Breakthrough ACTION DRC

Design & Test Report: Medium Fidelity Prototyping

Using human-centered design to encourage essential family practices and healthcare seeking in DRC

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USAID FROM THE AMERICAN PEOPLE

MINISTERE DE LA santé

Breakthrough ACTION FOR SOCIAL & BEHAVIOR CHANGE

Contents

Acronym list

ANC	Antenatal Care	**MOH**	Ministry of Health
AC	Animateur Communautaire	**PNLP**	Programme National de Lutte Contre le Paludisme
EHHP	Essential Household Health Practices	**PNCPS**	Programme National de Communication Pour la Santé
FP	Family Planning	**PNSR**	Programme National Pour la Santé Reproductive
HCD	Human-centered Design	**ReCo**	Relais Communautaire
ITN	Insecticide Treated Net	**SBC**	Social and Behavior Change
MCH	Maternal and child health	**USAID**	United States Agency for International Development
MCZ	Médecin Chef de Zone (Head of Health Zone)	**ZS**	Zone de santé (Health Zone)

1. Background & Overview

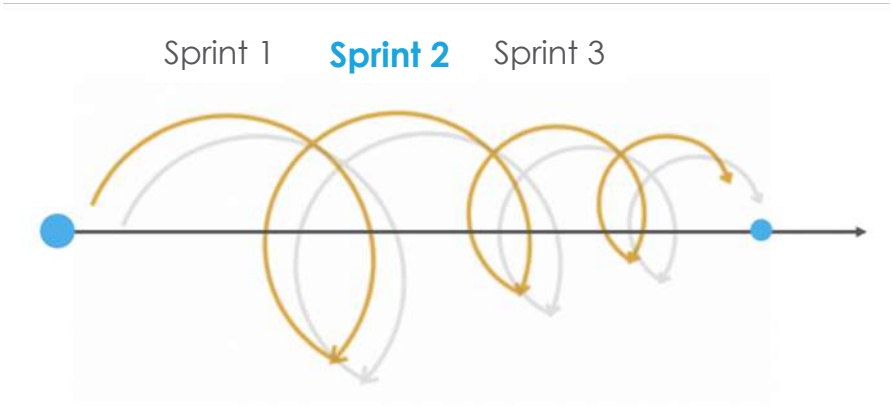
Introduction

This document was developed as a result of four weeks of intensive medium-fidelity prototyping conducted in DRC, aimed at testing insights and design concepts created during the first Design & Test sprint conducted in June, 2019.

This report provides an understanding of how medium-fidelity prototypes were designed; results from four weeks of testing in two different provinces in DRC, including impact of each prototype and users that were reached through each strategy, along with a suggested strategy to be followed for Sprint 3: High-Fidelity prototyping.

In order to understand if the prototypes were successful, during Sprint 1 and 2, prototype's efficacy was measured using using 2-5 variables, such as the number of people attending an event, brochures distributed/taken, number of people who followed up, etc. The main intention was to understand, through these indicators, how awareness and sensitization can translate to action and, ultimately, to behavior change.

In this project, the Design & Test phase is structured into design sprints that place an emphasis on continuous learning and rapid prototyping. Design sprints ensure a highly action-oriented, evidence-based process in which users are able to give feedback on concrete design solutions as early as possible.



The second testing sprint was facilitated to validate a set of design solutions that proved to have potential of behavior change during Sprint 1. During Sprint 2, prototypes were refined and re-tested.

Breakthrough ACTION DRC

Breakthrough ACTION is a global social and behavior change (SBC) project funded by the United States Agency for International Development (USAID) that is designed to increase the practice of priority health behaviors and enable social norms, including gender norms, for improved health and development outcomes, with an emphasis on family planning /reproductive health (FP/RH), HIV, maternal, newborn, and child health (MNCH), and malaria. The Johns Hopkins Center for Communication Programs (CCP) leads the project, which was launched in 2017, in partnership with Save the Children, ThinkPlace US, ideas42, Camber Collective, the International Center for Research on Women (ICRW), and Viamo.

The DRC is one of the world's top five contributors to maternal and child mortality, and multi-sector outcomes indicate that pregnant women and children under 5 are the priority populations on which to focus, affecting change that will address health, DRG, and education outcomes. The maternal mortality rate is 846 deaths per 100,000 live births, and nearly two-thirds of maternal deaths result from

Taking a holistic approach, Breakthrough ACTION will focus on understanding the determinants of key behaviors and, based on evidence, designing interventions to address behaviors across sectors, not just in health. The Breakthrough ACTION program works with partners within civil society, donors, and national and district-level government to improve the overall management and coordination of SBC activities within the DRC.

The Breakthrough ACTION project will produce the following intermediate results (IRs):

IR1 Proven, evidence-based practices to address key barriers and incentives to positive behaviors institutionalized.

IR2 USAID-supported social and behavior change (SBC) investments in key sub-sectors mutually reinforced by shared behavioral objectives.

IR3 Increased capacity of Congolese communication and SBC organizations to coordinate, design, implement, and evaluate evidence-based SBC interventions.

Project intent at-a-glance

DESIGN CHALLENGE

How might we improve essential family practices and health care seeking for households with pregnant women and children under 5 in two provinces of the DRC?

