



Re-imagining technical assistance in the DRC

BILL & MELINDA
GATES foundation

JSI

sonder collective



Project context

This Child Health Task Force, in partnership with Sonder Collective, JSI Research & Training Institute, Inc. (JSI), and funded by the Bill & Melinda Gates Foundation, is supporting the Ministry of Health in the Democratic Republic of Congo (DRC) to understand what effective technical assistance (TA) looks like for all actors involved in setting up and running TA - donors, TA providers, governments, and beneficiaries - and to find ways to concretely improve the process of designing and implementing TA in the DRC.

In March 2019, the project scope expanded from child health to Maternal, Newborn, Child Health and Health Systems Strengthening. With this shift, the project focused on re-imagining aspects of technical assistance that impact the broader health system including, interactions among the key actors and shifting the power to decide priorities from the funders to the countries. This is based on the recognition that while technical services for MNCH remain central to the SDGs/2030 vision and donor funded TA projects, these services can only be delivered if the health system has the capacity (leadership and governance) to manage services and funding to provide key inputs into service delivery (refer to health systems building blocks). Re-imagining TA to improve the governance and capacity of the health system will ensure that MNCH services are delivered in an equitable manner and will bring down maternal, newborn and under five mortality.

Objectives of the phase

Thanks to a previous anthropological research phase, we gained a deep understanding of the nature of the relationships between technical support providers, government, donors and the community. Our second phase of work focuses on further exploration of design principles, their practical application, and the gathering of missing point of views from certain actors.

The ultimate goal of this project is to better TA in the DRC and to reduce maternal, newborn, and child mortality and to strengthen the health system. The general objective of this phase was to create a roadmap for the application of new norms and standards for TA for:

- (i) reinforcing knowledge of the various typologies of TA in the DRC
- (ii) identify common and key points to these initiatives
- (iii) identify bottlenecks in the TA journey
- (iv) integrate the perspective of donors, funders and decision makers
- (v) define further the design principles created during the past work phases
- (vi) elaborate a roadmap for change

These norms and principles will be shared among all actors and at the global level, and will result in effective means for technical assistance to be redefined in the DRC.

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01 Executive Summary

01 EXECUTIVE SUMMARY

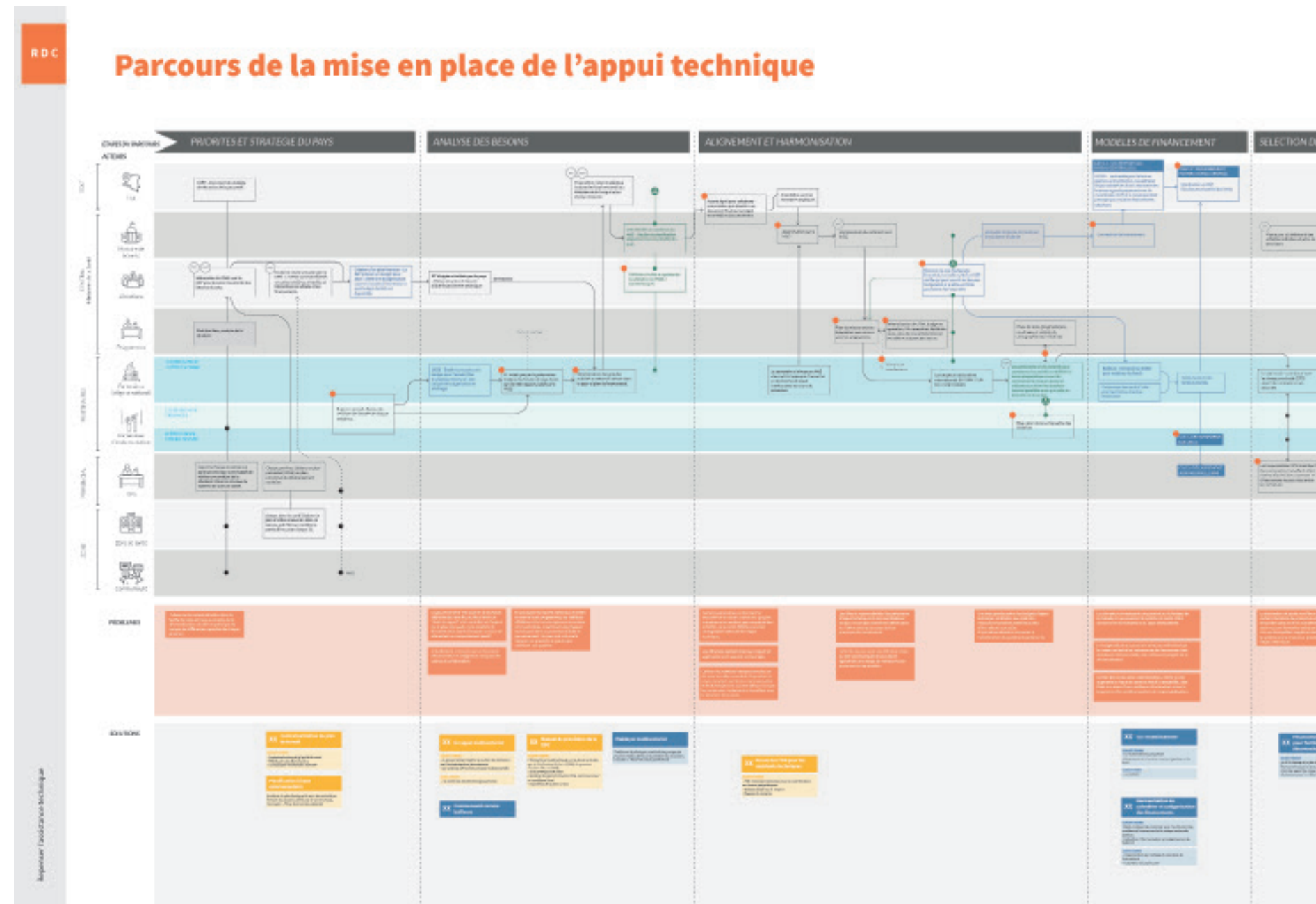
Blueprint of technical assistance

Examining the interactions between the different actors of TA during the whole lifecycle of an initiative help us understand the ecosystem and break down all the problems and bottlenecks highlighted during the interviews with TA actors and decision makers.

A TA blueprint (or journey) has been created to help target these specific issues and highlight the most predominant manner that actors manage TA in the DRC today. It also presents in a visual, clear manner, friction points and pain points that need to be rethought at every stage of the journey of setting up and executing TA.

This blueprint highlights the most predominant way of managing technical support in the DRC today and the interaction between all actors.

The blueprint was conceived as a summary of research and was then used during a co-creation workshop in December 2019.



The file is available in pdf annexe.



Roadmap for change

AREA OF CHANGE

CAPACITY BUILDING IS ESSENTIAL AND IS APPLICABLE TO THESE 4 DOMAINS.

DESIGN PRINCIPLES TO RESPECT

THE PRINCIPLES APPLY TO ALL (COMMUNITY, DONORS, PARTNERS AND THE GOVERNMENT) AND ALL MUST WORK TOGETHER TO ENFORCE THEM.

CONCEPTS



GLOBAL TA RECOMMENDATIONS



COUNTRY TA RECOMMENDATIONS



STATE/GOV. RECOMMENDATIONS

01

Optimize finances to build on the long term

- *Direct finances toward the provincial and zone level rather than the central level.*
- *Minimize the duplication of activities in the health zone and the dispersion of funds*
- *Optimize spendings and foster the reinforcement and improvement of infrastructures.*
- *Implement an initiative system that promotes state accountability.*
- *Reflect the real operational costs of the implementation context.*
- *Change the incentive structures so that the individual gain contributes to the collective.*
- *Fair repartition of funds in the country.*
- *Support innovative sources of funding internal to the country.*
- *Comply with agreements and commitments.*

02

Support to foster governance

- *Align with common goals and priorities.*
- *The TA is led by the country and all respect the rules of engagement.*
- *To support and not to execute, with respect.*
- *Avoid a cookie cutter approach. Adapt TA to the context.*
- *Think of the patient rather than the singular disease as the central factor.*
- *Balance aid to the provinces equally.*
- *Technical assistance providers must be experts in capacity building.*
- *Promote community knowledge, demands and needs.*

03

Cultivate collaboration and transparency between all actors

- *Distribute strategic decisions at all levels.*
- *Share lessons learned on vertical and horizontal platforms.*
- *Identify, socialize and reward success.*
- *Strengthen accountability to the country and evaluation of TA services*
- *Joint assessment of TA services.*
- *Moving from a competitive environment to a transparent collaborative environment*
- *Make data accessible to everyone.*

04

Reduce external dependencies in favor of sustainability

- *Build for financial sustainability after the departure of donors at national and local level.*
- *Develop local resources even if it means sacrificing some immediate gains.*
- *Community has the ownership of projects.*
- *Increase state budget allocations for health.*
- *Increase sustainability and longer-term thinking.*
- *Reinforce evaluation and internal accountability models in the country to minimize dependence on third parties.*
- *Establish government accountability mechanisms after the departure of donors.*

- *Rethinking the impact of incentives and funding*
- *Advocate for infrastructure funding*
- *Provincial funding to facilitate decentralization*
-

- *Multisectoral TA*

- *Sharing best practices*
- *Country health indicators is a consequence of the provision of TA*

- *Sustainability plan for initiatives*
- *Investment plan for the sustainability of initiatives (donors)*

- *Community seen as donors*
- *Co-investment*
- *Update of intervention map*

- *Review of TORs for technical assistance providers*
- *DRC Standard Operating Procedures (SOP)*
- *Update of intervention map*

- *Mandatory consultation platform*
- *Strategic decisions dashboard*

- *Investment plan for the sustainability of initiatives (state)*
- *Reinforcing the IGS/IPS*

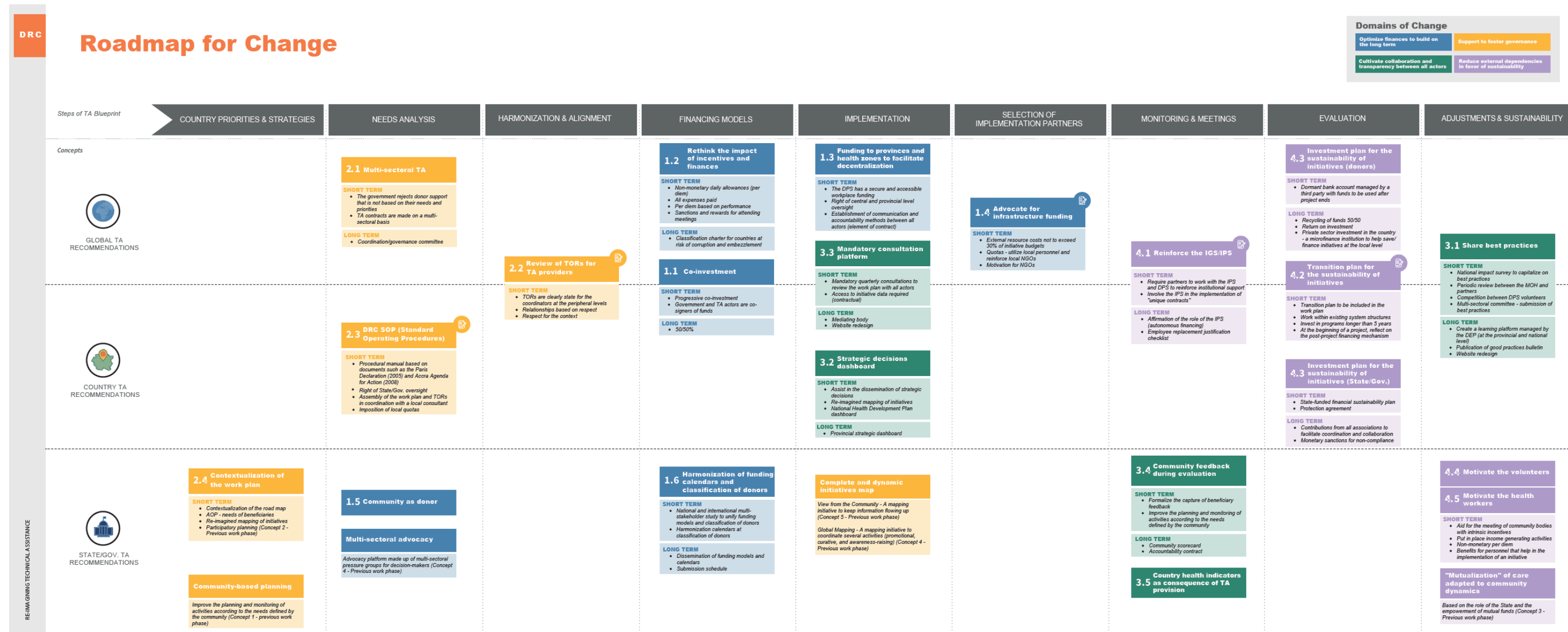
- *Harmonization of calendar and categorization of funding*
- *Advocacy platform made up of multisectoral pressure groups*
- *Updated resource mobilization plan*

- *Contextualization of the roadmap*
- *Map from the top to the bottom*

- *Community feedback loop during the evaluation*

- *“Mutuelle” care adapted to community dynamics*
- *Motivate volunteers*
- *Motivate health workers*

Visualization of the roadmap for change over the blueprint of technical assistance



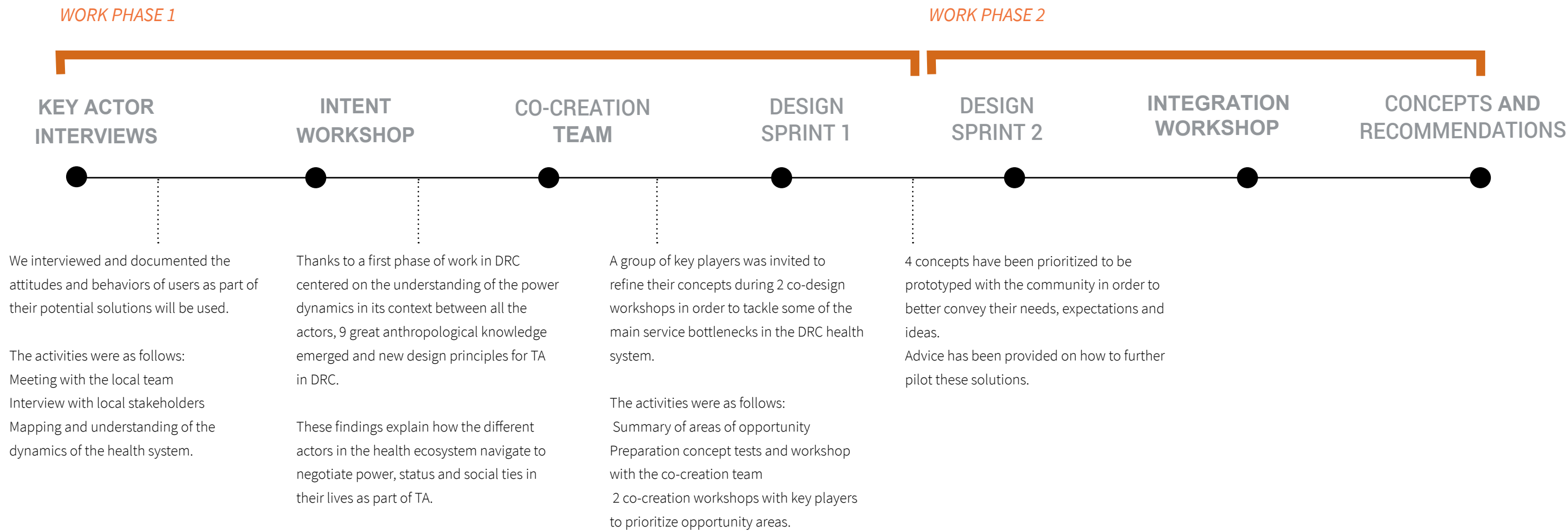
02

Summary of past phases

02 SUMMARY OF THE PAST PHASES

Work phases

Based on a previous anthropological research phase, we gained a deep understanding of the nature of the relationships between technical assistance providers, government, donors and the community.



