Re-Imagining Technical Assistance for Maternal, Newborn, and Child Health and Health Systems Strengthening

DRC Country Case Study

March 2021

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This country case study complements the Nigeria country case study.

Les deux études de cas sont aussi disponibles en français (RDC et Nigeria).

Background

The Re-Imagining Technical Assistance for Maternal, Newborn, and Child Health and Health Systems Strengthening project (RTA) was an initiative funded by the Bill & Melinda Gates Foundation and implemented by the Child Health Task Force, which is managed by JSI Research & Training Institute, Inc.– JSI. The project took place in the Democratic Republic of the Congo (DRC) and Nigeria from March 2018 to September 2020.

JSI served as the technical partner for RTA, drawing on decades of experience implementing projects and conducting research in maternal, neonatal, and child health (MNCH), family planning, and health systems strengthening. Sonder Collective, the design partner, brought expertise in facilitating human-centered design (HCD) and co-creation processes with in-country technical assistance (TA) stakeholders.

RTA collaborated with in-country TA stakeholders (i.e., representatives of the government, civil society, multi- and bi-lateral organizations, and the private sector) in a co-creation process to 1) map barriers and opportunities in how TA is designed and delivered, 2) co-create a shared vision and concepts for a new approach to TA, and 3) test, iterate, and develop new models for TA.

To achieve these goals, it was critical to begin with a multidimensional understanding of how people experience TA in their environment. As a result, RTA employed an integrated approach that combined HCD, co-creation, and systems thinking. The project's HCD activities focused on understanding the human experience of TA, including individuals' attitudes, motivations, and behaviors, as well as social and cultural determinants, such as social norms and group identity. Learnings from this process were leveraged to explore systems-level ideas with the most potential for addressing TA challenges described by key stakeholders and identifying potential improvements. (More information on the HCD process can be found in the Nigeria country case study.)

The project's co-creation process involved activities to co-construct with key stakeholders knowledge about the landscape of TA and co-design concepts of what TA could look like in the future, while taking into account the diverse needs and preferences of stakeholders within and across countries.

RTA's combined HCD-co-creation approach used in-depth interviews and collaborative workshops to engage country stakeholders and facilitate interchange among them. Interactions with stakeholders explored key questions such as the following:

- Who are the "users" of TA?
- What are the characteristics of TA?
- What are users' experiences with TA?
- What user problem(s) are we solving for?
- What does the ideal future of TA look like from users' perspectives?
- What are the leading opportunity areas for change?
- What are the guiding design principles for change?

More information about RTA overall is available at https://www.childhealthtaskforce.org/countries/ and more information about RTA in the DRC is available at https://www.childhealthtaskforce.org/countries/drc

Tool Spotlight: Co-Creation Process

RTA adopted co-creation as a tool to enable a wide range of stakeholders to collaborate on identifying TA challenges and potential solutions. Co-creation emphasizes collective creativity and collaborative design; its results are quickly integrated throughout the design process.[1-2] Co-creation enables stakeholders from diverse disciplines to share their explicit and tacit knowledge of TA challenge and solutions, with the goals of creating a common understanding of, integrating, and exploring knowledge, as well as achieving the initiative's larger objectives.[3-4]

RTA held four workshops in the DRC: an intent workshop, two design sprints, and an integration workshop. Workshops were intended either as a forum for brainstorming, co-creating, and prototyping or to provide a space for sharing, reflection, and joint ownership of project findings. Figure 1 (see next page) visually represents the activities conducted during each co-creation phase, from intent to delivery.

RTA began with an intent phase focused on building a shared understanding of the project's purpose and approach. During the intent workshop, participants formed a co-creation team to pool their experience and ensure ownership of the ideas developed throughout the design process. Approximately a dozen professionals participated in the DRC co-creation team, with individuals' attendance varying from meeting to meeting. The team was composed of individuals from stakeholder groups in the health sector (i.e., governmental programs, civil society, universities). One or two team participants took on the role of moderator or chair during meetings. JSI also contracted with a consultant to coordinate the team.

The intent workshop was followed by a HCD discovery research phase (i.e., stakeholder interviews, observation, guided storytelling—further described in the Nigeria country case study), which allowed for inquiry into nine topic areas falling under the three broader thematic umbrellas of "collaboration", "financial management and resisting quick fixes" and "resilience and sustainability", and the gathering of insights from a variety of actors. The project then distilled the concerns into key insights and opportunity areas.