The approach

Within the framework of Breakthrough ACTION's SBC Flowchart, this activity follows an HCD approach. The objectives of the Breakthrough ACTION DRC activity are to:

- Establish a shared vision for the activity's intent, challenges, opportunities, and future success.
- Build the capability of the in-country team to be able to apply HCD principles and activities.
- Develop a deep understanding of the behaviors, attitudes, and beliefs of people in Haut Katanga and Kasaï Oriental.
- Design and implement innovative solutions to SBC challenges.

The challenge

Encourage parents to systematically follow essential household health practices (use of insecticide treated nets (ITN), exclusive breastfeeding, vaccination, hand washing), and seek care in health facilities, during pregnancy, cases of fever, cough and diarrhea, in order to improve maternal and child health, in particular by reducing malaria, tuberculosis and increasing the use of family planning.

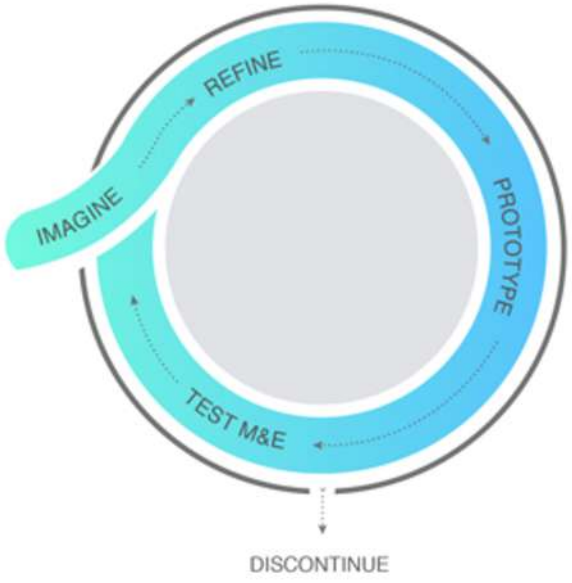
Scope

This project focuses on understanding the experiences and perspectives surrounding healthcare seeking and essential household health practices adoption by the communities in two provinces of the DRC: Haut-Katanga and Kasaï Oriental. The project will focus on the following target audiences:

- Couples whose wife is pregnant (first child or not);
- Parents of a child under the age of five, and;
- Key influencers of the targeted behaviors.

Design & Test phase overview

PHASE II | DESIGN & TEST



The Design and Test phase builds on the opportunities and design strategy identified during the Define phase to generate ideas and test early prototypes with target audiences. This is an iterative and fast-paced process to develop and test multiple designs to address the opportunity areas. Key activities to be undertaken during the Design and Test phase are described below.

The second phase of the SBC Flow Chart is a cyclical and iterative process that focuses on generating and refining ideas to suit a specific target audience and context. From low fidelity to progressively higher fidelity, prototypes are iteratively tested and refined with users. The higher the fidelity of the prototype, the closer it gets to being implemented.

Refine
Develop the ideas into something that can be built by identifying assumptions and designing the finer details of the concept.

Prototype
Build ideas into tangible prototypes that can be taken and tested with communities.

Test, M&E
Give users the chance to interact with the prototypes and provide feedback on the idea. At this stage it is possible that some ideas will be identified as undesirable, unfeasible or inappropriate, and will be discontinued.

Design & Test Phase II: Approach and methods

Review results from Phase I

Testing results from Phase I were reviewed and those that were the most desirable from the user perspective were selected to be re-tested during Phase II.

A total of 19 prototypes were tested during Phase I and for Phase II, 11 prototypes were prioritized to be refined due to the positive feedback received from users.

Select new testing sites & mobilize users

A work plan was built together with the teams in Kasai Oriental and Haut Katanga to select the best testing sites for each prototype and understand the mobilization criteria for participants.

Select testing variables

Each of the 11 prototypes were revised from their behavior change objectives and the hypothesis perspectives. This, to make sure that during the Phase II the prototyping methodology used for each of them was appropriate to understand the level of feasibility of each intervention.

Refine prototypes and feedback questionnaires

Prototypes were then refined and built for a second time. Some elements that were not successful during the first phase were modified and some other variables were kept.

Qualitative and quantitative feedback questionnaires were rebuilt to match the modifications done to the interventions

Deploy & test prototypes

Once the prototypes were refined, they were tested in different health zones in both provinces of the DRC. For a period of 4 weeks users interacted with the concepts.

Gather feedback from users

After the testing time, the team went back to the locations in which prototypes were deployed and applied different feedback questionnaires to them.

Each prototype had its own qualitative and quantitative feedback questionnaire to make sure results of testing were as objective as possible.

Design & Test fieldwork

Who was in the team?