Vision re-framing

Although previous work phases revealed basic principles for good technical assistance, the objective of this phase was to fill the knowledge gaps on the dynamics between technical assistance providers and government agencies at a higher level.

We have identified the need to deepen and go beyond the concepts already identified (present on this table) to encompass the entire ecosystem of technical assistance.

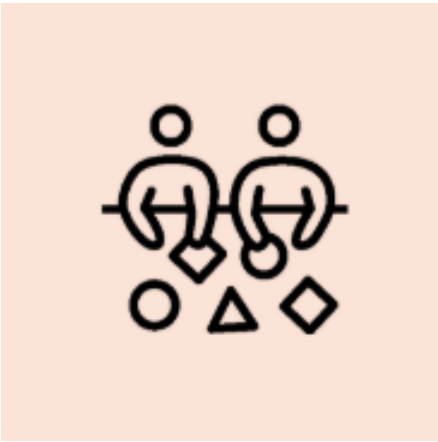
As this phase of work aims at a systemic change, the final result will have to generate critical political changes.

| | International | Central | Provincial | Zone and community |
|------------------------|---------------|---|---|--|
| Systemic and political | | | CONCEPT 4 - Advocacy platform made up of multisectoral pressure groups aim at decision-makers | CONCEPT 1- Improve the planning and monitoring of activities according to needs defined by the community |
| Technical | | CONCEPT 5- A mapping of the initiatives to coordinate several curated promotional and awareness activities. | CONCEPT 6 - A mapping initiative to keep information flowing upwards. | CONCEPT 2 - Tools for collecting information at the community level and for the community to organizing itself in structured groups CONCEPT 3 - Community Cooperative “Mutualisation” of care adapted to community dynamics |

03 Approach

Plan of the work phase 2

This second phase of work explores in more depth the design principles and their practical application as well as the creation of a roadmap for change.



Alignment Sep - Oct 2019

- Alignment of the Co-Creation Team
- Re-frame and align on the objectives of the next phases
- Review of existing data from previous phases
- Highlight gaps and missing perspectives



Immersion Oct 21-26 2019

- Kick-off workshop with the Co-Creation team, JSI and Sonder
- Gathering missing perspectives - interviews with decision makers
- End of week workshop - iterate and prioritize results with the Co-Creation team



Reframe opportunities Oct - Nov 2019

- Continue remote interviews to fill the remaining gaps
- Merge and reorganize results (from all phases)
- Review opportunities and further refine the TA journey



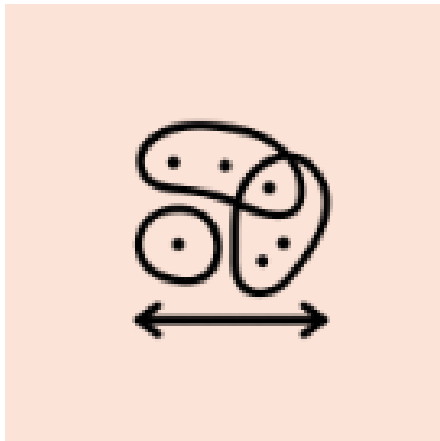
Co-Creation Workshop 6-11 Dec 2019

- Co-creation workshop with government officials at all levels and with key partner organizations
- Generation of ideas based on design principles and the blueprint of TA
- Prioritize concepts



Definition of the roadmap Jan-Feb 2020

- Refine priority concepts
- Create a roadmap for change, strategies and design principles defining clear actions to be taken by the actors



Integration Workshop 4-6 Mar 2020

- Presentation of the roadmap, strategies and design principles for the DRC to members of the government and partners
- Identify the steps to follow for the implementation of these recommendations

02 APPROACH

Considerations

While using this technical document, it is important to keep in mind certain aspects that may limit the implementation of concepts presented in this document.

1

We noted that there were different perspectives and attitudes toward change among the stakeholders we worked with. Within the DRC, there are tensions between the push for a fundamental shift in how the health system is managed versus incremental change or tweaking existing procedures. Change will require the leadership to negotiate and manage the tension. Some are willing to experiment with new ways of approaching systemic issues, but others are more idealistic experts who see the drafting of documents and the legal system as a way forward. Both of these approaches to change may hinder the implementation of these concepts.

2

Recommendations have been created in a collaborative manner, the implementation phase should continue to include all voices (NGO, Donors, Government). However, it is important to note that a large part of actors present during the co-creation phase were made up of representatives of the DRC government. It is essential that all groups are represented equally so the points of view captured are not biased toward one group only. Moving forward, donors and technical assistance opinion partners should be consulted regarding the feasibility of some of these concepts.

3

TA is an internationally established process. We recommend that, in order to move forward, it would be necessary to gather views and experiences from TA experts with an international experience (having worked in multiple countries with different contexts) in order to extrapolate global recommendations. We suggest using the design principles highlighted in the 4 areas of change included in this document to conduct these conversations.

04

Context - Definitions of TA in the DRC

Definition of technical assistance

During the first phase of work, the Co-Creation team defined “technical assistance” as having technical, human, and material aspects, but also financial.

The following quotes emerge from a shared vision that highlights the importance of the main roles of the state (internal actors) and the support provided by partners (external actors) that meet needs not covered by the state.

**The term “technical support” is used in DRC instead of “technical assistance” as “assistance” in French (assisté) is pejorative.*

“Technical support is empowering local teams to fully play their role. This capacity building includes technical, material and financial aspects ”*



TECHNICAL

Knowledge
Reinforcement of
capacities



MATERIAL

Equipments
Inputs
Consumables



FINANCIAL

Transport
Premiums
Financing of activities

Definition of technical assistance

Technical assistance is...

- “A complementary contribution to what we do on behalf of the other or an organization.”
- “Provide assistance through transfer of capacity and funds.”
- “A contribution that is technical, financial, training and logistical assistance to country given as needed. ”
- “Bring the required expertise; facilitate empowerment; respond to needs felt. ”
- “Where the country is limited we can help it. If I have ideas and someone else has ideas he adds them on, we walk together. What we consider as technical support for us French speakers is this support of the means so that the ideas that we have put together move forward. ”
- “It is also the motivation in French-speaking understanding. Take for example a person who has to provide health data every week. The motivation for the person is communication credit, transportation. If he does not have these resources and intrinsic motivations, despite his willingness to work, he will not be able to do the job well. ”
- “The technical support must be global; it’s resources that come from different places. Computers, fuel, supplies ... we must take into account the country’s fragility. We have plans developed with international and national expertise. Execution is hampered by a lack of resources that the country cannot fully cover. The idea is to provide the financial, logistical and other resources that the country cannot fully cover. ”
- “Sharing of knowledge or skills (transfer); help with the implementation, the extension of activities, their implementation. “

Technical assistance is not...

- “An imposition; a substitution of tasks.”
- “Create unemployment; or not aligning with the policies of the country.”
- “An executive secretary, for example, who comes from abroad while there are skills on site to do this job. “
- “To work instead of, to impose on... Trust is earned on both sides by respect. You come to give me your technical support but you don’t want to align yourself with what I did. You say that you bring new ideas that you don’t want to share and you want them to become a priority for you while my priority is another. “
- “Does not consist of working for the partner.”
- “A duplication of human resources.”
- “Paying wages: technical support is not there to pay people’s wages.”

Support, and not assistance

“Technical assistance has a connotation of assisted, which is derogatory even if it is a common term. Technical support should be the same, but with an attitude of mutual respect and collaboration ”

“TA must be rational and have added value. The future is strong leadership and provincial tools adopted.”

Ministry of health representative

“TA is about holding hands and working together appropriately.”

Ministry of health representative

“TA has value if the receiving hand is also ready to accept. We should have a clear rationale for all outside technical support.”

Ministry of health representative

Technical assistance from the partners point of view

“Partnership, collaboration and communication are of the utmost importance. Sitting down with the department is what TA should be about to make sure everything is coordinated and to provide appropriate support.”

-Bilateral Partner

“TA is an integrated approach to the health system to meet the country’s needs.”

-Donor

“TA must not be imposed, it must be useful and conform to country priorities.”

-Multilateral Partner

“The future of TA is the proper identification of the overall problem, the sharing of TORs between partners and validation from the government, and finally the provision of a multi-sectoral solution to the problem.”

-Multilateral Partner

“TA is about working together, sweating together, and not just about success, it’s also about failures and our ability to learn from mistakes.”

-Bilateral Partner

Pain points of TA from the point of view of decision makers

“TA is a solution but also a problem. Without it, the country doesn’t really progress, but it still doesn’t always provide results.”

-Multilateral Partner

“Leadership that is weak is not in a position to make strong decisions related to donors.”

-Donor

“If we call ‘Papa Government,’ it won’t find the money we need to organize our workshop [or other program activities]. And the government machinery is very heavy. So that’s where the partners come in: they help with the logistics. Because today the theoretical solutions come from the government. But what’s holding us back is our inability to implement them.”

- Ministry of health representative

“The basis of TA is wrong in the DRC. Donors all intervene in different ways: there is no harmonization.”

- Ministry of health representative

“Leadership is a problem. Every project should have a sustainability plan. The state often struggles to support projects.”

- Ministry of health representative

“TA has become a substitute to the government.”

-Donor

“There are no issues with the TA. There’s a problem with the way we approach it. We don’t take risks, we just expect to talk about successes. In doing so, we don’t learn from our mistakes.”

-Bilateral Partner

“There’s too much focus on process rather than impact; more on quick fixes than accountability.”

-Bilateral Partner

“People are constantly complaining about us, but it is not the donor’s responsibility to fix the air conditioning or electricity of your hospital, it’s up to our government. Sometimes I feel like we’ve developed very bad dependency habits.”

-Bilateral Partner

The need for strong leadership

A good respect for the country's priorities can contribute to the strengthening of all health structures.

All of this depends on strong state leadership. However, it is weakened due to internal pressures but also by the very organizations which provide it with support, reinforcing the dependence of the State on the parallel system.

The quality of technical capacities of TA providers and beneficiary capacity building is also a major factor alongside leadership or governance.

To alleviate this problem, this document proposes a series of design principles to be respected by all actors of influence for the establishment of a more efficient TA system and which would encourage the DRC MOH to take responsibility for the long term development of the country.

Elements contributing to the chronic weakening of the current healthcare system and the weakening of leadership, are the following:

- **A “paternalistic hierarchy,” structures the interactions between civil servants.** This type of hierarchy is characterized by employer-employee relations that are close to those of a family. It promotes the strengthening of personal networks, protects those who respect its existence, leading to informal privatisation, opaque information systems and contagious irresponsibility, and does not encourage independent thinking or individual proactive action.
- **Another difficulty lies in the interests and status quo of actors of the health ecosystem.** That is to say to maintain a less transparent health system where the government, suppliers and donors work in parallel. The current state of instability, poverty and emergency in DRC favors the prioritization of contemporary needs rather than making the sacrifices necessary to put in place development strategies that would respect the longer-term priorities issued on paper by the country.
- **Finally, technical assistance is part of a global system whose decisions are taken at**

an international level. The pressure exerted by donor investments and their priorities reduces the capacity of local health experts and makes it difficult to respect the priorities and emergencies of the provinces and communities.

05 Areas of change and principles for TA

The design principles and concepts have been grouped into 4 areas of change.

The areas of change are transversal and must be applied together for lasting change. This means they must be considered as a system to be implemented for the resolution of the underlying problems.

An area of change addresses a systemic and political theme that affects the TA system. Design concepts and principles are systemic in principle but technical in nature, requiring a series of reforms, restructuring and strengthening to ensure successful government processes and more streamlined relationships with donors, partners and communities.

05 AREA OF CHANGE AND PRINCIPLES FOR TA

Principles for good TA can be regrouped in 4 domains of change. Capacity building is an integral part of these for 4 domains and is cross-cutting to all.

Optimize finances to build on the long term

Encouraging better management of finances, budget and incentives in order to ensure that resources are used more efficiently and are distributed in a more balanced way within the health system.
Promoting government accountability and strengthening the health system.

01**Support to foster governance**

Ensure that the approach to TA is country-led, that the objectives and rules of engagement are common to all, and that the limits, roles and responsibilities of all TA actors are supporting, rather than executing, State responsibilities.

02**Cultivate collaboration and transparency between all actors**

Develop platforms and procedures for stakeholders in the health ecosystem to collaborate and share knowledge.
Build collaborative mechanisms that encourage more reciprocity between actors and better governance.

03**Reduce external dependencies in favor of sustainability**

Put in place sustainability mechanisms to reinforce the durability of initiatives once the donors and funding agencies have left.

04





Roadmap for change


AREA OF CHANGE
CAPACITY BUILDING IS ESSENTIAL AND IS APPLICABLE TO THESE 4 DOMAINS.

DESIGN PRINCIPLES TO RESPECT
THE PRINCIPLES APPLY TO ALL (COMMUNITY, DONORS, PARTNERS AND THE GOVERNMENT) AND ALL MUST WORK TOGETHER TO ENFORCE THEM.

CONCEPTS

 GLOBAL TA RECOMMENDATIONS

 COUNTRY TA RECOMMENDATIONS

 STATE/GOV. RECOMMENDATIONS

| 01 Optimize finances to build on the long term | 02 Support to foster governance | 03 Cultivate collaboration and transparency between all actors | 04 Reduce external dependencies in favor of sustainability |
|---|--|---|---|
| <ul style="list-style-type: none">• <i>Direct finances toward the provincial and zone level rather than the central level.</i>• <i>Minimize the duplication of activities in the health zone and the dispersion of funds.</i>• <i>Optimize spendings and foster the reinforcement and improvement of infrastructures.</i>• <i>Implement an initiative system that promotes state accountability.</i>• <i>Reflect the real operational costs of the implementation context.</i>• <i>Change the incentive structures so that the individual gain contribute to the collective.</i>• <i>Fair repartition of funds in the country</i>• <i>Support innovative source of funding internal to the country</i>• <i>Comply with international agreements and commitments</i> | <ul style="list-style-type: none">• <i>Align with common goals and priorities.</i>• <i>The TA is led by the country and all respects the rules of engagement.</i>• <i>To support and not to execute, with respect.</i>• <i>Avoid a cookie cutter approach. Adapt TA to the context.</i>• <i>Think of the patient rather than the singular disease as the central factor.</i>• <i>Balance aid to the provinces equally</i>• <i>Technical assistance providers must be experts in capacity building</i>• <i>Promote community knowledge, demands and needs.</i> | <ul style="list-style-type: none">• <i>Distribute strategic decisions at all levels.</i>• <i>Share lessons learned on vertical and horizontal platforms.</i>• <i>Identify, socialize and reward success.</i>• <i>Strengthen accountability to the country and evaluation of TA services.</i>• <i>Joint assessment of TA services.</i>• <i>Moving from a competitive environment to a transparent collaborative environment.</i>• <i>Make data accessible to everyone.</i> | <ul style="list-style-type: none">• <i>Building for financial sustainability after the departure of donors at national and local level.</i>• <i>Develop local resources even if it means sacrificing some immediate gains.</i>• <i>Community has the ownership of projects.</i>• <i>Increase state budget allocations for health.</i>• <i>Increase sustainability and longer-term thinking.</i>• <i>Reinforce evaluation and internal accountability models in the country to minimize dependence on third parties.</i>• <i>Establish government accountability mechanisms after the departure of donors.</i> |
| <ul style="list-style-type: none">• <i>Rethinking the impact of incentives and funding</i>• <i>Advocate for infrastructure funding</i>• <i>Provincial funding to facilitate decentralization</i>• | <ul style="list-style-type: none">• <i>Multisectoral TA</i> | <ul style="list-style-type: none">• <i>Sharing best practices</i>• <i>Country health indicators is a consequence of the provision of TA</i> | <ul style="list-style-type: none">• <i>Sustainability plan for initiatives</i>• <i>Investment plan for the sustainability of initiatives (donors)</i> |
| <ul style="list-style-type: none">• <i>Community seen as donors</i>• <i>Co-investment</i>• <i>Update of intervention map</i> | <ul style="list-style-type: none">• <i>Review of TORs for technical assistance providers</i>• <i>DRC Standard Operating Procedures (SOP)</i>• <i>Update of intervention map</i> | <ul style="list-style-type: none">• <i>Mandatory consultation platform</i>• <i>Strategic decisions dashboard</i> | <ul style="list-style-type: none">• <i>Investment plan for the sustainability of initiatives (state)</i>• <i>Reinforcing the IGS/IPS</i> |
| <ul style="list-style-type: none">• <i>Harmonization of calendar and categorization of funding</i>• <i>Advocacy platform made up of multisectoral pressure groups.</i>• <i>Updated resource mobilization plan</i> | <ul style="list-style-type: none">• <i>Contextualization of the roadmap</i>• <i>Map from the top to the bottom</i> | <ul style="list-style-type: none">• <i>Community feedback loop during the evaluation</i> | <ul style="list-style-type: none">• <i>“Mutuelle” care adapted to community dynamics</i>• <i>Motivate volunteers</i>• <i>Motivate health workers</i> |

How to interpret the recommendations of this document?

