauss les Hommes "donnent pour recevoir"...

- ... du **Pouvoir** (Information et Finances)
- ... du Status (Reconnaissance et Sens)
- ... des Liens Sociaux (Réseau et Protection)

Dans une société où l'économie est dite "morale" le don sert à renforcer l'appartenance à son réseau et une hiérarchie sociale; dans une société dite d'économie "libérale" le don permet à renforcer ses droits et responsabilités individuels et ses moyens de production.

Cette échelle nous permet de comprendre certaines différences, et nous voyons dans l'appui technique et financier un don qui est utilisé de manière différente entre les bailleurs, l'État de la RDC et le peuple Congolais, qui, vivent dans des économies différentes avec le modèle plus libérale de la communauté internationale et celui plus morale en RDC.

Sers-toi de ces insights pour mieux comprendre les barrières et facilitateurs pour travailler dans le système de santé en RDC...

1/ Une Structure Paternaliste

→ Renforcer le réseau Étude de Cas: Le PAO, Ce qui Monte Rarement Redescend

2/ Privatisation Informelle

→ Repenser la motivation Étude de Cas: Perdre sa Crédibilité

3/ Gratification Immédiate

→ Sacrifier le développement Étude de Cas: Urgence Pharmaceutique

4/ Instrumentaliser l'Opacité

→ Être désavantagés par la transparence Étude de Cas: La Maturité Provinciale

5/ Des Systèmes Parallèles

→ S'aligner difficilement Étude de Cas: Sont-ils Prêts?

6/ Solidarité Collective Temporaire

→ Bricoler sa volonté Étude de Cas: Fabriquer son indépendance

7/ Un Bon Leader

→ Incarner le politique et la technique

8/ Prévoir la sécurité

 \rightarrow Une deuxième occupation

9/ Une contagion d'irresponsabilité

→ Se dédouaner de responsabilité Étude de Cas: Beau Début

Annex 5: User journeys in progress

Participants developed a user journey map of technical assistance in the DRC, a set of insights that emphasize the underlying dynamics of the system as well as opportunity areas for stake-holders to co-create solutions together. The left photo shows the mapping process of TA after completed the interviews with end users. The right photo shows the second iteration of the mapping process of TA being able to more clearly illustrate key steps, facilitators and barriers of TA.



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