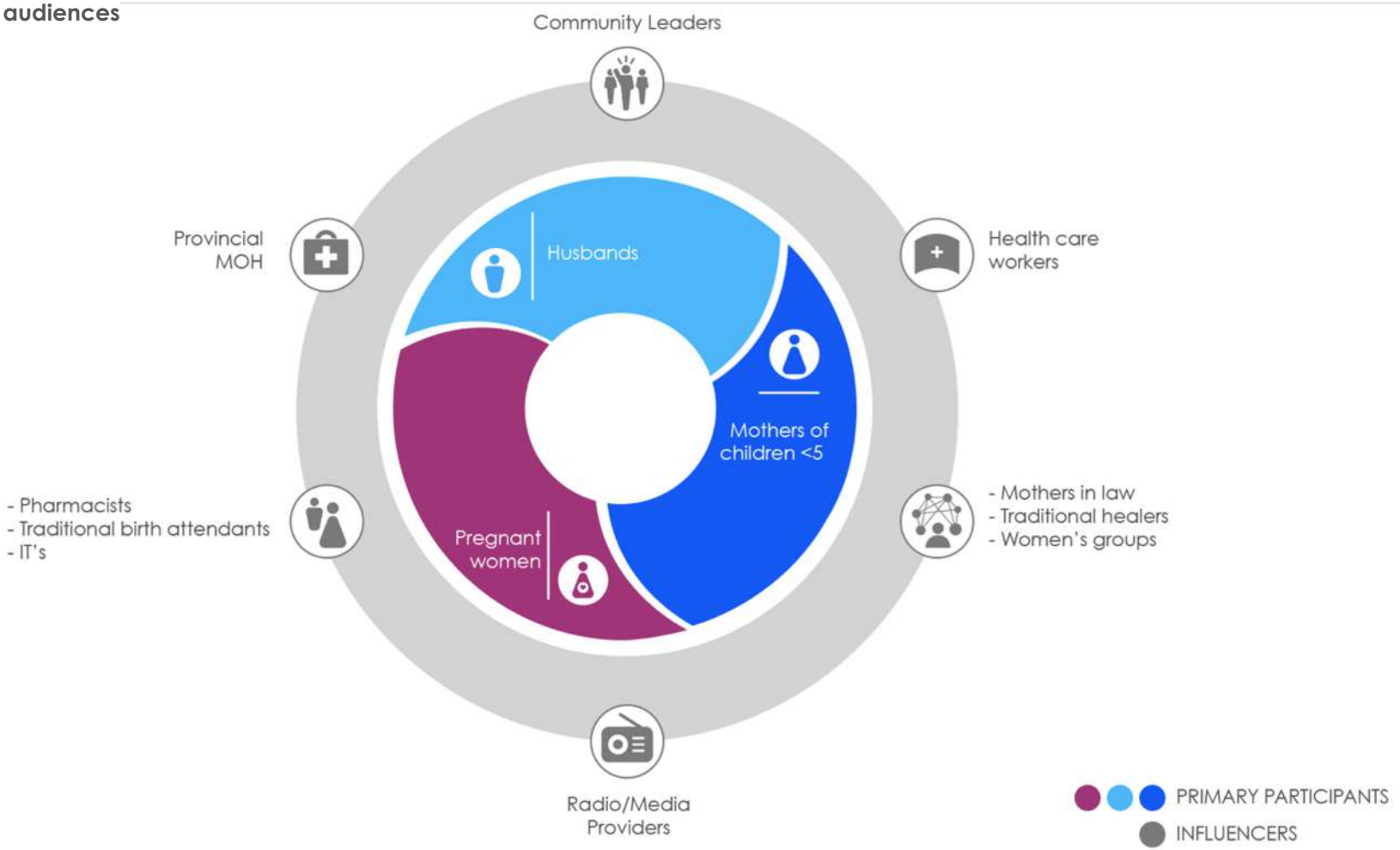
The Design & Test team consisted of the following individuals:

- **Breakthrough ACTION**
  Two lead designers (ThinkPlace US)
  Five members of the Breakthrough ACTION team
- **Ministry of Health**
  Three PNCPS members
- **Other partners**
  Three local partner NGOs