The intention behind the creation of this document is to give the different actors of the TA health ecosystem the tools to use and the steps to follow to make their concepts a reality.

Thus, in this presentation each group of actors - global actors, implementing partners and government officials - are given different aspects and concepts to take ownership of and implement.



Global TA recommendations

Out of the control of a country or region: the concepts under this section are based on design principles that highlight systemic problems of TA at a global scale.

What to do with these recommendations?

Use the results of the DRC to initiate global discussions on how to improve TA to countries. For example, a 2 to 3 day concept-based workshop with international TA experts would provide a vision to improve TA globally.



Country TA recommendations

Depending on country actors: these concepts are looking at how TA is provided in the DRC and how it should be improved. These concepts depend on national aspects that are slowing down the development of good TA.

What to do with these recommendations?

The concepts referring to this section will be subject to an in-depth review and selection by the co-creation group. Once the concepts have been reviewed, the group will work to implement these recommendations in a formal document to be presented to the Secretary General and submitted to different revue commissions.



State/Gov. recommendations

Depending on the State's willingness: concepts that are systemic and specific to state governance. These concepts should be used as a base to better the political system of the country. Ultimately to yield positive consequences on the way TA is provided.

What to do with these recommendations?

Members of the government and the Ministry can refer to the “Considerations” section of the concepts for the State to think about improving the existing system. For some of these reflections, consider including donors.

Optimize finances to build on the long term

This area of change brings together, in the decentralized context of the DRC, the principles that encourage better management of finances, budget and incentives so that resources are used more efficiently and distributed in a more balanced way within the health system. Together these principles put in place financial foundations that promote State accountability and help strengthen the health system.

From the budget of an initiative 40 to 45% goes to the partners. A lot of money is pouring into the country, but it is mainly used by TA, which sends its team rather than helping an institution to function.

- Ministry of Health

Since the programs do not receive the money, it is a double-edged sword because [the programs] also wait without doing anything. It allows them to buy pillows to rest on. I understand them! If they are faced with a fait-accompli they are forced to work and to report ...

- Multilateral partner

The best sailors are the ones on the shore; the people who don't do the work (...) are the ones who shout how things should be done from the shore. We tell them [in the ministry], progress but "not with our money.

- Bilateral partner

Design principles

Reflect the real operational costs of the implementation context.

In contexts of great imbalance, TA should take into account disparities between different provinces. An analysis of the situation with the beneficiaries must be mandatory before the operationalization of the budgets.

CONCEPTS

- **1.3** Funding to provinces to facilitate decentralization
- Advocacy platform made up of multisectoral pressure groups (see appendix)

Change the incentive structures so that the individual gain contributes to the collective.

TA must find innovative ways to motivate officials and communities without destabilizing the State system. TA must promote a standardized incentive that creates a level playing field for all.

CONCEPTS

- **1.2** Rethinking the impact of incentives and funding

Minimize the duplication of activities in health zones and the dispersion of funds.

TA must distribute the support equally. The solutions proposed by all are complementary and avoid duplication.

CONCEPTS

- **1.6** Harmonization of funding calendars and classification of donors

Direct finances toward the provincial and zone level rather than the central level.

Donors are helping to strengthen financial accountability mechanisms attributable to the provincial level to be closer to the beneficiaries and to support decentralization.

CONCEPTS

- **1.3** Funding to provinces to facilitate decentralization
- **1.5** Community as donor

Implement a system of initiatives that promote government accountability.

Since a country's extreme dependence on international monetary aid can lead to passive behavior within the State, TA must put in place systems to hold the State accountable for funding its own system.

CONCEPTS

- **1.1** Co- Investment

Optimize spending and foster the reinforcement and improvement of infrastructures.

TA should minimize expenses that fuel a parallel system by promoting the use of the public system and by investing in local infrastructure and personnel.

CONCEPTS

- **1.4** Advocate for infrastructure funding

Design principles

Support innovative sources of funding internal to the country.

TA should help the State to identify new and innovative sources of internal finance in the country.

CONCEPTS

- Updated resource mobilization plan

Comply with international agreements and commitments.

The State must respect international commitments for the financing of health sectors. (e.g. Abuja Declaration, Paris Principles on Aid Effectiveness, Accra Agenda)

Fair distribution of funds within the country.

The TA must help to upgrade the capacities of the provinces to promote decentralization, and this fact divides and is supported equitably among all.

Support to foster governance

This area of change brings together the principles that ensure that the approach to TA is country-led. These principles ensure that the objectives and rules of engagement are common, and that the roles and responsibilities of all the actors of TA are defined to support and not execute, the State responsibilities. Finally, they encourage good governance and capacity building through collaborative mechanisms based on respect and reciprocity.

02

If you saw a house with no door, no window with lots of richness inside, what would you do?
- Ministry of Health

Partners should use local people. I have the impression that they say that they help but that they really replace. And after their departure, they are surprised that nothing takes!
- Ministry of Health

Money comes in for one purpose, such as malaria, to treat a life-threatening illness that fits their [the partner] purpose. The partner does not see that everything must be viewed as a network of disease: it is the patient who must be the goal, not the disease.
-Bilateral partner

A provincial road-map is necessary because not all [the provinces] are at the same level. We need context, we have to adapt the type of support to each.
- Ministry of Health

In DRC, there are a lot of studies and documents - this is not what is missing, it is simply not applied - there is nothing that can make people responsible.
- Multilateral Partner

Design principles

Think of the patient rather than the singular disease as the central factor.

TA must approach the entire health system, like an ecosystem, to strengthen it in the long term and plan in a more multisectoral way.
TA must move from an ecosystem made up of fragmented solutions to an ecosystem structured around defined problems.

CONCEPTS

- 2.1 Multisectoral TA

Balancing support to the provinces equally.

TA is organized in such a way as to minimize duplication of activities and to bring provinces up to standard.
TA must avoid the spread of NGOs and build local capacity to support decentralization.

CONCEPTS

- 2.1 Multisectoral TA
- 2.4 Roadmap contextualization

Aligning with common goals and priorities.

TA aligns with the country’s priorities first and foremost to enable the development of a more effective and sustainable health system.

CONCEPTS

- Updated map of initiatives (see appendix)

To support and not to execute, with respect.

TA is not imposed but is inclusive, is done in partnership on the basis of trust and conviviality.
TA is developed through a two-way dialogue rather than a one-way hierarchical transaction.

CONCEPTS

- 2.2 Review of TORs for technical assistance providers

Technical assistance providers must be experts in capacity building.

TA should help build capacity at all levels.
Technical assistance providers must have the training and experience to provide the highest standards of services and build capacity.

CONCEPTS

- 2.2 Review of TORs for technical assistance providers

Promote community knowledge, demands and needs.

TA is rooted in the needs of the community, not just the needs of the institutions and organizations that put it in place.

CONCEPTS

- Community-based planning (see appendix)

Design principles

TA in country-led and all respects the rules of engagement.

TA is not exercised without the knowledge and consent of the Ministry of Health. TA helps to build a strong system of accountability for the application of rules and agreements for all actors in the system (international and national).

CONCEPTS

- **2.3** Standard Operating Procedures of the DRC

Avoid a cookie-cutter approach. Adapt TA to the context.

TA contextualizes the roadmap to ease decentralization and interventions are based on the disparity and need of each zone and province.

CONCEPTS

- **2.4** Roadmap contextualization

Cultivate collaboration and transparency between all actors

This area of change brings together design principles that promote the development of platforms and processes for actors in the health ecosystem so that they can collaborate and share their respective knowledge.

These principles focus on rebuilding trust by rethinking the interactions between stakeholders, vertically and horizontally, emphasizing transparency, ownership and sharing of data to ensure a functioning health system.

The data belongs to the partners before being public, and it can be very disabling because the Congolese cannot use it in an operational manner.
- Ministry of Health

Data sharing is a problem but not the main problem. There is no shared decision-making system. The Ministry is a Titanic, everyone has their information. It's solo work in a system without leadership.
- Bilateral Partner

There is not a lot of coordination between programs, everyone is in their program and does not communicate with others, and even internal coordination is not done well.
-Multilateral Partner

Partners can be criticized for being numerous in certain areas, but I think there is also a blame on the sites that do not inform the higher level of the area that there are already many partners.
-Health care professional (zone manager)

Design principles

Distribute the communication of strategic decisions at all levels.

TA should help build communication platforms to facilitate shared decision making at all levels.

CONCEPTS

- 3.2 Strategic decisions dashboard

Share lessons learned on vertical and horizontal platforms.

TA needs to rethink how lessons and best practices are socialized across different health units to facilitate the exchange of best practices. In the long run they will be popularized and implemented in a homogeneous manner, thus helping the country to progress more quickly.

CONCEPTS

- 3.1 Sharing of best practices

Identify, socialize and reward success.

TA needs to develop an iterative initiative model where the implementing partner can learn from mistakes (and not be punished for them), to gradually develop better interventions.

Moving from a competitive environment to a transparent collaborative environment.

TA must minimize competition between actors, facilitate dialogue between government and partners, align with national priorities to have common priorities to maximize results. To do this, TA must develop platforms and procedures so that actors in the health ecosystem collaborate and share their knowledge.

CONCEPTS

- 3.3 Mandatory consultation platform

Make data accessible to everyone.

TA must respect that the data collected in a country belongs to the country above all. The possession of data from a country must belong to that country, without restriction of use.

CONCEPTS

- Data Initiative - data to the State (see appendix)

Reinforcing feedback loops from the community.

TA must strengthen local voices to support contextualization. The TA must support the creation of a formal community feedback loop before, during, and after the implementation of an initiative.

CONCEPTS

- 3.4 Community feedback loop during evaluation



Design principles

Strengthen accountability to the country and evaluation of TA services and provide joint assessment of TA services.

TA must be accountable to the beneficiaries and the main investors.

TA will go through a verification of health activities, services provided and their quality at the community level.

CONCEPTS

- **3.5** The country's health indicators are the consequence of the provision of TA
- **3.3** Mandatory **consultation** platform

Reduce external dependencies in favor of sustainability

This area of change encompasses principles that put in place sustainability mechanisms to strengthen the longevity of initiatives once donors and funders have gone. These principles emphasize reducing the dependency of the State on donor parallel systems which perpetuates short-term solutions. Instead, they bring focus on strengthening local ownership and building a system that is self-regulating according to the country's internal available resources.

It is training and awareness that helps change people. We need to build support for the long term because it takes time to embody change.
- Ministry of Health

When piloting a project, it must be evaluated so that we can learn from its strengths and weaknesses and how to correct them. This is where big problems arise because people want to grow without evaluating or learning from this piloting phase. This is why many projects do not have positive results, or there are results, but they are untapped.
- Bilateral partner

People are constantly complaining about us, but it is not the donor's responsibility to fix the air conditioning or electricity needs of your hospital, it depends on your government. Sometimes I feel like we have set up very dependency habits.
- Donor

There is too much external funding in DRC, this weakens the country. The DRC becomes very dependent on external funding. The health budget is low, lack of resources and national funding.
- Multilateral partner

Design principles

Increase sustainability and long-term thinking.

TA must think about the long term and the sustainability of an initiative and therefore prioritize projects that last beyond 5 years, to observe a change.
TA also needs to **create** a sustainability plan to see significant measurable results.

CONCEPTS

- **4.2** Sustainability plan for initiatives

Building for financial sustainability after the departure of donors at national and local level.

TA must promote program self-sufficiency to help decentralization. TA must therefore move from a model based on donor dependence to the establishment of a self-generating funding model for / by the government and / or the community.

CONCEPTS

- **4.3** Investment plan for the sustainability of initiatives (donors)

Develop local resources (human, material, financial) even if it means sacrificing some immediate gains.

TA must help build an autonomous system, which regulates itself according to the country's internal resources and according to what is available.
TA must use existing infrastructure and capacity, even if that means sacrificing some immediate gains and revising its priorities.

CONCEPTS

- **4.3** Investment plan for the sustainability of initiatives (state)

The community has the ownership of projects.

TA must include communities during the planning, application, implementation, monitoring and evaluation of an initiative.

Reinforce evaluation and internal accountability models in the country to minimize dependence on third parties.

TA needs to strengthen internal assessment models to deal with corruption, duplication of work, and to make the country's internal accountability and assessment system stronger and more stable.

CONCEPTS

- **4.1** Reinforce the IGS/IPS

Increase State budget allocations for health.

The State must increase budget allocations at the level of the health sector to move away from dependence towards the parallel system.

CONCEPTS

- Mutualisation of care adapted to community dynamics (see appendix)

Design principles

Establish government accountability mechanisms after the departure of donors.

In a fragile economic context, TA must put in place State accountability mechanisms so that funding helps to ensure the sustainability and stability of the healthcare system. TA must obtain government responsibility towards their community once the donors have left the country. In cases of co-funding a program with a donor, the government **plans** to take over at the end of the initiative.

CONCEPTS

- **4.4** Motivating volunteers
- **4.5** Motivating health workers

06

Details of the concepts



**Optimize finances to
build on the long term**

1.1 Co- Investment

What is the current problem?

The budget allocated to provinces is not **disbursed** by the central level **due to a lack of accountability** systems. As a consequence, partners have put in place a series of mechanisms to avoid embezzlement **and therefore** funds are rarely made available to public administration, which makes it dependent on partners. This reinforces the inability of the State to provide its services and, therefore, not to assume responsibility for its work and to develop a better culture of responsibility and accountability.

The State has the capacity to manage the funds but due to donors' lack of trust in the government, NGOs are the ones who receive and manage the money allocated to support health zones.

Program Direct or

There is too much external funding in DRC, this weakens the country. The DRC becomes very dependent on external funding. The health budget is low [and there is a] lack of resources and national funding.

Bilateral Partner



Solution

To help reduce the government's dependence on external funds and increase its sustainability and accountability, the government co-invests up to a percentage determined by all initiative stakeholders. The goal being, over time, to arrive at a contribution at least equal to that of the donors, to ensure equal stakes (losses and gains).