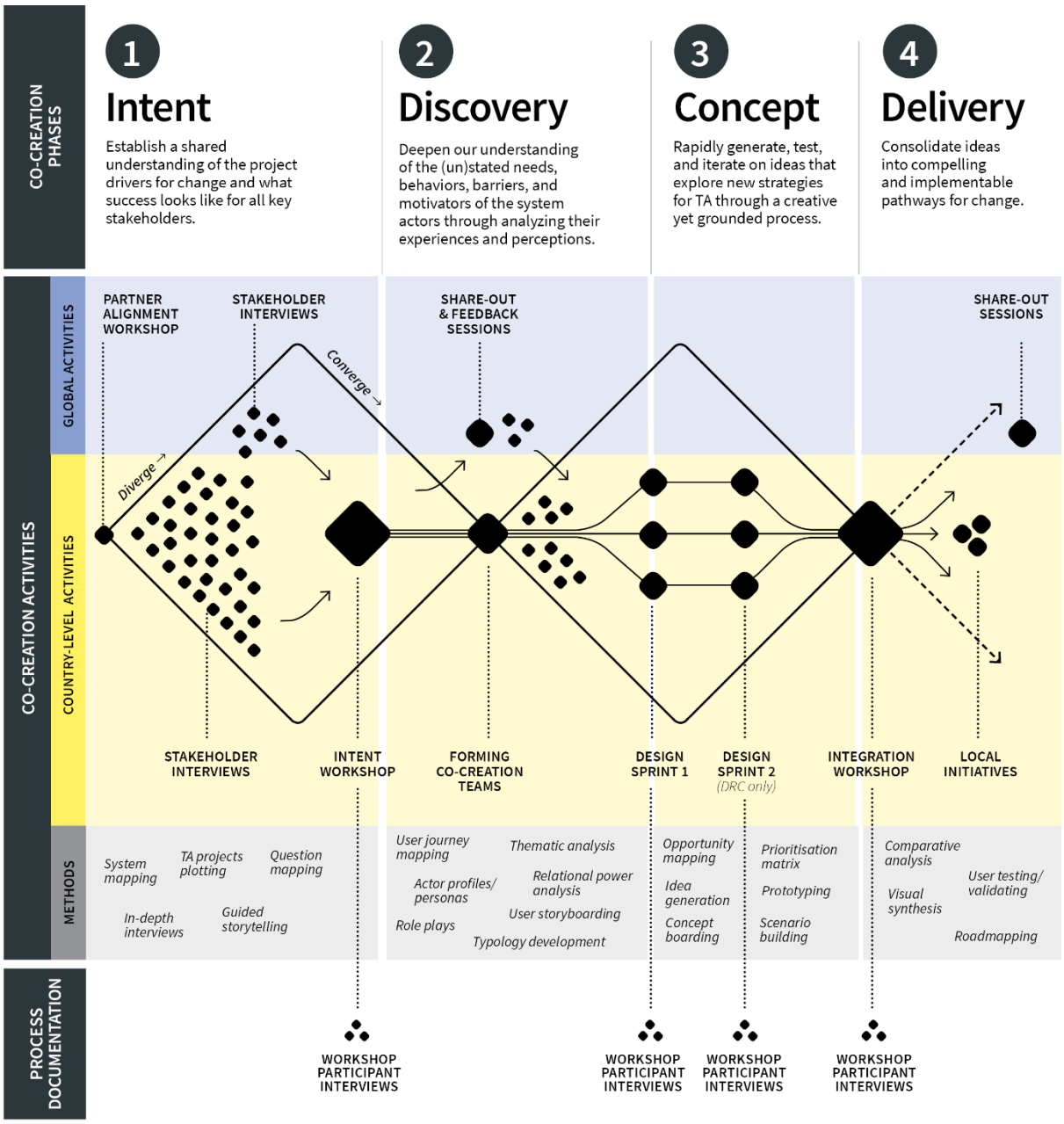
Co-Creation Output Spotlight: Insights and Opportunity Areas

During the ethnographic research and collaborative synthesis sessions, the co-creation team created a TA blueprint and identified three opportunity areas for change to address potential bottlenecks and related systemic problems. These opportunities were also used as the basis for a co-creation workshop with actors in the DRC health ecosystem. The opportunity areas are presented in Table 1 below.

Table 1. Opportunity Areas Identified in the DRC Co-Creation Process

Re-imagining interactions to build local ownership and support strategic decision making	Re-imagining feedback loops and data sharing to support contextualization and decentralization	Re-imagining incentives and budgeting structures to maximize impact and support health system strengthening
Change how system actors interact, share, and own decisions to evenly distribute ownership; address gaps and challenges to strengthen leadership and country priorities.	Change how progress in implementing initiatives and TA information flows are communicated among system actors to promote more informed, context-based decision making.	Change existing incentive and budgeting structures to use resources more efficiently and balance individual and collective gain for mutual benefit.