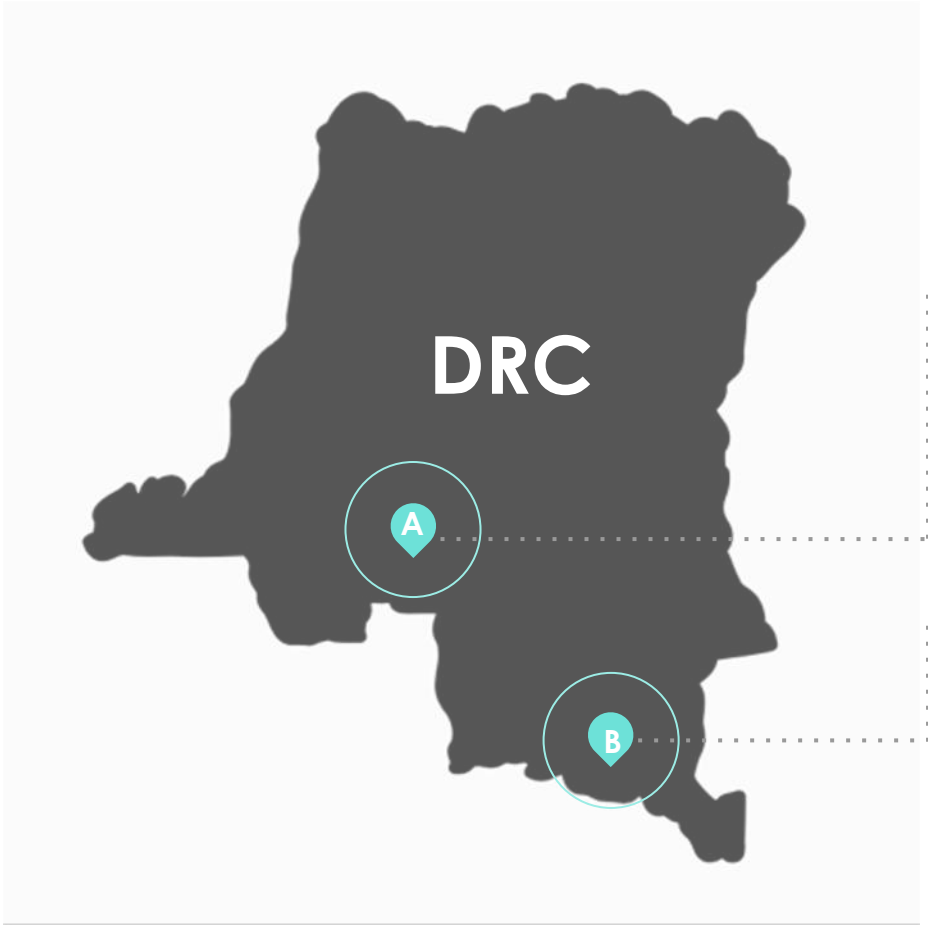
13 people

Participants

Target audiences



Geographic scope



Two teams made up of local, national, and international researchers conducted the second design sprint in Kasaï Oriental and Haut-Katanga. Successful solutions from Sprint 1 were exchanged among locations, meaning that prototypes that emerged and were tested in Kasai Oriental were tested during Sprint 2 in Haut Katanga and vice versa:

The Design & Test Phase II of the project was conducted in:

A Kasaï Oriental (Mbuji-Mayi area)

- Bibanga (Rural)
- Kabeya Kamuanga (Rural)
- Tshishimbi (Peri Urban)
- Bonzola (Urban)
- Bipemba (Urban)

279
Users reached

B Haut-Katanga (Lubumbashi area)

- Kilongo (Rural)
- Lumata (Rural)
- Malambwe (Rural)
- Mamba (Peri Urban)
- Munwa (Peri Urban)
- Panda (Peri Urban)
- Kikula (Urban)

427
Users reached

2. Design & Test Phase II: Results

dans les églises → pour un prix réduit des Soins au C.S.

Emission radio à téléphone ouverte pour dire entre l'inconvenient/conséquences de l'auto-médication

GROUPE 10

① PROJECTION DES FILMS EDUCATIVES SUR LA CONDOM

② FORCE SANTÉ (ACTIVITÉS DE RECREATIO

③ 8004 TAXI-ÉGLISE

Selections ♡

① Kit de BPM + projet de films → signes de dangers

② Taxi eglise pour aider à transporter les FE + les malades au C.S.

③ Quiz au marché sur les signes de danger avec un prix de consolation gratuite.

④ Fete pour les couples, ser

Behavior and health outcome indicators

After the first phase of Design & Test in which 19 interventions were tested across both selected provinces, results were evaluated and mapped with the different Breakthrough ACTION's behavior and health outcome indicators to prioritize the ones that had the biggest potential of impacting positively the project's results. Since the first phase was focused on understanding the desirability level of the different prototypes, feasibility constraints were overlooked and reserved for Phase II in which different aspects related to project's resources were deeply analyzed.

IMPROVE EHHP

- % Married women using any modern method of contraception.
- % Children age 12-23 months who received all basic vaccinations.
- % Pregnant women attending at least 4 antenatal visits with a skilled provider from USG-supported health facilities.
- % Children 0-59 months who slept under an Insecticide treated net (ITN) the previous night.
- % Children 12-23 months of age who received measles vaccine from USG-supported programs.
- % Children under 6 months living with the mother who are exclusively breastfed.

IMPROVE HEALTH CARE SEEKING

- % Children 0-59 months of age for whom treatment/advice was sought for acute respiratory infection.
- % Children 0-59 months for whom treatment/advice was sought for diarrhea.
- % Children under 5 years of age for whom treatment/advice was sought for fever.
- % Individuals reporting satisfaction with health center services.
- % Stakeholders who agree that their views are reflected in planning/policy processes.
- % Population who use selected facilities.
- % Population reporting improved availability of selected services *available at health facilities.*
- % Target population who report that they are able to access the basic health services available to their community.
- % Citizens reporting improvement and equity in service delivery of local level institutions with USG assistance.
- % USG-supported health zones that demonstrate improvement in key accelerator behavior indicators.