Features



SHORT TERM

Progressive co-investment

The government invests gradually: each year the percentage of its investments in initiatives is increased.

Government and actors are co-signers of the funds

Donors and the Ministry of Health write the objectives of the initiative in the same office.

Respect for the Abuja Declaration



LONG TERM

The 50/50%

Donors invest at least 50% of what the State disburses in a common fund for initiatives.

06 CONCEPT DETAILS

1.1

Limits and feasibility

The state will first have to be selective and prioritize the type of projects to which it wants to apply this model more regularly. This requires a budget review for the year. This solution is not adaptable to all types of initiatives.

REFERENCES

With GAVI, the Ministry of Health invested in the purchase of goods and equipment before partners signed the agreement. Both feel responsible for monitoring where the money is going and the proper appropriation of funds.

Considerations

INTERNATIONAL

- N/A

DRC

- What are the criteria for identifying projects/initiatives already in place that we can apply this model to?
- What can we learn from projects like GAVI to make this experience a success?



1 ADVANTAGES FOR THE MINISTRY OF HEALTH

- State accountability to the community
- Reduces State dependence on donors
- Self-determination
- Right to monitor the use of funds and the objectives of the initiative.

2 ADVANTAGES FOR THE PARTNERS

- Less risk-taking by having more confidence in the state
- Ensures equal stakes (losses and gains)

3 ADVANTAGES FOR THE COMMUNITY

- Ensures sustainability of programs after the departure of donors
- Reduces the monetary burden

Responsibility



Global TA
Recommendation



Country TA
Recommendation

1.2 Rethink the impact of incentives and financing

What is the current problem?

Financial incentives for projects led at the operational level to encourage civil servants to participate in the implementation of TA unintentionally weaken the authority of the State.

Due to the State's weak commitment to a decent wage for its civil servants, monetary aid distracts them from their job responsibilities.

When a donor arrives, people wake up and jump on a plane to collect the per diem!

Bilateral partner - Project manager

I totally refuse to take money from donors. If they give me money, everyone comes to get their share ... The State is a predator and rumors are rife. So now I say what I need by consulting my staff and they send me the equipment, period.

Service provider

National programs should be aware of their mandate and missions and not engage at the operational level. Their staff prefer to work on operations as they receive allowances when they go to the field for supervision. In national programs, 60 to 80% of staff do not receive their salary and to survive they have to get involved at an operational level to find sources of income, but they have to stay at a strategic level.

Hospital Director



Solution

By categorizing the countries at risk of corruption and identifying the countries where the arrival of monetary aid would have a negative impact on the economic and political situation of the context, the actors in partnership with the government put in place incentive mechanisms that push State officials to participate in initiatives without, however, deviating from their job responsibilities.

Features



SHORT TERM

Non-monetary daily allowances (per diem):

- All expenses paid

Per diem covering daily expenses. For example lunch, accommodation, etc.

- Per diem based on performance

Per diem is issued after the work is completed, not on the basis of attendance or the number of hours spent in the field. The focus is more on the performance of each civil servant in relation to a given task.

Rationalization of the amount of per diem and enforcement and popularization of single contracts by all



LONG TERM

Classification charter for countries at risk of corruption and embezzlement

Donors must classify countries at risk of corruption according to a scale of risk of misuse of funds and carry out an in-depth study on the consequence of inserting per diem in an unstable economic model before deciding on the type of incentive (monetary or non-monetary) to be implemented.

1.2

Limits and feasibility

A global study and a review of the existing literature must be **done** to define the exact factors of improper use of **incentives**, funding and per diem, as well as behaviors associated with positive or negative effects on the economic and political situation of a country.

For non-monetary per diem to work, there must be alternative rewarding motivations (such as status, benefits in kind, etc.) and applicable sanctions.

Considerations

INTERNATIONAL

- To re-frame the idea of per diem, what are the values (other than financial) that can motivate civil servants?
- Can daily allowances be based on performance?
- What are the known factors where the use of per diem and monetary motivation negatively affects the economic and political situation of a country? Are these factors recurrent and can they be used to set up evaluation mechanisms and/or classification charts for countries negatively influenced by monetary aid models?

DRC

- Can we keep public servants from knowing where the money is coming from (anonymity) to change the sense of affiliation?
- To re-frame the idea of per diem, ask yourself what are the values (other than financial) that motivate civil servants?
- What type of model should be put in place to sanction or reward the bad and good use of the various funding methods?



1

ADVANTAGES FOR THE MINISTRY OF HEALTH

- Public servants are more likely to stay on the job rather than “chasing after” a per diem or **other incentive**.
- Funds are used in the right way.

2

ADVANTAGES FOR THE PARTNERS

- Officials sent to the field will be more likely to be chosen based on their skills and, therefore, more able to perform their duties.

3

ADVANTAGES FOR THE COMMUNITY

- It is less likely that the State will come to get its share of the funds.

Responsibility

Global TA
Recommendation



Country TA
Recommendation

1.3 Funding to provinces and health zones to facilitate decentralization

What is the current problem?

For decentralization to be effective, it is essential that the provinces develop in a homogeneous manner. But the budget allocated to the provinces and **health** zones is not redistributed in an equitable manner by the central level and the partners intervene in a disparate manner.

TA is currently focused on funding and numbers. Some NGOs that want positive results “fight for space” and keep the Ministry in the dark as per what they are doing and where they are located. As a result, it creates a concentration of aid in areas that are easily accessible and have better results, and a **lack** of aid in other provinces that are harder to access and with less infrastructure.

There is a balkanization of NGOs. The initiative health map should know where everyone is but this is not the case, NGOs are going where they want.

Ministry of health representative

The capacity building of health zones can only be done by giving them responsibilities. In the country's texts on health zones, they have the capacity to manage the funds. But due to donors' lack of confidence in the government, NGOs are the ones receiving and managing the money allocated to support health zones.

Program Director



Solution

By directing funding to the provincial and health zone level rather than the central level, donors help to strengthen each province and foster decentralization. This will allow the majority of provinces to strengthen their capacities and infrastructure in a harmonious manner, and over time, build better accountability mechanisms.

Features



SHORT TERM

The DPS has a secure and accessible workplace and funding.

Channel funds from central to operational levels.

The money is sent to an implementing partner/ coordinator at the provincial and zonal level who is closer to the final beneficiaries.

Right of inspection at central and provincial level.

The State and donors control funding and the DPS and zones can withdraw funds using an agreed disbursement mechanism. The central level is informed of the money coming from donors going to the DPS, but cannot have full access to it (access restricted to the province).

Establishment of communication and accountability methods between all actors (element of contract).

Partners must make the flow of finances, the amounts and beneficiaries of funds transparent.

06 CONCEPT DETAILS

1.3

Limits and feasibility

The strong hierarchy and paternalistic behavior of the government in the DRC can be an obstacle to the proper implementation of this concept. Also, the provinces that benefit from this system will need to have a good accountability structure in place at the DPS level.

REFERENCES

Take the example of the EU model - Partner with COFED (donate money in increments, the government can see the ins and outs of the money, have a say but the provincial coordinators are in charge of disbursement at the provincial level).

Considerations

INTERNATIONAL

- How to support the decentralization of a country by ensuring that the provinces receive an equal level of attention?
- How do you find and motivate the right human resources to manage the provincial implementation of these funds?

DRC

- What mechanisms should be put in place so that the central government can have access to the ins and outs of funds, while allowing the DPS to manage the funds in a sovereign way?



1

ADVANTAGES FOR THE MINISTRY OF HEALTH

- Aid for decentralization and therefore for the implementation of the law.
- Homogeneous aid and therefore reducing the clustering of NGOs.
- Investing in State administration to build better infrastructure and in the long term, a better accountability system.

2

ADVANTAGES FOR THE PARTNERS

- Increase efficiency by getting closer to the end user.

3

ADVANTAGES FOR THE COMMUNITY

- Harmonize funding structures.
- Ability to manage funds without going through central government.
- Better trained staff/civil servants and better management of beneficiaries (trained staff, adequate infrastructure, access to premises, skills, etc.)
- Reinforced infrastructure.

Responsibility

Country TA
Recommendation

1.4 Advocate for infrastructure funding

What is the current problem?

The real cost of operationalization of an initiative is often overlooked when developing TA budgets. Much of the cost (40-45%) is dedicated to external human resources instead of being allocated to the operational costs necessary to improve the already existing health system. This reduces the sustainability of the health system.

In some remote, dangerous and difficult to access provinces, there is a lack of context to the funds which penalize them.

From the budget of an initiative, 40 to 45% goes to the partners. A lot of money is flowing into the country, but it is mainly used for technical support which sends its team rather than helping an institution to function (infrastructure, public services).

Ministry of health representative



Solution

By establishing quotas to be respected in the budgets allocated to the operationalization and use of local resources, the government can encourage partners to invest in its infrastructure in order to strengthen the health system beyond strengthening the capacities of its personnel. The use of local resources and local NGOs will also allow the country to develop its institutions.

Features



SHORT TERM

CAP to 30%

The costs dedicated to the recruitment of external resources must not exceed 30% (actual percentage to be determined) of the budget of an initiative, leaving the 70% of the budget remaining for the implementation of activities and the improvement of the country's infrastructure.

Quotas on the use of local resources and reinforcement of local NGOs

Establish quotas on the number of external people entering the country as part of the initiative and how much local resources should be taken into accounts.



LONG TERM

Motivation for NGOs

Implementing partners who agree to work in difficult-to-access provinces receive a surplus of budget (from the State or to be determined) for their initiative to help build better infrastructure in partnership with other sectors, to help set up better conditions of their staff, State officials and service providers once in the field.

The coordination/governance committee

A third party, other than the Ministry of Health, able to make executive decisions on priorities (decisions on budgetary priorities for the year between the parties).

1.4

Limits and feasibility

Investing funds in administration, even if it increases the risk of loss and reduces traceability, helps the country to have better infrastructure and a **better health system** in the long term. However, taking responsibility for building better infrastructure requires reassembling the priorities of all stakeholders and negotiating who will bear the costs.

The State will first have to be selective, prioritize and put in place a new intersectoral budgeting model, among other things, to review competing priorities and budgeting between all actors (MOH and partners).

REFERENCES

N/A

Considerations

INTERNATIONAL

- Who will support the State and help implement such a model? Who would be the steering committee? Which third parties should be involved?

DRC

- The coordinating committee must come from a third party **who is senior** to the Minister: Who would be the steering committee? Which third parties should be involved?



1

ADVANTAGES FOR THE MINISTRY OF HEALTH

- Better strengthening of the health system.
- Infrastructure development for the long term.

2

ADVANTAGES FOR THE PARTNERS

- Better infrastructure promises better provision of health care and easier access to certain sectors.

3

ADVANTAGES FOR THE COMMUNITY

- Access to better infrastructure for better access to care and improved mobility from one place to the other.

ResponsibilityCountry TA
Recommendation

1.5 Community as donor

What is the current problem?

Community needs are rarely represented at the central level, however the community contributes 46% of the financing of the health sector.



Solution

The community is considered an investor who should have the same rights and power as donors.

Features



SHORT TERM

A donor like any other

Community representatives (e.g. COCODEV) have the right to be a part of GIBS and to be part of the conversation regarding the alignment of priorities, like any other donor.

1.5

Limits and feasibility

N/A

REFERENCES

N/A

Considerations

INTERNATIONAL

- N/A

DRC

- Who would be represented in GIBS: the municipality? the areas? regions? other?
- How to differentiate community representatives in terms of demography so that the population is fairly represented in GIBS?

1 ADVANTAGES FOR THE MINISTRY OF HEALTH

- The representation of community needs at the central level allows a reflection of the local context in national planning and the implementation of appropriate activities.

2 ADVANTAGES FOR THE PARTNERS

- The representation of community needs in GIBS will allow for a reflection of the local context in national planning and the implementation of appropriate activities.

3 ADVANTAGES FOR THE COMMUNITY

- The community is officially recognized and participates in decision making at the national level.
- Possibility of creating a culture of “mutualization.”

Responsibility



Country TA Recommendation



State/Gov. recommendation

1.6 Harmonization of funding calendars and classification of donors

What is the current problem?

The partners all have unique funding structures with their own rules and mechanisms for disbursing and distributing money.

The multiplicity of budget cycles and types of funding, as well as the low level of dissemination of standards and regulations, increase overlap and duplication of activities.

The unification of the system is not possible. Donor approaches are not defined locally and all have their own logic.

Multilateral Implementation Partner



Solution

By harmonizing the budgetary cycles and funding calendars between the State and partners on the one hand, and the different sectors within the government on the other, the public authorities would have an overview of the budgeting cycles of donors in their own country. This would allow the Ministry to have an overview of cash inflow and thereby plan certain activities based on funding arriving in the country.

Features



SHORT TERM

National and international multi-stakeholder study to unify funding models and classification of donors.

A study of international funding models that offers the best systems (e.g. in relation to accountability, trust, or decentralization, etc.) must first be made; as well as an internal study in the country to discover the advantages and obstacles of existing financing models

Harmonization calendar, classification of donors.

This calendar will allow the Ministry to have an overview of the cash inflow and therefore plan certain activities according to the funds arriving in the country.



LONG TERM

Submission schedule - Dissemination of the budget cycle and funding schedule.

Conversations with donors and partners for possible alignment and the creation of time periods on which they align and can submit budget proposals for initiatives. The aim is that budget submissions are based as much as possible on the Ministry of Health's timetable.

Standardization of several funding models and methods at different levels of government.

1.6

Limits and feasibility

Budgeting is determined by each country for the year, so it is not realistic for the international community to align with the DRC schedule. Therefore, the full harmonization of funding models and budget schedules is not a completely viable solution. It is best to get the **classification** and alignment of some donors beforehand.

The current lack of feedback and organization on the part of the State itself, independently of donors, also adds to this problem.

REFERENCES

N/A

Considerations

INTERNATIONAL

- N/A

DRC

- To facilitate alignment with partners and implementation of the multi-stakeholder study:
 - How to revitalize the GIBBS + CAGF / DAF framework?
 - How to define the coordination mechanism between actors and the principles and purpose of the study?



- 1

ADVANTAGES FOR THE MINISTRY OF HEALTH
 - Alignment on funding models that are the most successful.
 - Better visibility of partner funding schedules.
 - Identification of existing bottlenecks and ineffectiveness of the model.
 - Budget optimization to make funds available according to the disbursement plan.
- 2

ADVANTAGES FOR THE PARTNERS
 - These studies would allow better planning of initiatives and the design of funding models which would tend to be more functional and, therefore, be less risky for donors.
 - Rationalization of interventions.
- 3

ADVANTAGES FOR THE COMMUNITY
 - Smooth implementation of activities.

Responsibility



Country TA Recommendation



State/Gov. recommendation

Support to foster governance

2.1 Multi-sectoral TA

What is the current problem?

Donors invest only on the burden of disease, which pushes the health system to be compartmentalized and the country’s indicators unbalanced. The allocation of donor funds also depends on their “headquarters” and there is no flexibility in the allocation of funds for other purposes or areas that have not been previously agreed upon. Funds that have already been allocated to a single objective (e.g Malaria) can not be allocated to another disease, where they might be most needed (e.g Cholera).

Donors that encourage and insist on funding based primarily on the burden of disease rather than on the strengthening of the health system can, by consequence, have a negative influence on national health indicators. In addition, inequality in the country based on security, access and convenience, often creates an imbalance between the different regions of a country

“You could solve malaria and save a child one day, and yes, your result will be good for that, but the next day, he will die from cholera.”

Bilateral Implementation Partner



Solution

TA is multi-sectoral and contextualized. In countries where there is a clear lack of Infrastructure, linking the health sector with education, or a sanitation and hygiene program for health and water, will help strengthen the health system. Donors and investors should consider joining forces with other sectors on a vision of the whole patient rather than the disease.