Figure 1. Simplified Visualization of DRC Co-Creation Phases and Activities



The small black diamonds (♦) represent the data elements collected, which are then synthesized and analyzed (hence becoming a larger black diamond). The aggregate data are then refined and prioritized (medium-size black diamond). A second phase of divergent thinking accompanied by focused data collection begins based on the refined findings, which then leads to the organizing, ordering, and structuring of data (three streams of diamonds). This is followed by the integration of solutions and recommendations (larger black diamond), which are finally disseminated. For more information about the HCD diverging and converging thinking processes, please consult the complementary Nigeria country case study.

After each co-creation workshop, project staff summarized the primary takeaways and conclusions and documented the workshop's visual materials and conversations. Following a workshop, the design team then analyzed the materials created and synthesized them into outputs and artifacts, which are summarized in the output spotlights in this section. The outputs and artifacts were used to prompt and guide discussion during the subsequent workshop.

Through collaboration during the two design sprints and a series of iterative ideation and prototyping activities, the co-creation team developed concepts that incorporated the previous phases of work (see Figure 2).

Figure 2. Co-Creation Team Refining Concepts during the November 2019 Design Sprint in Kinshasa

Co-Creation Output Spotlight: Concepts

Co-creation workshop participants ideated potential solutions to the opportunity areas. During the concept phase, the solutions were synthesized and prioritized into 19 concepts, which contained recommendations for short- and long-term TA improvements.

The concepts were collectively reviewed, refined, and prioritized based on their feasibility and viability. From each concept, a broader principle related to good TA emerged. The principles were thematically assembled under four domains of change: optimizing finances to build on the long term, reinforcing governance, reducing external dependencies in favor of sustainability, and cultivating collaboration and transparency. By

matching principles with actions to be taken and owned by actors in the system, Sonder Collective and JSI then developed a roadmap for change that addresses the challenges highlighted in the DRC's TA system.

The opportunity areas and concepts are described in further detail in the final project report developed by the DRC Ministry of Health.

Co-Creation Output Spotlight: Roadmap for Change and Design Principles

During the final integration workshop (March 4–6, 2020) and delivery phase, co-creation team members prioritized the design principles and concepts into a roadmap for change. The project's findings and the roadmap were presented at a meeting that brought together a broader group of stakeholders, including TA providers, donors, and national and provincial representatives from the DRC government.

The key outputs of the DRC co-creation process were the insights gathered to identify opportunity areas, the concept definitions, the roadmap for change, and the 20 design principles.

The DRC RTA team and co-creation group developed an action plan for implementing the project's recommendations. The success of the co-creation method became evident when the government took ownership of the process, as demonstrated by the General Secretary for Health assuming responsibility for implementing the co-creation team's recommendations, including the following:

- Synthesize RTA findings in a country policy proposal aligned with the universal healthcare strategic plan and the National Health Development Plan (PNDS)
- Validate the country policy proposal and concepts (renamed "tools") at a stakeholder meeting
- Submit the country policy proposal and tools to DRC regulatory bodies, including the Governance Commission, the Technical Coordination Committee, and the National Steering Committee for the Health Sector (CNP-SS). (Ever since their validation by the CNP-SS, the country policy document and tools are now considered political documents to be disseminated and implemented.)
- Disseminate the country policy proposal and tools at the central level and in all 26 provinces. A TA follow-up committee was formed, including a focal point within the Directorate of Planning (DEP).

The roadmap for change is presented in further detail in a one-pager developed by Sonder Collective.

The co-creation process as a whole and its outputs are described in further detail in a report developed by Sonder Collective.

Final Thoughts

From the start, co-creation emphasizes alignment and trust among country stakeholders along with building stakeholder ownership. Staff external to the country serve as facilitators of the process, not experts. The DRC's ownership of RTA's approach and recommendations can be partially attributed to the co-creation process.

The effectiveness of co-creation is a result of the opportunities and processes it provides to address a complex multi-stakeholder systems issue by bringing diverse voices and perspectives to the table. Unlike consultations that hire subject-area experts to provide insight, the co-creation process assumes that all participants have equal and valid perspectives regardless of their expertise, thereby establishing a safe space for everyone to express their views and share their experience with the issues at hand. Co-creation was an excellent fit for this initiative because it required candid exchanges about the positive and negative impacts of TA, which led to a shared understanding of TA opportunities and challenges.

The co-creative nature of RTA's work enabled team members to gain a broader perspective and develop empathy for each other's experiences. This stands in contrast to participants simply listening to and learning from the most powerful voice in the room, a dynamic that frequently plays out between donors and TA consumers, national and subnational government representatives, senior officials and young recruits, and healthcare providers and community members. Developing a deeper understanding of each other's viewpoints enabled the co-creation team to coalesce around priority TA challenges and solutions.

It is important to note that this process was successful in the DRC because co-creation team members actively and consistently participated in workshops and activities and brought their energy and commitment to the work. As a result of their attendance and full participation, team members became invested in the group's thought processes and the evolution of the project's findings. This, in turn, increased team members' sense of ownership of the project—essential elements in its sustainability and success.

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