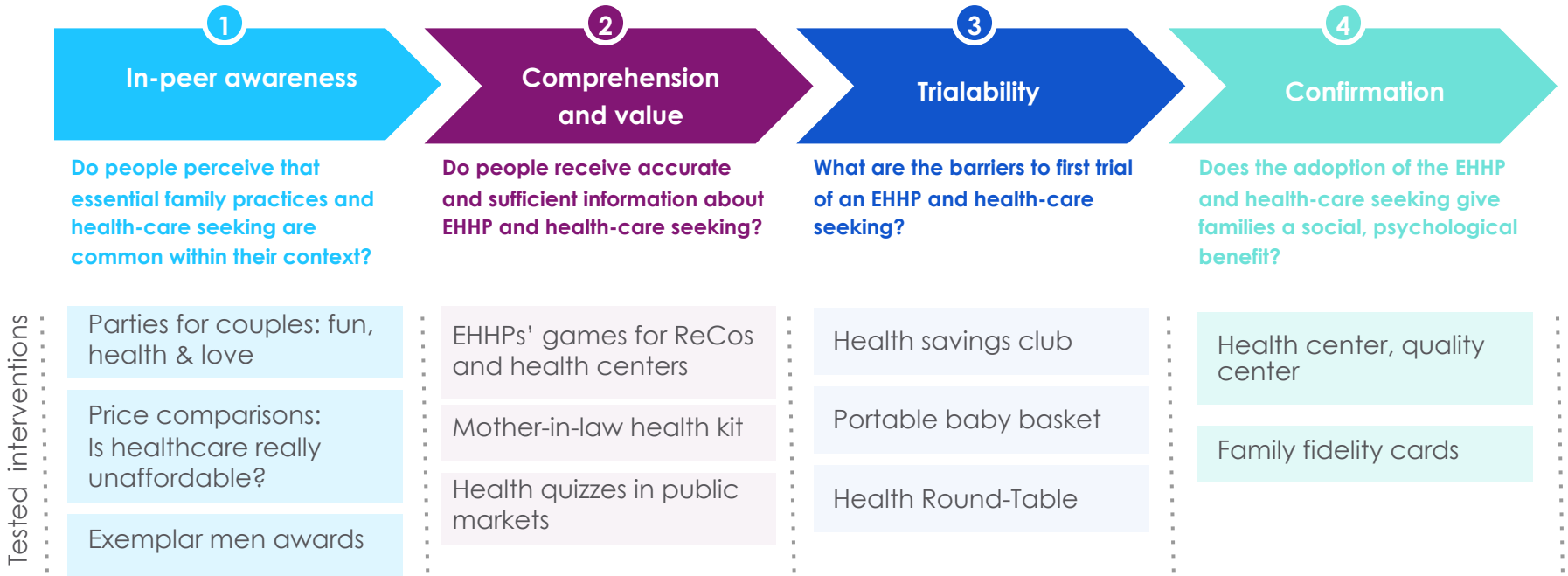
Prioritized prototypes for Phase II vs. indicators

How does the prototype address the design challenge?

PROTOTYPE	IMPROVE EHHP	IMPROVE HEALTH CARE SEEKING
1 Parties for couples: fun, health & love	●	●
2 Price comparisons: Is healthcare really unaffordable?		●
3 Exemplar men awards	●	●
4 EHHPs' games for ReCos and health centers	●	
5 Mother-in-law health kit	●	●
6 Health quizzes in public markets	●	●
7 Health savings club		●
8 Portable baby basket	●	
9 Health Round-Table		●
10 Health center, quality center		●
11 Family fidelity cards		●

Individual adoption model and tested interventions on Phase II

To ensure short, mid and long- term objectives are reached through this HCD process, the team made sure that the suite of selected prototypes were not only targeting one or two specific phases in the individual adoption model of a new behavior. Instead, prototypes to be re tested during Phase II were carefully selected to ensure a holistic suite of prototypes to decrease the risk of having too many interventions focused for example only in trialability without building enough in-peer awareness of the different behaviors. In case one of the prototypes failed, it had at least one other option for the same stage that achieve better results.



1 Parties for couples: fun, health & love

Public event targeting married couples lead by an animator and ITs or RECOs. The party is a moment in which couples are invited to share time together while participating in general knowledge contests against other couples. Questions during the contest are related with health issues but also with topics in which both of them can contribute with their answers. The event is open to other couples who want to participate as observers and also learn from the contest.

1 Parties for couples: fun, health & love

Prototyping

This concept was comprised of the following components,

Human resources (per testing site)

1 person to prepare logistics (venue set up)
1 ReCo
1 community agent
1 facilitator/animator
1 evaluator

Material resources (per testing site)

60 printed invitations
10 certificates
20 heart necklaces (made of paper)
Questionnaires and score sheets
1 Microphone / Megaphone and music player
Prizes (1 radio, 24 soaps)

Total cost (per testing site) = $60

Adjustments from Phase I

How was this concept refined based on the results of the first test phase?

- The couples that were participating in the contest were not mobilized but selected with two questions during the party.
- Two sets of questions were used during the test: one set with closed questions strictly related to health and another set of open questions related to everyday life and the couples' knowledge about each other. For each set, 5 questions were asked to each couple.
- A score sheet allowed the team to keep track of each couple's answers and made the winners designation easier.

Testing sites Phase II

The test took place in 2 different urban locations: Panda (Likassi) Ruashi (Lubumbashi).

1 Parties for couples: fun, health & love

Results

94 people attended the party

18 couples participated in the health contest

95% of participating men recognized that they should talk more about health care and household matters with their wives.

100% of participating men committed to going to the ANC with their wives and inform themselves on childbirth.

Within the community, ReCos reported several couples asked them for the dates of the next party.

What worked well

- The audience was actively engaged in the activity and asked lots of questions on health.
- Having the event in an open-air venue allowed for good interactions between participating couples and the audience.
- The couples were happy to play and hugged and kissed in public when they had correct answers.

Having a good sound system and an animator was important to keep the audience and the participants engaged.

Some of the closed questions on health were difficult for most couples to answer which proved the need to provide accurate health information to couples.

What did not work

- The first attempt to conduct the activity on a Wednesday in Ruashi failed due to the low availability of men, who were working. The event was then rescheduled to a Saturday afternoon.
- In the majority of couples, the men gave the answer without asking his wife and the moderator had to remind them several times to discuss the answers. In the case where the husband gave a wrong answer, none of the wives dared giving a different one.
- People generally arrived very late to the event.