Features



SHORT TERM

Government rejects donor support that is not based on their needs and priorities.

TA contracts are made on a multisectoral basis.
Investors should work with government to link their initiatives to other sectors as much as possible. Proposals for initiatives should include an element of multi-sectorality and twinning with other sectors as much as possible.



LONG TERM

The coordination/governance committee
Third party other than the Ministry of Health, able to make executive decisions on redesign priorities (decision on budgetary priorities for the year between the parties).

2.1

Limits and feasibility

The State will have to be selective and set up a new model of intersectoral budgeting, among other things; review competing priorities and budgets between all actors (MOH and partners) and sectors (water, health, education, etc.)

REFERENCES

N/A

Considerations

INTERNATIONAL

- Who will support the State and help implement such a model?
- Who would be the steering committee? Which third parties should be involved?

DRC

- The coordination committee must come from a third party **senior to** the Minister. Who would be the steering committee? Which third parties should be involved?

1

ADVANTAGES FOR THE MINISTRY OF HEALTH

- Better strengthening of the health system and development of infrastructure
- Better country indicators - progress in eradicating certain diseases more generally

2

ADVANTAGES FOR THE PARTNERS

- Better country indicators - progress in eradicating certain diseases more globally

3

ADVANTAGES FOR THE COMMUNITY

- Assurance that beneficiaries are covered and treated for a range of illnesses
- Eradication of certain diseases.

Responsibility



Global TA Recommendation



Country TA Recommendation

2.2 Review of TORs for TA providers

What is the current problem?

Cultivating interpersonal relationships is the key to working together. However, mutual respect, good communication and exchanges are often lacking when the partners approach and work with the Ministry of Health.

The roles and responsibilities of TA partners and local coordinators are not clearly defined in the TORs and also during the recruitment process.

It was pathetic. The study coordinator's background was as a logistics manager. When we asked him what he was supposed to do, he told us that no one had told him what his job description was.

Implement ation Partner - Project Manager

A qualified technical assistance provider is a person with international experience who has already worked with a Ministry of Health. He must also go to the field and know the realities of the Congo.

Multilateral Partner

He [former Minister] made us work hard. We had to be at the office at 7am and for several months I didn't come home until midnight. But it was with this will and discipline that he read all of the files and moved the system forward.

Former Program Director



Solution

Project TORs and job descriptions for technical assistance providers and coordinators must be drawn up by the programs and the State and then harmonized by the partners.

To ensure greater government participation in the drafting of the TORs, the drafting and implementation process is done collaboratively.

Features



SHORT TERM

The TORs are clearly stated for the coordinators at the peripheral levels:

- Defining the roles and responsibilities of each actor

For each specific project, planning the missions to be carried out in the field as well as the movements of the teams at the different levels and structures, establishing the projections in terms of budget and supervision, etc.

- Establishing the basis of relationships based on respect

Technical assistance providers must be flexible in their work, without assuming the responsibility of the MoH or giving orders. Trust is based on a relationship of "truth" where the ministry is approached with respect, and the specific context of the Congo is understood and approached with humility.

- Requiring technical assistance providers to have an understanding of the Congolese context

Technical assistance providers must have international experience in public health and be open to listening to the people they support to deepen their expertise and knowledge.

2.2

Limits and feasibility

N/A

REFERENCES

N/A

Considerations
INTERNATIONAL

- N/A

DRC

- N/A



1

ADVANTAGES FOR THE MINISTRY
OF HEALTH

- With a clear document on the procedures followed by each donor and shared through the government, the State will be able to get involved with the donor and its interventions in the country.

2

ADVANTAGES FOR THE PARTNERS

- Harmonized procedures and better job description
- Better relationship with the State

3

ADVANTAGES FOR THE
COMMUNITY

- Better coordination of initiatives and provision of care

Responsibility



Country TA
Recommendation

2.3 DRC SOP (Standard operating procedure)

What is the current problem?

Technical assistance **providers** are seen as being unaccountable to government because they depend on the donors who recruit, manage and pay them. This can manifest itself by non-compliance with reforms and be perceived as a lack of respect, **rather than the role** technical assistance **providers** should portray **of bringing** support to the State.

Some partners are bypassing the Ministry of Health and implementing initiatives in regions without **MOH** consent. **This causes a** feeling of “colonialism” as the **TA providers** impose their ways.

Even though they sit in the ministry, some partners are perceived as “occupying space” working for their own interests, serving external partners and not regularly sharing their conclusions or results with the Ministry of Health. **Often they** miss alignment meetings which make it difficult for the government to know what is in place and what **may or may not be** working.

I learn after the fact that initiatives are being implemented in one province [without my approval]. In a case like that, I invite you to leave. (...) TA obtains value if the receiving hand is also ready to accept it. We should have a clear rationale for any outside TA.

Ministry of Health - Representative Level Central



Solution

An SOP document sets-up national procedures and guidelines to help standardize procedures, share best practices, and define compliance frameworks. This would give national experts the tools to influence the application of the National Health Strategic Plan so that the leadership takes ownership of the strategy and the design of work plans.

Features



SHORT TERM

Procedural manual based on documents such as the Paris Declaration (2005), Accra Agenda for Action (2008)

State oversight

The State must have oversight over all tenders and submissions, as well as decision-making power over the choice of NGOs made by donors/partners.

Assembly of the work plan and consensual TORs with a local consultant

Imposition of local quotas

Obligation of people from outside to strengthen internal skills and give way to local NGOs and local consultants (e.g. any project can and/or must hire at least one local NGO).

Technical assistance providers must sit at the national level and/or Department of Planning level and report on their activities

By sitting at the national level, the coordinator must be able to be flexible and available to respond to government requests and build trust with State officials. It will also increase transparency between actors.

2.3

Limits and feasibility

N/A

REFERENCES

N/A

Considerations

INTERNATIONAL

- N/A

DRC

- N/A



1

ADVANTAGES FOR THE MINISTRY OF HEALTH

- Relationship based on trust and respect
- Imposition of standards according to their terms
- Oversight over tenders, submissions and decision-making regarding the choice of NGOs made by donors

2

ADVANTAGES FOR THE PARTNERS

- Harmonized rules to follow

3

ADVANTAGES FOR THE COMMUNITY

- Reduced fragmentation in the provinces by NGOs
- Use of local human resources

Responsibility



Country TA Recommendation

2.4 Contextualization of the work plan

What is the current problem?

The lack of contextualization of the roadmap hampers the progress of decentralization because it does not take into account the different capacities of each province.

Although the health zone must have a say in the selection of technical assistance (because the aid it will receive is based on their local needs), the initiative plans emanating from the implementing partners are sometimes based on old health indicators and **older versions of the National Health Development Plan**, which leads to additional misalignment **with** the current context of the country.

A provincial roadmap is necessary because not all [the provinces] are at the same level. We need contextualization, we have to adapt the type of support to each.

Ministry of Health - Representative Level Central

Partners are not aligned to the provincial AOP.

Provincial Project Manager



Solution

By contextualizing the roadmap and putting in place community AOPs, the State/Gov. assures that the National Health Development Plan reflects that real state of each province and thus can propose solutions adaptes to each.

Features



SHORT TERM

Contextualization of the roadmap

Do community studies to contextualize approaches

Needs of the Beneficiaries

Development plans for community groups such as CODEV, which is multi-sectoral and takes into account volunteers, churches, NGOs, etc.

Participatory planning (Concept of the previous phase - see appendix for details)

Tools to collect information at the level of participants and thus allow the community to organize itself in a structured group.

Global mapping (Concept of the previous phase - see appendix for details)

A mapping initiative to coordinate several activities (promotional, curative and awareness-raising)

View from the community (Concept of the previous phase - see appendix for details)

A mapping initiative to keep information flowing up.

2.4

Limits and feasibility

This plan must be linked by a performance contract for each health zone. An inventory of the type of monitoring is necessary to ensure that the right factors are taken into account in the performance contract.

REFERENCES

N/A

Considerations

INTERNATIONAL

- N/A

DRC

- What consensus methods need to be put in place for the CODEV Affairs Officer to collect **what they** need impartially and where everyone feels heard?

1 ADVANTAGES FOR THE MINISTRY OF HEALTH

- Better representation of community needs in the roadmap and National Health Development Plan
- Priorities reflect community needs

2 ADVANTAGES FOR THE PARTNERS

- Implementation of initiatives representative of the context which therefore have a better chance of success

3 ADVANTAGES FOR THE COMMUNITY

- Implementation of initiatives representative of the context which therefore have a better chance of success
- Initiatives implemented meet community needs

Responsibility



Country TA Recommendation



State/Gov. recommendation

Cultivate collaboration and transparency between all actors

3.1 Sharing best practices

What is the current problem?

As some NGOs do not sit at or share their results at the national level, important progress data is not passed on to programs. Communication and joint engagement is weak, reducing transparency.

Success factors (good practices and success stories) are not shared at all levels and between partners, and can therefore hamper better planning in the long term.

The type of questions asked by external countries have changed in the past 15 years. They want to see an impact too quickly, so we are not allowed to make mistakes.

Bilateral Partner

NGOs are experimenting and doing interesting things at the local level, but the systems (best practices) that work are not connected at the provincial level.

Donor



Solution

Identifying and sharing best practices to spread successful TA procedures between provincial (DPS) volunteers would allow for the dissemination of the reason for success (such as the resolution of a typical problem by innovation and its application / transferability to others areas and contexts).

Features



SHORT TERM

National survey on the impact of successful initiatives to capitalize on best practices and their dissemination.

Periodic review between the MOH and partners with reminders of missions and recommendations / sharing of good and bad experiences at all levels.

Competition between DPS volunteers to motivate agents to rigorously collect data.

Each DPS presents its best lesson before all the other provinces. At the DPS level, each province files its case before a multisectoral committee which agrees on the best practice. The winning province will receive an incentive / motivation (possibly a basket for scaling up its best practices).

Multisectoral Committee - Submission of best practices (to encourage their use) a platform for dialogue with a wider audience. Best practices are presented and shared in dialogue forums at all levels and then go up through State communication channels.



LONG TERM

Create a learning platform managed by DEP (at provincial and national levels)

Publication of good practices information bulletins formally, analogically and digitally (email, government web portal, radio, newspaper, information campaign, etc.). The aim being to multiply communication channels.

Website redesign to aid dissemination

Any information updated by the MOH should be available on its website. The website is a means to have electronic copies in case a manual is lost, to store the results of surveys and project reports (routine data, program and project data, and survey data [requested by the country]).

3.1

Limits and feasibility

Best practices should be taken to a higher level by dedicated staff who share and write these stories - consider transferring this to a guideline so that it is mandatory for each project. Routine visits and supervision assessments are good ways to get promising practices or success stories, to identify the recent point in time when data was used to solve a local problem, and the use of data to change behavior or implement a new policy.

REFERENCES

Data Use Champion - Guinea (JSI 2017)

Considerations

INTERNATIONAL

- What would be the motivation for each party to share the results and the gains between them?
- What would be the motivation for data collectors?
- How can we make sure that such a provincial competition mechanism does not spread the creation of false data in order to win the prize pool? What are the safeguards to put in place?

DRC

- What are the best practices that already exist that should be disseminated?
- How to collect and classify best practices? What would be the distribution channels? (radio, newspaper, website, etc.)
- Once they have been transcribed, who reads them and who uses them to influence?
- How can we make sure that such a provincial competition mechanism does not spread the creation of false data in order to win the prize pool? What are the safeguards to put in place?



1 ADVANTAGES FOR THE MINISTRY OF HEALTH

- Capitalize on lessons learned (formalized information sharing)
- Better value for money and time saved at the start of a project

2 ADVANTAGES FOR THE PARTNERS

- Better value for money and save time at the start of a project
- Facilitate a spirit of collaboration and not of competition/competition between the actors

3 ADVANTAGES FOR THE COMMUNITY

- Putting reliable systems in place from the start
- Become more proactive in data collection and motivate success

Responsibility



Global TA Recommendation



Country TA Recommendation

3.2 Strategic decisions dashboard

What is the current problem?

There are no strong communication structures at all levels to share and disseminate decision-making, tasks to be accomplished, and the roles and specifications of each (management, coordination, training, configuration, implementation, etc.) which reinforces general confusion.

Not having a clear definition of the roles and the number of personnel that are supposed to be affiliated with a project at the provincial level and health zones, also gives leeway to extra civil servants and service providers in surplus to insert themselves into projects.

Multisectoral TA requires good vertical as well as horizontal communication, but it is only when a health crisis occurs that programs and partners develop good communication practices.



Solution

Establishment of strategic decision dissemination platforms at the provincial level. These platforms will provide provinces with access to essential information, enabling better coordination of their personnel and precise indicators which can help in reframing proactive priorities rather than reactive and planning for the long term.

Features



SHORT TERM

Implementing partners assist in the implementation and dissemination of strategic decisions at the provincial level

- Implementation of KPIs to target the implementing NGOs which are the most proactive in terms of information distribution.
- Require in contracts that part of their work be dedicated to information sharing and dissemination of government strategies.

Publish a bulletin / dashboard on the National Health Development Plan and AOPs quarterly

(potentially piloted by the National Steering Committee of the Health Sector or Inspectorate of Health)

Institutional analysis: this dashboard will present the problems and priorities of the State so that all actors (partners, donors, civil servants) have a better view of current problems.

This dashboard will publicly track commitments by all parties.



LONG TERM

Provincial strategic dashboard

Digitized comparative dashboard with collection of routine information indicating synthesized indicators such as: the main priorities of the country, the human resources allocated to the project, the budget and funding, the roles of the persons assigned, precise indicators, and a summary of the results.

Routine / quarterly data updates should be done to have a true reading of the progress (or lack thereof) of initiatives and indicators to help reframe proactively.

3.2

Limits and feasibility

Consider using existing platforms (eg. DHIS2) to consolidate and facilitate access to this data. The use of an existing platform can also alleviate the problem of funds for data dissemination at all levels. The digital version is only possible if the infrastructure allows it.

REFERENCES

N/A

Considerations

INTERNATIONAL

- N/A

DRC

- N/A

1

ADVANTAGES FOR THE MINISTRY OF HEALTH

- Clear definition of roles and responsibilities for all and distributed at provincial levels

2

ADVANTAGES FOR THE PARTNERS

- Less leeway for staff who “add” to a project
- Better definition of each person’s roles and provision of services

3

ADVANTAGES FOR THE COMMUNITY

- Less leeway for staff who “add” to a project
- Better definition of each person’s role and provision of services

Responsibility



Country TA Recommendation



State/Gov. recommendation

3.3 Mandatory consultation platform

What is the current problem?

It has already been mentioned that a **complete and transparent health/intervention map** is lacking. Without an update on everyone’s progress and clear definitions of roles make reciprocity and accountability difficult at all levels.

TA **providers** are seen as having no accountability to government. This contributes to increased opacity **along with** the lack of data sharing between implementing partners/NGOs and government agencies, and feeds individualistic planning based on the needs of partners rather than on country priorities.

The role of GIBS is to facilitate coordination between partners, but also to allow all partners to have an overview of each other’s activities, each one’s geographic areas and to avoid duplication of activities. However, GIBS is currently not open to members of the government.

The data belongs to the partners before being public, and it can be very disabling because the Congolese cannot use it operationally.

Ministry of Health - Representative Central Level



Solution

A mandatory consultation platform to provide an overview of progress and potential problems of initiatives and regular internal, vertical, and horizontal alignment between different stakeholders (government agencies, partners, and donors).

This allows for improved and shared decision-making processes on a regular basis, a better view of the health map, while ensuring that everyone can have a space to express themselves freely.