1 Parties for couples: fun, health & love

Key learnings and recommendations

Add family planning private counseling
As the party will be joined by couples, it is a perfect opportunity to provide them with more information about family planning. Therefore, a nurse and a private tent or a discreet place within the event location can be adjusted to the intervention to provide counseling and methods if possible. From user's feedback, the information delivered on family planning was the one they found the most interesting as they learned new things about birth spacing and limiting the number of children.

The event provides an efficient framework for couples to dialogue while learning about EHHPs and improves shared decision making within the household
Targeting the intervention to married couples demonstrated the need of addressing their internal dynamics as there is a profound lack of dialogue and a clear authority of men over their wives. Women who were interviewed a month after the party mentioned having had a positive experience during and after the event. They appreciated having a moment of fun with their partners and confirmed that the event triggered a conversation within their household about the need for more dialogue for the benefit of the whole family.

Resource intensive intervention
It is recommended that people who will be implementing this intervention have previous experience organizing events.

Guarantee follow-up
Sufficient follow-up should be applied to guarantee that the indicators are reached. For example, providing family planning methods during the party could increase the uptake immediately and ease the measurement of the indicator.

Adaptation is key
The parties were relevant in both provinces. However, cultural differences within other provinces have to be considered when designing the questionnaires, especially in rural areas.

2 Price comparisons: Is healthcare really unaffordable?

This prototype uses a comparison between the price of non-essential items usually purchased in everyday life and the cost of key health services delivered by health centers. The objective is to raise awareness among the community on the accessibility of healthcare services that compared to some expenses are not at all expensive, given the benefit to get proper healthcare in case of symptoms like fever, cough or diarrhea.

2 Price comparisons: Is healthcare really unaffordable?

Prototyping

This concept was comprised of the following components,

Human resources (per testing site)
1 graphic designer
1 ReCo
1 Market Manager
1 Activity leader

Material resources (per testing site)
1 PVC poster
6 batteries
1 Megaphone

Total cost (per testing site) = $115
Printing = $73
Megaphone & batteries = $32
Mobilization cost = $10 x ReCo

Adjustments from Phase I

How was this concept refined based on the results of the first test phase?

- On the poster, healthcare items were illustrated by pictograms in addition to the title.
- The size of the poster was increased to 80 x 120 cm
- Soaps were given away to the best respondents and awareness on the importance of hygiene, hand washing and healthcare-seeking was raised just after the activity.
- The activity was framed as a game which consisted of inviting participants to identify the item which price was the closest to the health service featured on the poster and place side nearby, triggering discussions on costs and spending, and the relation to healthcare in the community.
- The activity took place in public markets

Testing sites Phase II

The test took place in 3 different locations in Haut Katanga: Panda, Lumata and Malambwe.

2 Price comparisons: Is healthcare really unaffordable?

Results

145 people participated in the activity, including pregnant women, mothers, and men.

Further testing should be conducted to ensure the behavior change capabilities of this intervention.

What worked well

- The recognition of the importance of prioritizing healthcare-seeking was high.
- Participants and attendees asked multiple questions to better understand essential family practices and the interaction was positive.
- Participants suggested new items that could be used to build price comparisons like caps, men shirts and trousers, wigs and make-up.
- The question of savings was brought up by several participants: some suggested that as they were going to reduce their comfort expenses, they could do it on a regular basis and save this money for emergency healthcare seeking.

What did not work

- Selected villages had very small markets (less than 30m2) so the number of attendees to the event was not as high as expected and the space was limited.
- ReCos are not known by the market women and therefore had difficulties mobilizing and engaging them at the beginning.
- The rules of the game were difficult to understand at the beginning and had to be explained at least twice, with various examples.

2 Price comparisons: Is healthcare really unaffordable?

Key learnings and recommendations

This intervention has the potential of becoming a mass media campaign
This prototype tackles an important insight uncovered during the discovery phase related to price uncertainty and lack of importance of healthcare-seeking from users due to the "lack" of financial means. However, the way in which the intervention has been prototyped incurred into logistical and financial considerations that might decrease its impact. A mass communication campaign with this subject could increase the reach and the adaptation needed of the intervention among provinces be related mostly with language.

Effective for awareness raising
This prototype was effective in raising awareness on the importance of healthcare-seeking by demonstrating to the community that healthcare is not as expensive as they thought and is affordable to all if they prioritize it and trade some unnecessary purchases with health care. This activity could be combined with other prototypes to increase its reach or developed as a tool for ReCos. The game was a good opportunity for further explanations on key preventive behaviors related to breastfeeding, impregnated bed nets usage and hand washing but price comparisons were difficult to understand at the beginning because people were not used to it.

Merging possibilities:

- Health savings club
- EHHPs' games for ReCos and health centers

Afia m[illegible]

TARIFS DES SOIN

LES SOINS	PRIX (FC)	EQUIVALENTS
Consultation/fiche	2000FC	
CPN (Kipimo ya mama na nimba)	500 FC	
Accouchement (Voie basse)	6.500 FC	
Accouchement (Césarienne)	300.000 FC	
CPS (Kipimo pesée)	500 F	

3 Exemplar men awards

Recognition to men who accompanies his wife to the 4 ANC visits before delivery, joins her for the delivery at the health facility level and whose child finishes his vaccination schedule.