Features



SHORT TERM

Mandatory quarterly consultation platform work plan review with all stakeholders (GIBS, WHO, MoH)

GIBS should invite the government to sit in meetings to increase transparency regarding the progress of initiatives, report on activities, and assist in updating the mapping of initiatives / health map.

Mandatory access to initiative data (contractual)

Partners can not put binding clauses on the use of their data that will prevent the government from enriching and using the results for their planning.



LONG TERM

Definition of a mediating body who has the role of setting up laws - independent of policies, emanates from the citizen body, and ensures the power of the public. The mediating body ensures the application of the common vision of the government and the security of the implementation.

Website redesign

(Refer to concept 3.1 for details)

3.3

Limits and feasibility

The feasibility of disseminating decisions depends on the capacities of the structures set up in all the regions.
Use existing structures such as GIBS and DHIS2 to help realize this concept.

REFERENCES

N/A

Considerations

INTERNATIONAL

- N/A

DRC

- Who will manage this mediating body? Who will be part of this group?
- How to convince the parliament **that it** must vote for this body which will control it?
- What tools and restrictions should be put in place to facilitate these discussions - to facilitate collaboration?

1

ADVANTAGES FOR THE MINISTRY OF HEALTH

- Better **knowledge** of the progress of initiatives in the country
- Better access to data on a regular basis to help planning for the long term
- Regain ownership / leadership at all levels
- Define the **roles** and **responsibilities** of each stakeholder

2

ADVANTAGES FOR THE PARTNERS

- Ensure continuity of knowledge
- Establish a follow-up element with the government in a collaborative and non-competitive spirit

3

ADVANTAGES FOR THE COMMUNITY

- As a result of regular data sharing, better provision of activities adapted to the local context
- Ensure continuity of knowledge

Responsibility



Country TA Recommendation

3.4 Community feedback during evaluation

What is the current problem?

Currently, evaluation is done to assess the outcome of an initiative rather than the quality of the type of TA provided or **the TA providers themselves**. This leads to a feeling of non-reciprocity between the technical assistance **providers** and the Ministry of Health.

In addition, the inclusion of beneficiary feedback is often done by word of mouth rather than formally. **Also**, the evaluation of a service **may** be done remotely or through external consulting firms, and does not include the comments of the beneficiaries or the participation of **State** officials for cost reasons. **This** makes it difficult to understand the quality of TA provided to the government.

As a result, **TA providers** are seen as their own assessors. This can lead to a situation of hypocrisy, where officials will refrain from asking questions of those supposed to help them.



Solution

The assessment should include feedback from beneficiaries to ensure that the TA is inclusive and responds to local needs. Their feedback on the quality and effectiveness of the support received will then be used to improve the provision and delivery of services by TA providers.

Features



SHORT TERM

Formalize the capture of beneficiary feedback in a written report rather than word of mouth.

The community defines its needs. Improve the planning and monitoring of activities according to the needs defined by the community.



LONG TERM

Community “Scorecard”

Verification of health activities, services provided and their quality at community level. A “check list” to verify that all the promised supplies and activities have been properly put in place and delivered.

Accountability and evaluation processes/contracts of providers and compulsory services between the government and the partners managed by the Inspectorate of Health, which deals with constraints and sanctions if the evaluation of the services proves negative, based on the Community Score-Card.

3.4

Limits and feasibility

Ensuring that that government officials and beneficiaries are present during the evaluation is often costly.

REFERENCES

N/A

Considerations

INTERNATIONAL

- How to set up an inclusive evaluation system at a lower cost?

DRC

- How to set up an inclusive evaluation system at a lower cost?



1

ADVANTAGES FOR THE MINISTRY OF HEALTH

- Assurance of the efficiency and quality of the services received
- Help with evaluation and accountability

2

ADVANTAGES FOR THE PARTNERS

- Community capacity building
- Receive an assessment from beneficiaries (state officials, service providers) on what needs to be improved

3

ADVANTAGES FOR THE COMMUNITY

- Community capacity building
- Improved services based on local needs

Responsibility



Country TA Recommendation



State/Gov. Recommendation

3.5 Country health indicators as consequence of TA provision

What is the current problem?

NGOs that want positive results “fight for space”, keeping the MoH in the dark about their activities and **presence** in certain provinces, fueling individualistic and competitive behaviors between providers and between providers and the MoH.

Currently, an evaluation is done for the outcome of an initiative rather than for the quality of the type of technical support provided. This leads to a feeling of non-reciprocity between the technical assistants and the MoH.

We need a case-by-case assessment, but also a project assessment in general to see if the expected results are there and if they [the implementing providers] should continue.

Ministry of Health - Representative

How can you execute plans for which you have not received training? The structures are unable to fulfill their role.

Provincial representative (DPS)



Solution

To create a sense of reciprocity, the evolution of the country’s health indicators must be linked to the type of TA received. Therefore, if the health indicators are stagnant, a review of the type of TA should be done in addition to an assessment of the factors that contributed to the stagnation of results.

Features



LONG TERM

The country health indicators are linked to TA provision

DRC health indicators, which support the evidence to describe the health of a population, are highly dependent on a strong health system and could therefore be an indicator of the effectiveness of the type of technical support that the DRC receives. For example, influencing factors could be: strengthening of infrastructure, proper training for providers, equal dissemination of NGOs in the provinces, etc.)

3.5

Limits and feasibility

Consider the factors that contribute to the fluctuation of a country’s health indicators that are beyond the control of implementing partners and NGOs. TA is part of a complex ecosystem and therefore cannot be solely responsible for the poor results and indicators of health of a nation.

REFERENCES

N/A

Considerations

INTERNATIONAL

Considering the factors that contribute to the fluctuation of a country’s health indicators that are beyond the control of implementing partners or donors, how could we think of a support system that is more accountable to the government or the results can be more visible and measurable?

DRC

- N/A

1 ADVANTAGES FOR THE MINISTRY OF HEALTH

- Assurance that the TA received is of high quality
- Build a sense of trust in between the State and TA partners.

2 ADVANTAGES FOR THE PARTNERS

- Assurance that the TA received is of high quality
- Build a sense of trust in the State

3 ADVANTAGES FOR THE COMMUNITY

- Assurance that the quality of services received is intended to improve the quality of life in the community

Responsibility



Global TA Recommendation



Country TA Recommendation

Reduce external dependencies in favor of sustainability

04

4.1 Reinforce the Inspectorate of Health (IGS)/ Provincial Health Inspectorate (IPS)

What is the current problem?

The lack of dynamism, capacity and funding of institutions internal to the DRC in charge of evaluation and implementation of safeguards, sanctions, and enforcement of laws, contributes to non-compliance with reforms and reinforces a behavior of impunity.



Solution

Partners can support strengthening the mission of IPS and IGS by helping to set up a strong internal evaluation system while also increasing its capacity. The goal is to make the IGS and IPS independent of government, a neutral third party, and thereby help them to fulfill their role in a wholesome manner. This would increase accountability, limit embezzlement, influence the establishment of laws, and protect jobs.

Features



SHORT TERM

Contract - Require partners to work with IPS and DPS to strengthen institutional support

The partners give the IPS the means to exercise their mission (training, logistics, per diem, etc.). At the start of a project, the partners' budget must include a percentage that takes into account the funding of the IPS to help the partners increase accountability and use the capacities of IPS to help hold the provinces accountable and limit embezzlement.

Involvement of IPS in the implementation of "unique contracts."



LONG TERM

Affirmation of the role of IPS (Autonomous Financing)

Strengthen the institutional capacities of IPSs to represent the Court of Auditors at the provincial level.

Employee replacement justification checklist

To strengthen the employment law and not dismiss or place an agent without valid reason, set up a strict procedure for justifying dismissal. To avoid destabilizing a team and protecting the people concerned on the job, imagine signing the contract on behalf of the people and not by post.

4.1

Limits and feasibility

The challenge arises in the financial model of such an institution. Inspectors routinely investigate public spending and the risk of buried cases is high. Ideally, so that the IGS and the IPS can be strengthened to put an end to a culture of impunity, these two institutions should become, as much as possible, financially independent of the government and partners to limit the influence of these on the evaluation of the health system and on the sanctions applied.

REFERENCES

N/A

Considerations

INTERNATIONAL

- What are the interests of the partners in supporting this system?
- Are there models applied in other countries that could be taken as inspiration?
- Obligation of results for agents - how to make it a reality in the current context?

DRC

- What mechanism of sustainability of funds could be set up in the long term to support such an institution?
- How to ensure the neutrality of the IPS / IGS?
- What should be the role of donors in this system?
- An agent replacement checklist may be a good idea - how to make it a reality in today's environment?

1

ADVANTAGES FOR THE MINISTRY OF HEALTH

- Reigniting the spirit of the IGS and IPS and of its themes through a capacity building workshop would make State officials more responsible
- Representation of the court of accounts at provincial level (IPS) - compensatory system

2

ADVANTAGES FOR THE PARTNERS

- Increase accountability by using the capacity of IPSs, limit embezzlement, influence the implementation of laws and protect job.
- In the LONG TERM, strengthening internal assessments and safeguards will facilitate the work of partners

3

ADVANTAGES FOR THE COMMUNITY

- Avoid destabilizing a team and protect the competent people on the job
- Obligation of results for agents
- Continuity of the offer of quality services

Responsibility



Global TA Recommendation



Country TA Recommendation

4.2 Transition plan for the sustainability of initiatives

What is the current problem?

It is not because an initiative is participatory in its creation and implementation that it must necessarily be pursued by the government. As the mechanisms to facilitate continuity are not effective, a feeling of defeatism emerges at the end of projects and reduces their lifespan to that of donor funding.

When someone wants to come to the DRC and offer me a plan, I always ask and what happens after?

Ministry of Health - Representative Central Level

Sustainability of government means unsustainability of NGOs. NGOs want to prove to donors that the ministry is incompetent to get the next round of funding.

Bilateral Implementation Partner - Coordinator

*Working for a donor allows me to have fuel every morning to get to work, whereas if I worked for the **State**, it would not be safe, so I understand when [state officials] ask for daily allowances, but that makes things more complicated.*

Implementing Partner



Solution

To ensure the sustainability of initiatives and, therefore, strengthen the health system in the long term, it is necessary to unify the way in which partners approach the end of initiatives and their sustainability. In a decentralized framework, the government must require donors to have a sustainability plan in their initiatives, while partners must ensure that the State puts the mechanisms in place to take over.

Features



SHORT TERM

Contract specification

- Transition plan to be included in the work plan
- Work within existing system structures
- Investment in programs over 5 years long

During project preparation, reflect on the budget and post-project financing mechanism by the State

4.2

Limits and feasibility

N/A

REFERENCES

N/A

Considerations

INTERNATIONAL

- N/A

DRC

- N/A

- 1

ADVANTAGES FOR THE MINISTRY OF HEALTH

 - Guaranteed maintenance of activities in the long term
 - Widespread long term initiatives
- 2

ADVANTAGES FOR THE PARTNERS

 - Guarantee of a long-term project
- 3

ADVANTAGES FOR THE COMMUNITY

 - Guaranteed maintenance of activities in the long term and continuity of quality health services

Responsibility



Global TA Recommendation



Country TA Recommendation

4.3 Investment plan for the sustainability of the initiatives (donors)

What is the current problem?

TA initiatives without a clear exit strategy can sometimes create dependencies, leaving gaps in health services when funding dries up.

Financial sustainability planning at the end of projects must be included in initial budgets. Likewise, all the actors involved (MoH and partners) must set up financial independence mechanisms for the localities to help the continuity of the procedures put in place after the departure of donors.

*Over-medication is a real problem. Since the **health centers** must find a form of profit, they sometimes prescribe too much and this erodes the trust between the beneficiaries and the health professionals.*

Implementing Partner

*You realize that the hospitals that work well are the ones that have an agreement protecting them from **State** intervention. There was a former minister who had a lot of foresight and without giving the hospital the **agreement**, it would have been much more difficult to stay the course with our initiative there.*

Donor



Solution

Financial sustainability at the end of the projects must be included in initial budgets. Part of the remaining funds is redirected to the beneficiary institutions rather than returning to donors or being recycled in the parallel system. These funds are set aside in a dormant bank account with clear disbursement rules supervised by a third party to ensure that the money is used for the project after the donor leaves.

Features



SHORT TERM

A dormant bank account managed by a third party, (partners, government or donors) with funds to be used after project ends

Part of the initiative's budget is set aside at the start of the project. The account has clear disbursement rules overseen by a third party such as a microfinance institution, or invested / managed by a third party as a responsible party to ensure that the money is used for after the project funding ends.



LONG TERM

Recycling of funds 50/50

An account will be opened so that the funds remaining at the end of the life of a project are returned to the community which aims to take care of this project (50% is recycled to other initiatives while 50 % returned in favor of the existing project / to the community).

Return on investment

Risk capitalization for donors: funds recycled into the health system are considered an investment and, as a result, the government becomes accountable to donors and must show the results of the continuum of certain initiatives even after the departure of donors.

Private sector investment in the country

A microfinance institution based in the DRC helps service providers to save / finance initiatives at local level. This makes it possible to set up a system for after the departure of donors, thanks to which microfinance institutions will help to fill the gap for a while until the system becomes more efficient. The use of microfinance to cover the costs of services, infrastructure, etc. would strengthen the health system because the hospital would not have to go into debt when beneficiaries can't afford the treatment.

4.3 Investment plan for the sustainability of the initiatives (State)

What is the current problem?

TA initiatives without a clear exit strategy can sometimes create dependencies, leaving gaps in health services when funding dries up.

Financial sustainability at the end of the projects must be included in the initial budgets for sustainability aid. Likewise, all the actors involved (MOH and partners) must set up financial independence mechanisms for the localities to help the continuity of the procedures put in place after the departure of donors

Over-medication is a real problem. Since the health centers must find a form of profit, they sometimes prescribe too much and this erodes the trust between the beneficiaries and the health professionals.

Implementing Partner

You realize that the hospitals that work well are the ones that have an agreement protecting them from State intervention. There was a former minister who had a lot of foresight and without giving the hospital the agreement, it would have been much more difficult to stay the course with our initiative there.

Donor



Solution

Financial sustainability at the end of the projects must be included in the initial budgets. The State must commit to putting in place a financial viability plan, including aid such as funds devoted to daily allowances, planning to facilitate consultation platforms, training, and activities at the local level once the partners have left.

Features



SHORT TERM

State-funded financial sustainability plan

Initiative work plans must indicate that, for projects lasting more than 5 years, a certain amount will be devoted to daily allowances, to planning to facilitate communication platforms, training, and activities at locality level once the partners have left.

A protection agreement signed between the MoH and public hospitals, with the support of partners / providers of TA, in order to preserve capacities once the partners are no longer on the ground.



LONG TERM

Aid after project coordination - Funding through contributions from all associations to facilitate meeting planning

During the annual review, the associations must contribute 10 USD (TBD) to cover the cost of the meeting (coffee break per diem, etc.) and all are responsible for supporting their representative at the meeting.

Monetary sanctions for non-compliance

Withhold the supervisor's salary if the manager does not attend data review meetings and utilize salary reductions to force the staff to take responsibility after the donors leave.

4.3

Limits and feasibility

Currently, technical assistance providers have no incentive to save funds for the end of a project.

Considerations

INTERNATIONAL

- How do we find ways to create a savings mechanism or revenue-making mechanisms when setting up a project to help sustainability?
- What could be an incentive to save for the end of a project for technical assistance providers?
- How can we rethink the incentives for technical assistance providers so that they are not pushed to spend the rest of the budget at the end of a project?
- Can we build discretionary funding for the end of projects?
- Can the remaining funds be used as a venture capital investment model?
- What role should financial institutions play to help a model be sustainable?