3 Exemplar men awards

Prototyping

This concept was comprised of the following components,

Human resources (per testing site)
1 ReCo
1 AC
1 IT

Material resources (per testing site)
1 register to track men's visits
1 radio + batteries as prize
1 megaphone for the mobilization + batteries

Total cost (per testing site) = $84
Mobilization cost = $10 per ReCo
Megaphone + batteries = $32
4 Radios (prizes) = $10 x 4 = $40
1 register sheet = $2

Adjustments from Phase I

How was this concept refined based on the results of the first test phase?

- A register sheet to track men's visits was added to the concept and left at the health center.
- A more detailed briefing presentation was done with the ITs, who received a document explaining the concept and their role, then the same was done with the ReCos.
- The intervention was tested for a longer period of time: 4 weeks.

Testing sites Phase II

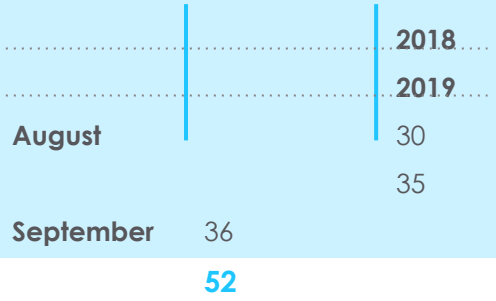
The test took place in 2 different rural locations (Kilongo and Malambwe) in two health centers in Haut Katanga.

3 Exemplar men awards

Results

All health centers confirmed an increase in men's presence at the ANC or for consultations with their partners and/or children, during the testing period.

None of the ITs recorded the names of the husbands who went to the health center with their wife, so the awarding ceremony did not take place. However, in Kilongo there was a clear increase in men's attendance to the ANC appointments:



What worked well

- The number of men attending the consultations with their wives significantly increased compared to SPLY and the previous month.
- Interviewed men confirmed that they learned things about pregnancy and childbirth that they did not know before.
  "Now I understand better what my wife goes through to give birth to our children"
- One of the men declared that he was also surprised by the affordability of the ANC and consultation at the health center.
  "This information encourages me to bring my children when they present symptoms like fever, cough and diarrhea"

What did not work

- The ITs did not play their role and therefore impeded the prototype to be tested as planned.
- The improvement of the quality of service delivery could help encourage men to come more often with their wives at the health center, if the waiting time is not too long or the ANC takes place out of working hours.
  Unfortunately, only one out of the two health centers visited was ready to adjust the time of the ANCs to accommodate men.

3 Exemplar men awards

Key learnings and recommendations

Health workers need to be trained on how to attend couples during ANC appointments
The kind of information that is being provided during each ANC appointment is crucial to ensure both men and women return to the next appointment. Therefore, it is important to train health workers and produce supporting materials that can interest men too regarding pregnancy, childbirth and other subjects usually discussed during ANCs, so as to be relevant to them and get them more involved alongside their wives.

Low-cost intervention and high increase in men's involvement
The prototype could be implemented in other provinces in the DRC due to the facility of implementation. Multiple competitions can be held per month needing only small recognition for men (which can be diplomas acknowledging his role as a responsible household head).

Among the participants of the competition during the first testing phase, there were some community leaders that also suggested that they could help spreading the message around the community and sharing their experience with others through churches or community meetings to encourage more men to participate and be involved.

Traditional beliefs regarding the presence of men at childbirth
This issue came up during the second phase of testing in Haut Katanga. Further inquiry is needed to understand the viability of promoting the presence of men at childbirth.

4 EHHPs' games for ReCos and health centers

A series of games to convey key health messages among the community. Men and women are encouraged to share playful moments while learning about the importance of malaria prevention through the systematic use of impregnated bed nets, exclusive breastfeeding practices, handwashing practices and health-care seeking. The games are designed for RECOs to be used in their outreach strategies, and at health centers during waiting times.

4 EHHPs' games for ReCos and health centers

Prototyping

This concept was comprised of the following components,

Human resources (per testing site)
1 ReCo for mobilization
1 IT
1 AC
12 users (4 pregnant women, 4 mothers of children under five, 4 fathers of children under five)

Material resources (per testing site)
3 printed sets of card games

Total cost (x3 sets of games) = $11

Adjustments from Phase I

How was this concept refined based on the results of the first test phase?

- The games were tested at health facilities and immediate feedback was gathered by the team.
- Two teams were randomly created during the test, making sure there were mixed groups of users.
- The testing process involved ReCos, health providers and users.
- Two new games were created in addition to Kilaku (the game that was tested during Phase I). The three prototyped games were :
    - Kilaku, a memory game with different EHHP
    - Charades for EHHP and health-care seeking
    - EHHP and health care seeking Q&A's card game

Testing sites Phase II

The test took place in 2 different locations in Kasai Oriental: Kabeya Kamuanga (rural) and Bipemba (urban)

4 EHHPs' games for ReCos and health centers

Results

91% of participants reported learning new things about EHHPs and health care seeking through the dynamic games. Most of the key learnings were acquired through the EHHP and health care seeking Q&A's card game.

100% reported being willing to play the games again either at health centers or at their own houses.

The competition aspect of the games improves the continuous engagement of participants.