DRC

- What alternative motivations and sanctions for state employees (status, benefits, etc.) can be put in place to help sustainability?
- What role should financial institutions play in helping short or LONG TERM sustainability?
- Should the Government invest in advance in a dormant account?



1

ADVANTAGES FOR THE MINISTRY OF HEALTH

- Measure on the basis of project achievements
- Improved project finance management
- Better governance and resource management

2

ADVANTAGES FOR THE PARTNERS

- Sustainability of achievements
- Assurance of service continuity

3

ADVANTAGES FOR THE COMMUNITY

- Continuity of services
- Continuity of supply inputs

Responsibility



Global TA Recommendation



Country TA Recommendation

4.4 Motivate the volunteers

What is the current problem?

Volunteers raise funds in their communities, but due to a structural lack of motivational mechanisms they do not receive incentives for their work.

Once the donors have left, without a structure to motivate the volunteers, the initiatives often fail to be sustainable.



Solution

The implementation of income-generating activities and access to certain advantages, motivate volunteers to maintain their position and, as a result, revitalize community institutions and bodies.

Features



SHORT TERM

Aid for the meeting of community bodies with intrinsic incentive

- Pay transportation costs to facilitate their presence at the meeting (bicycle, fuel, etc.)
- Awareness (CCC/IEC)
- Community training and support maintenance system
- Identification of risks and management plans

Non-monetary per diem (e.g. telephone credit, work uniforms, transport, office supplies, supply of essential medicines, training)

Benefits for personnel helping to implement an initiative

The volunteers who are part of the implementation of an initiative have first choice on a series of services (pantry or food collections, donation of medicines or clothing, paid schooling for children, partnership with the local school, etc.)

4.4

Limits and feasibility

A situational analysis will be able to determine the needs of the volunteers and specific bottlenecks in the lack of motivation and sustainability. Non-monetary benefits may be difficult to apply and institute in general, but are a workable alternative to the existing model.

REFERENCES

N/A

Considerations

INTERNATIONAL

- N/A

DRC

- N/A

- 1

ADVANTAGES FOR THE MINISTRY OF HEALTH
 - Stronger, more self-sufficient communities
- 2

ADVANTAGES FOR THE PARTNERS
 - Guarantee of the sustainability of an initiative after the departure of donors
- 3

ADVANTAGES FOR THE COMMUNITY
 - Needs of volunteers and bottlenecks identified

Responsibility



State/Gov.
recommendation

4.5 Motivate health agents

What is the current problem?

The lack of decent wages, long-term stability and the absence of both positive and negative sanctions leads healthcare providers to develop their own alternative sources of income.

These secondary savings may allow some to benefit from greater personal security and independence, but lead providers to focus less on their primary function.

It will be fine. I have a large orchard outside of town. I can go there and make a good living.

Former Program Director

I can't really talk about it because my boss is here [laughs] but I have my own clinic, of course. To live in Kinshasa, no one can survive on the income provided by the State without bonuses.

Hospital Nurse

I think this is the great new story of all the medical staff: we all work in private clinics. We can not do otherwise. Especially the specialists, we all work at least a day or two.

Hospital Director



Solution

The implementation of income-generating activities and access to certain advantages motivate community health workers to maintain their position and, therefore, revitalize community institutions and bodies.

Features



SHORT TERM

Establishment of income-generating activities (e.g. cattle, seeds, etc.)

Both positive and negative sanctions

Non-monetary per diem (e.g. telephone credit, work uniforms, transport, office supplies, supply of essential medicines, training)

Benefits for personnel helping to implement an initiative

The service providers who are part of the implementation of an initiative have first choice over a series of services (pantry or food collections, donation of drugs or clothing, paid schooling for children, partnership with the local school etc.)

4.5

Limits and feasibility

Non-monetary benefits may be difficult to apply and institute in general, but are a workable alternative to the existing model. Income-generating activities should be channeled through work-related activities as much as possible to avoid developing secondary activities which would lead them to not maintain their main job.

REFERENCES

N/A

Considerations

INTERNATIONAL

- N/A

DRC

Engaging in secondary activities can distract agents from the task at hand; however, how can we think of a TA model that could integrate these secondary activities so as to encourage the sustainability of initiatives and a sense of empowerment?

1 ADVANTAGES FOR THE MINISTRY OF HEALTH

- Stronger, more self-sufficient communities

2 ADVANTAGES FOR THE PARTNERS

- Guarantee of the sustainability of an initiative after the departure of donors

3 ADVANTAGES FOR THE COMMUNITY

- Stronger, more self-sufficient community
- Needs of agents and bottlenecks identified
- Secondary activities that guarantee a more stable form of income

Responsibility



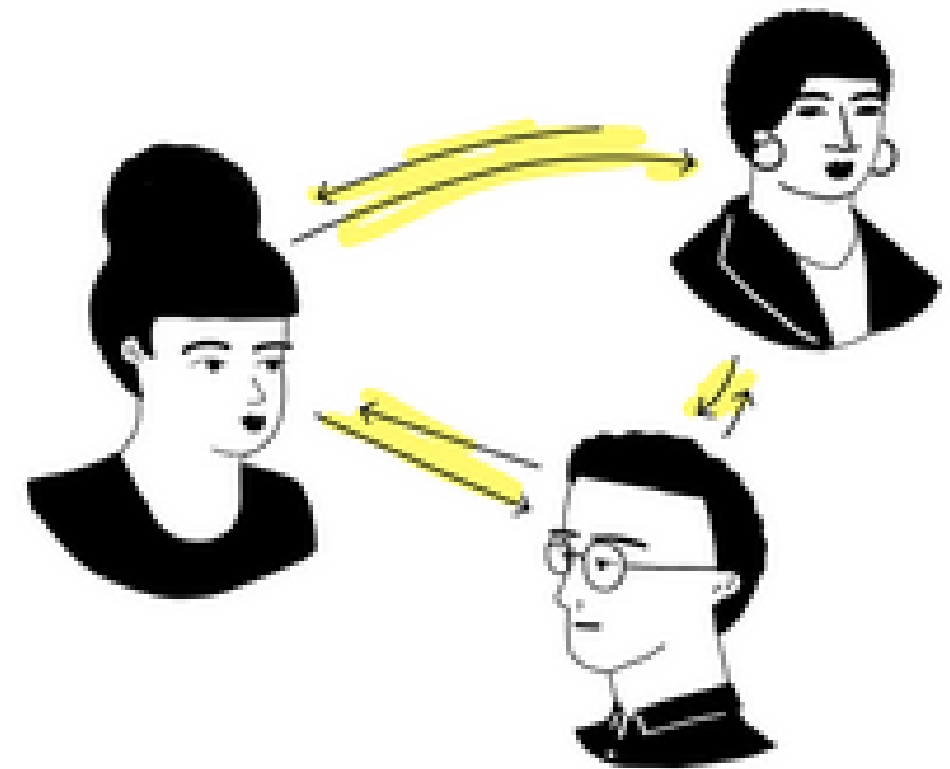
State/Gov. recommendation

07 Design tools

What is Human-Centered Design?

The Human-Centered Design (HCD) process examines an ecosystem in which a program, initiative or service exists in order to understand exactly who is involved throughout the life of that program, service or initiative.

The aim of this method is to take into account the point of view of all the actors in order to imagine together solutions that work for all.

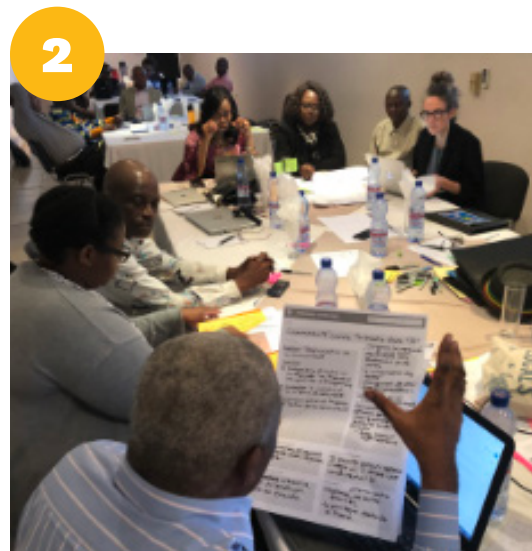


Design methods



Definition of opportunities for the creation of ideas

During our ethnographic research and collaborative synthesis sessions, and based on the design principles, we created a TA blueprint and defined three opportunities (*see appendix*) to solve the bottlenecks and related systemic problems linked to planning and executing TA in DRC.



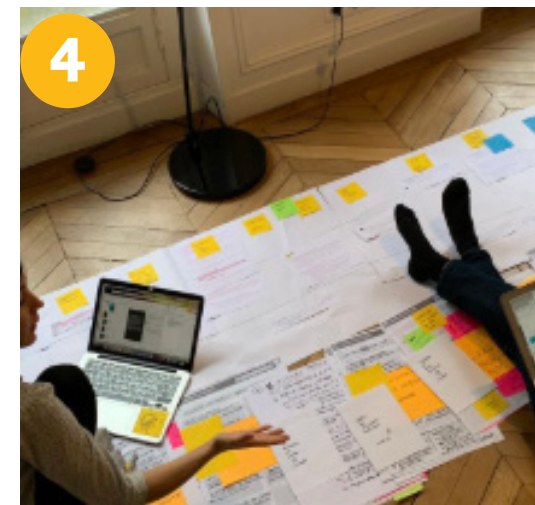
Co-creation workshop

These opportunities were used as the basis for a co-design workshop with all actors in the DRC health ecosystem. During the workshop, a knowledge sharing session and co-design session took place, using the TA blueprint to refine and prioritize TA problems and solutions.



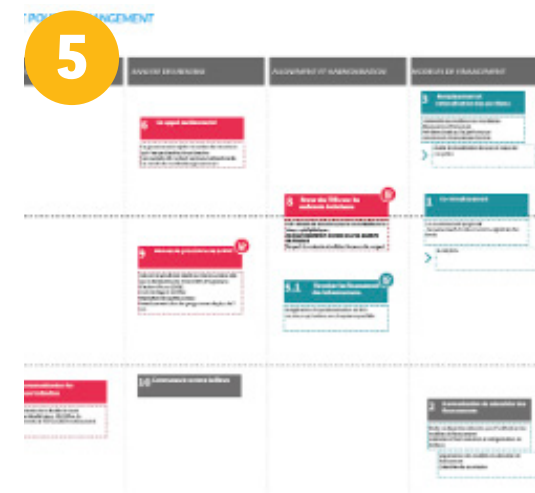
Definition of the concepts

From the co-design workshop emerged a series of ideas that aim to answer how might we questions posed in the opportunity areas. After the group had prioritized the ideas, we analyzed 29 ideas and combined them into 19 stronger concepts which each represent idea systems that can be implemented in the short and long term.



Refining the concepts and creation of the domains of change

Sonder and JSI then reviewed these concepts to solidify their feasibility and viability. Based on these conversations, the concepts were categorized into 4 areas of change and matched to the design principles.



Creation of the roadmap for change

In order for the Ministry of Health and the various TA actors to implement these principles and concepts, we have created a roadmap for change based on these 4 areas of change.

Human Centered Design (HCD) tools

All of the tools used in this project to which the co-creation team has been exposed or experienced are applicable to other project formats. (references from UXThink and Ideo.org)

Blueprint

Definition

A blueprint is the visualization of a service that describes the whole process by listing all the activities and interaction points that occur at each stage of the service by the different actors involved.

How to use this tool?

The service blueprint is built by first listing all the actors involved in the service process on a vertical axis, and all the steps necessary to provide the service on the horizontal axis. The resulting matrix represents the flow of actions that each role / actor must perform throughout the process, highlighting the actions that occur at each level. Roles can be performed by humans or other types of entities (organizations, departments, artificial intelligence, machines, etc.)

Use it to analyze an existing service or to visualize the concept of a well defined service, to highlight the bottlenecks of a service and the interactions which are causing blockages in a clear manner.

Keep in mind

The blueprint visually identifies and organizes each touch-point that a user has (or could have) with a specific service.

These interactions can be positive (delight points) or negative (pain points).

The blueprint also makes it possible to highlight each person's responsibilities, understand cross-functional relationships and align with upstream and downstream processes.

Design Principle

Definition

Design principles are attributes, rules or explicit goals that describe the core values of the experience of a product or service. They are defined to help a team create a consistent and useful experience for users.

How to use this tool?

The principles of design are generally short and memorable, presented as positive statements that guide the design.

Remember that the design principles work as a group and it is likely that you will need to identify several.

It may be that after a test phase, certain design principles need to be refined.

Keep in mind

Consider design principles as the safeguards for your solution - quick, memorable recipes that will help maintain consistency.

These principles describe the most important elements of your solution and give integrity and form to what you design.

07 HCD TOOLS

Human Centered Design (HCD) tools

Opportunity Area and “how might we”

Definition

Each problem is an opportunity for design. By adding “how might we” when faced with a problem, you create an opportunity for innovative solutions. (Ideo.org)

How to use this tool?

After identifying problem areas for the people you are designing for.

By reframing your insights (or problems) as questions you could turn these challenges into design opportunities. The “how might we” format suggests that a solution is possible because it gives you the opportunity to respond to it in different ways. A correctly designed question does not suggest a particular solution, but offers you the perfect framework for innovative thinking.

Keep in mind

Start by examining the insights you have created. Try to rephrase them as questions by adding “How might we” at the beginning. The goal is to find design opportunities, so your questions should allow for a variety of solutions. If not, expand it. Your question “how might we” should generate a certain number of possible answers and will become a launching pad for your brainstorm. Finally, make sure that your question is not too broad: your question must give you both a framework narrow enough to let you know where to start your design, but also wide enough to give you room to explore innovative ideas.

Co-creation Workshop

Definition

The purpose of a co-creation session is to bring together a group of people for whom you are designing, and then involve them in the design process.

How to use this tool?

The co-creation session is a great way to get everyone’s perspective, participation and consensus on ideas. You don’t just hear their voices, you give them the opportunity to do it by your side. You can co-create services, study how communities work, understand how to name your solution, or what it should look like. Not only is a community or organization much more likely to adopt a practice or service that it has helped create, but you will also get valuable information on all facets of your solution.

Keep in mind

The first step is to identify who you want in your co-creation session. It may be a handful of people you’ve already interviewed. This may be a specific demographic group. Once you know who you want, organize a space, get the necessary supplies (often pens, post-it notes, paper, etc.) and invite them to join you. Make the most of a co-creation session with activities to engage your group around the problem you are trying to solve. Capture the feedback your group gives you. The goal is not just to hear people, it’s to invite them to your design team. Make sure that you treat your co-creation team as designers and not as interview subjects.

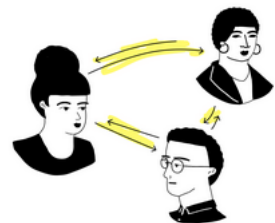
08 Appendix

Opportunity areas



Rethinking interactions to strengthen local ownership and support strategic decision-making.

Change the way in which the actors of the system interact, share and make their decisions with each other to equitably distribute the development of the priorities addressed and to strengthen the country's leadership.



Rethink feedback circuits and data sharing processes to support contextualization and decentralization.

Change the way information flows between different actors in the system to promote more informed decision making based on the local context.



Rethinking budget incentives and structures to strengthen the health system.

Modify existing incentive and budgeting structures so that resources are used more efficiently and in a more balanced way and promotes the collective good rather than individual gains.

Three opportunities were used during the co-creation workshop with all the actors of the health ecosystem in DRC to respond to defined problems of the TA journey or blueprint.

Best practices

During the research phases of the project, the stakeholders interviewed highlighted initiatives or processes that they considered to be examples of best practice. These were collected and used during the co-creation exercises of December 2019 to assist the group in developing innovative ideas.

"Contrat unique"

Fixed per diem, decided by all according to the capacities of the provinces.

Involvement of provincial levels and zones during project planning and resourcing (ex. RACE)

Partners seeking the advice of DPS and Health Zone for co-management of the project. This increases motivation, a sense of belonging to the initiative and the willingness to collaborate.

Create responsibility outside of your own network

Donors are accountable to people outside their network - so they must demonstrate tangible gains and a more objective timetable.

Shaming

Force transparency and responsibility - To ensure better governance, all DPS managers shame those who have not invested the money / time promised, etc. and it works.

Rotating TA staff to work in the offices of the Ministry of Health once a week (ex. PROSANI)

Get the Ministry of Health to invest in the purchase of goods and equipment (ex. GAVI)

The State pays a financial contribution before the signing of the agreement by the partners. Both feel responsible for monitoring where the money is going and the proper appropriation of funds.

A protection agreement is signed between the Ministry of Health and public hospitals

With the support of TAIP (TA partner / supplier), in order to preserve capacities once TAIP is no longer on the ground. This requires a Minister of Health who has a vision for LONG TERM and who understands some of the weaknesses of the Ministry of Health.

Training MoH/HCP

Canadian Cooperation finances around 80% of master's degrees in public health for certain area managers so that they are more "up to standard". Promotes an exclusive and motivating feeling for area managers.

Government and actors are co-signatory of the funds (ex. GAVI)

Donors and the Ministry of Health write the objectives of the initiative in the same office. The DPS has a secure workplace and secure and accessible funding. The state and donors control funding, while the DPS can withdraw funds using a disbursement mechanism.

A champion trained in problem solving

Japan funded a two-week retreat for a number of health professionals from across Africa who traveled to Japan and learned about the 5S management approach, which means (in Japanese): To order; Tidy; Dust, Discover anomalies; Make it obvious; To be rigorous. This approach means that there is more responsibility and transparency. In addition, the top can be replaced as all files are clearly classified.

Local fundraising to help community building

Fundraising with friends to resolve non-medical resource issues (eg, a burnt out hospital room). The funds do not come from hospital pockets and therefore keep funds for equipment and medicine.

Small informal spaces of collective solidarity to increase good governance, transparency and collective consent

Implementing partners can leave a state of mind behind them. The Red Cross hired a consultant for 10 years to review the structure and establish a management style based on transparency and advice. It has implemented a culture of internal public consultation with all staff. When profits decrease or when sacrifices have to be made, all staff are invited to come together to understand why decisions are being made or to allow them to give their opinion on what they think should happen..

Concepts with low viability

Due to the low feasibility in relation to the global context and the organizational difficulties of implementation between all partners and the DRC, certain concepts have been discarded.

Per diem/ joint fund where the government and partners collaborate on a common per diem model

Salary bonus and per diem are in a common fund - therefore government officials are not tempted to be more accountable to donors than to government, and are encouraged to stay put.

Difficulty

The salary bonus is in competition with the salaries paid by the technical assistance providers and not the per diem.
The daily allowances and the salary bonus have two different objectives.
People who receive salary bonuses (government employees) can receive daily allowances. It's not a deterrent to getting more money.

Harmonization of budget cycles

To overcome the multiplicity of budget cycles and to popularize standards and regulations (in terms of the budget cycle) and avoid overlapping of several activities, it is necessary to harmonize budget cycles between the State and partners within the sectors of government.

Difficulty

Low feasibility due to administrative burden.

Revenue generated for the end of projects

The health center opens an account in which it puts its income from medicine (or services) throughout the life of the project which is not touched and then used as "starting capital" for a form of sustainability after the end of donor funding.

Difficulty

Economic difficulty when institutions are in deficit.
This will contribute to sustainability, but will raise questions of management, revenue supervision and responsibility.
When you prepare your financial plan, financial responsibility passes to someone else. When a project closes, financial balance must be equal to 0.
The goal of TA is not to save money.

Concepts with low viability

Employee Replacement Rationale Checklist - Personnel Job Security

To avoid destabilizing a team and protecting the competent people on the job, imagine signing a contract on behalf of the people and not by post.
Obligation of results for agents.
To strengthen the employment law and not dismiss or place an agent without valid reason, set up a strict procedure for justifying dismissal.
Managed by the IGS.

Difficulty

The difficulty is high because it is highly dependent on the current entrenched paternalistic hierarchy and current leaders and would require a radical change in behavior and culture in government for this to happen

International Transparency Initiative

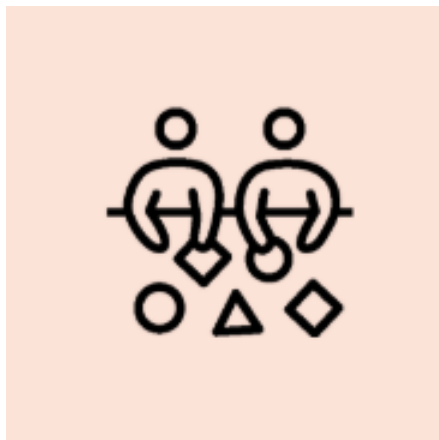
The government of Madagascar is using IATI data to uncover millions of dollars in spending on development and humanitarian projects. Government staff are better able to plan for the future using IATI forward-looking data to find out what donors plan to spend in the country, several years in advance.

Difficulty

The difficulty is high because it is highly dependent on the State being very organized and that corruption is not as prevalent.

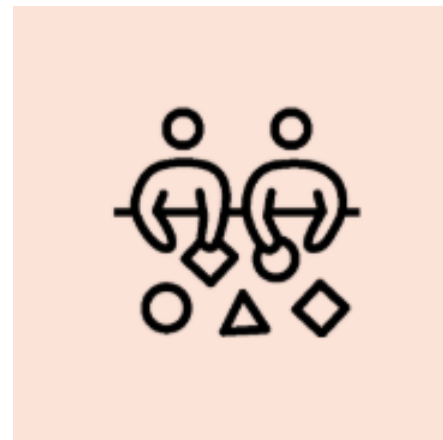
Concept phase 1 - Methodology

During the week of workshops, the co-creation team created 2 versions of each concept chosen during the March 2019 ideation workshop. Each concept is based on different underlying problems; focusing on important aspects that represent barriers to TA. The co-creation team then tested concepts 1, 2, 3 and 4 with the community.



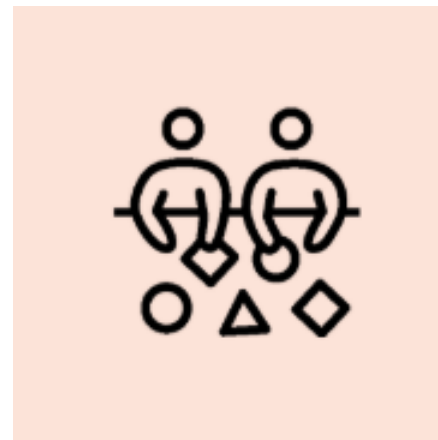
01 Re-frame and refine concepts

- The co-creation group brought its context expertise in order to reframe the hypotheses while thinking about the future and adding improvements.



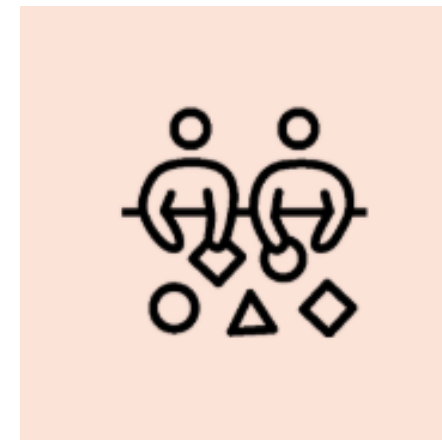
02 Build the prototype

- The objective was to refine the concepts in a more concrete way in order to test them (based on the central hypothesis) and making them tangible enough to communicate them to “users”.



03 Prepare questions to ask end users

- During the test, user views were collected. The questions validated or refuted the basic hypothesis. Following the test, the team integrated the learning and analyzed the test results.



04 Integration of comments

- The objective was to integrate the learnings and feedback to modify the concepts.

Concepts of previous phases

During the week of workshops, the co-creation team created 2 versions of each idea selected in the March 2019 ideation workshop.

Each concept is based on different underlying problems; focusing on important aspects that represent barriers to TA.

In addition, these technical concepts form a system that represents a paradigm shift in the current functioning of TA (top-down) hierarchy.



Community first

How to prioritize in a poorly functioning health system?

Concept 1 - Community-based planning

Improve the planning and monitoring of activities according to the needs defined by the community.

Concept 2 - Participatory planning

Tools to collect information at the participant level and thus allow the community to organize itself into structured groups.

Risk sharing

How to reduce the burden upon the households in the health system and be accountable to them?

Concept 3 - Multisectoral advocacy

Advocacy platform made up of multisectoral pressure groups for decision-makers.

Concept 4 - Mutualization

Pooling of care adapted to community dynamics, based on the role of the State and the empowerment of mutual funds.

Complete and dynamic initiatives map

How to resolve the duplication of activities and gaps on the ground?

Concept 5 - View from the community

A mapping initiative to keep information flowing up.

Concept 6 - Global mapping

A mapping initiative to coordinate several activities (promotional, curative and awareness-raising).

Community first

Description of the basic idea

The new community dynamic takes into account all the actors, starting with the villages, the CACs, the RECOs, CODESA and COCODEV. All these committees work around the village chief who is not exclusively in health. The population is involved from the bottom up to harvest the most urgent needs of all people at all levels. This does not only apply in the context of health; other sectors have an impact on health, such as agriculture and education.

“What we would like is for technical support to help the community be able to identify their own problems, be able to claim their rights and know that they are also accountable for all of this. It is to bring the community to reflect on its problems and identify possible solutions. Do we need help? If so what type, where to find it. ”

- Co-creation Team

Concept 1 - Community-based planning

02

Improve the planning and monitoring of activities according to the needs defined by the community. The community defines and prioritizes its needs.

PROBLEM

- Identifying community issues

TESTED ASSUMPTIONS

- A “capable” community manages to organize itself and identify health problems by consensus.
- An organized community becomes capable of integrating into the system.

RECOMMENDATIONS

- Develop the tools necessary to collect information at 2 levels: so that each participant collects data around them, and so that during data collection meetings they can gather and prioritize all information.
- Adapt the tools to community language.
- Orient community leaders.
- Empower the community to organize itself into structured groups.
- Strengthen the knowledge of different groups in different priority areas of health.
- Monitor community activities.

Concept 2 - Participatory planning

02

Tools to collect information at the level of participants and thus allow the community to organize itself in a structured group.

PROBLEM

- Act in the community and make the community capable of planning and monitoring activities according to the needs identified.

TESTED ASSUMPTIONS

- Better community engagement in planning would lead to better results.

RECOMMENDATIONS

- Need to be aware of the existence of community participation bodies.
- Increased knowledge of the quality and quantity of volunteer members.
- Need training / capacity building.
- Affirmation of the role of the State in the engagement of the volunteers.
- Improving relationships: the quality of curative services and the participation of members in activities.

Risk sharing

Description of the basic idea

Risk sharing is based on regular membership fees to pay for the care of those in need. Communities create mutuals with State support and partners who can subsidize the administrative cost, provide TA through a medical consultant.

“By putting everyone together, it can be a mutual fund, health insurance or any other form of risk sharing and everyone contributes regularly and the money is used to treat those who need care”

- **Co-creation Team**

Concept 3 - Community Cooperative

01

"Mutualisation" of care adapted to community dynamics, based on the role of the State and the empowerment of mutual funds.

PROBLEM

- Insufficient risk-sharing mechanisms (mutuals, etc.).
- It was the State that had to pay for health insurance but did not.

TESTED ASSUMPTIONS

- Sharing mechanisms lead to equity in access to health services for all households and strengthen community solidarity.

RECOMMENDATIONS

- Under the watchful eye of the State, the capable structures contribute to equity in the care and solidarity of the members. The co-creation of a multisectoral platform would make it possible to increase free healthcare by seeking complementarity for each. Strengthen the knowledge of different groups in different priority areas of health.
- 1. The State has the normative, regulatory and subsidizing role for mutuals. The State regulates, sets up the standards and fundamental principles of mutual health insurance. The state should subsidize mutuals, but does not.
- 2. The implementing partners support the State in the implementation of mutuals. They do advocacy and fundraising. The partners are in contact with the State to see where to set up mutuals according to the needs expressed.
- 3. The health zone is in the State, composed of structures or medical formations. The population is made aware of mutuals; then the members take care of themselves in the mutual.
- 4. The mutuals supervise the members with the support of partners and the ministry.
- 5. The role of the mutual's executive committee is to mobilize the funds of its members and identify a center that will provide quality health care.
- 6. Households have the role of making contributions and participating in meetings.
- 7. Advocacy (Concept 4) is needed for the state to subsidize already functional and operational mutuals

Concept 4 - Advocacy model

04

Advocacy platform made up of multisectoral pressure groups for decision-makers.

PROBLEM

- Disengagement / Low government commitment to health care spending.

TESTED ASSUMPTIONS

- A strong commitment from the State will improve financial accessibility to health services.
- Better State engagement - The State subsidy will ease the burden on households.

RECOMMENDATIONS

- An advocacy platform composed of multisectoral pressure groups towards decision-makers (presidency, prime minister, government, parliament, private sector) must be set up.
- Advocacy groups gain strong government commitment.
- Capacity of pressure groups and restructuring is necessary.

Complete and dynamic initiatives map

Description of the basic idea

The map aims to solve three major problems in the country. Strategic orientation of stakeholders is possible through this mapping and allows for tracking where resources are and where there is a surplus.

“With this concept, we know where to guide the stakeholders to get results. Also the equitable distribution of resources. We know where there are no resources and where there is overstock. ”

- Co-creation Team

Concept 5 - View from the community

02

A mapping initiative to keep information flowing up.

PROBLEM

- Identifying community issues.

HYPOTHESES

- Have a mapping at all levels of the system.
- Need for good coordination and effective leadership and capacity building.
- Ensure communication and feedback between the different levels of the system.

RECOMMENDATIONS

- Technical assistance intervenes for capacity building to make databases, buy materials, analyze data. Health policies determine the mechanism by which information flows:
- 1. The central level works for coordination and leadership; the level of production of tools, of data management. This will give strategic directions, distribute resources fairly and avoid duplication and dusting. It is possible to link it with the CNP (National Steering Committee).
- 2. The intermediate level which shows the needs at the provincial level thanks to a provincial committee.
- 3. The operational level where needs are reported and identified. The map here would certainly be paper and adapted to the level of health zones.

Concept 6 - Global mapping

02

A mapping initiative to coordinate several activities (promotional, curative and awareness-raising).

PROBLEM

- A mapping that adapts to different levels would be a tool at the national level and at the operational level.

ASSUMPTIONS

- A dynamic and complete mapping would avoid duplication, dusting and disparities.
- The existence of a mapping would lead to a judicious distribution of resources.
- The mapping must indicate where there are needs and in the long term it must help to reduce duplication, disparities and efforts being spread too thin.

RECOMMENDATIONS

- The concept centers on a map that would help decision makers in decision making and that would come from the community. For this a framework can be put in place. The card would be defined at national level and coordinated by a database manager.
- At the Health Zone level, data would be collected by the Zone doctors who would transmit to the central level. This group worked on the map at the community level.
- The map would display 3 types of activities: promotional, curative and awareness-raising activities.
- It would allow to see the established coverage, the intervention and the intervener, ie the Who / What / Where.
- It would show indicators of resources and results.
- In terms of format, the data would be divided between visualizations by cards and others by tables.
- The card could also be used for advocacy (Concept 4).