What worked well

- The games were tested in two different locations. During the first prototype, they were played in a private space and the second, at the front entrance of a health center. Understanding of the games and the EHHPs were better during the first test since participants did not have external distractions.
- The games and answers provided by participants evidenced a lack of knowledge and misunderstanding of several EHHPs.
- Waiting time at health centers are key intervention points in which ReCos or other health professionals could engage users.

There was a good disposition to play and engage with the game among all age groups.

What did not work

- Instructions were too complex and difficult to understand for most participants. It is important to simplify the games and their instructions according to people's literacy rates.
- Teams that will be implementing the games should have played each of them before putting them in practice with real users.
- Even though teams were mixed between men and women, the understanding of some concepts and information can be better explained among groups of only men and only women.

4 EHHPs' games for ReCos and health centers

Key learnings and recommendations

There are critical insights being tackled through this intervention
These series of games proved the importance of addressing lack of knowledge in users to allow them to comprehend the value of health care seeking and practicing the different EHHPs. Due to answers and interactions had during the games ignorance became evident.

There is a lack of accurate information on EHHPs, especially in remote rural areas, and the RECOs are not sufficiently trained on those practices
Most of the games were initially conceived as being tools for households. However, during the continuous testing in both provinces, it became clear it is important to explain the "Why" behind the recommendations because most of the users have previous misconceptions about some of the practices but claimed not applying them because they did not understand the reason behind it. Similarly, ReCos sometimes are not well trained and some of the questions that were included in the games were also new to them.

Add different games or create quarterly games with different health topics
In order to keep the simplicity of the intervention, there can be different set of questions that are updated for each game or topics that are talked about with each game. Even a yearly package of games can be designed for each health zone and distributed during different briefing sessions to ReCos and health centers.


Soins Appropriés pour les
Familles et les Enfants(SAFE)
en R.D. Congo
USAID

5 Mother-in-law health kit

The kit aims to provide information and facilitate the process of behavioral change for the mothers-in-law and young mothers. Two variations of the kits were designed. The first one consisted of a full kit of explanatory cards about what to do at home in case a baby presents fever, diarrhea or cough and also about EHHP, together with the necessary elements and detailed visual instructions to prepare hydrating serums, cough remedies and medicines for the baby in case of emergency. The second variation only included the explanatory cards but no material objects (such as soap, salt, cups, etc.)

5 Mother-in-law health kit

Prototyping

This concept was comprised of the following components,

Human resources (per testing site)

10 women with a grandchild under five and who live with their sons
1 AC
1 IT
1 MCZ

Material resources (per kit)

1 lt bottle to prepare and keep oral rehydration solutions
1 small plastic cups
1 package of sugar and 10 package of salt
1 soap
10 tablets of Paracetamol
10 oral serum sachets
1 teaspoon
200 gr of honey
4 EHHPs cards
4 Danger signs cards

Total cost per kit (complete kit) = $8.5
Total cost per kit (kit with only the cards) = $6

Adjustments from Phase I

How was this concept refined based on the results of the first test phase?

- Instead of building small cards, cards were printed in A4 format and one sided.
- An exclusive breastfeeding card was included
- Milk-expressing was added to briefing sessions

Testing sites Phase II

The test took place in 2 different locations in Kasai Oriental: Bibanga (rural) and Tshishimbi (peri-urban)

5 Mother-in-law health kit

Results

In average, each mother-in-law used the kit **2** times during a three week period. The utilisation rate was higher in the rural setting (2.4 average times used vs 1.4 in peri-urban setting).

100% of the women reported an increase in the number of breastfeeding times per day of their in-laws and a decrease in complementary feeding practices.

In Bibanga, **90%** of the women who received the kit used it and renewed the used material components.

Briefing sessions lasted around 1.5 hours. However, the users mentioned that for them that was positive because they could solve all the questions they had about the kit.

What worked well

- Similarly to phase I, mothers in law were actively engaged during the briefing sessions and appreciated receiving new information and their kits.
- There was a strategic identification of the mothers-in-law. It was critical that they lived with their son and he had at least one child under five.
- To facilitate the clear understanding from users during the briefing session, a question and answer exercise was facilitated to understand engagement and desire of the solution.
- Enlarging the cards and transforming some text into visual icons or illustrations helped reduce illiteracy barriers, especially in the rural setting.

What did not work

- Some women who received the complete kit used the bag of the kit for other purposes and put the content of the kit in a regular plastic bag.
- The team was not able to visit the houses of the different women to confirm if they actually pasted or hanged their cards in a visible place.

5 Mother-in-law health kit

Key learnings and recommendations

Providing the material resources in the kit made that women used it more often
During the second testing phase, women from rural areas reported using their kits more frequently than the ones in peri-urban settings. This was mostly since in rural areas women received the complete kit and in peri-urban settings, women received only the printed cards making it hard for them to find the resources to build their own kit.

Targeting mothers-in-law is critical
In rural or less developed regions, they are often responsible for the family of their sons. As their sons go looking for work, diamonds, money, they leave their young wives and mothers to manage the family on a daily basis. In many cases mothers-in-law advice from an ignorant perspective putting in danger babies' and their in law's health. Giving them accurate information is crucial and highly requested.

Tackling ignorance from the influencers' perspective
In rural or less developed regions, young mothers are victims of ignorance. Due to the fact that most of them leave school once they get married or pregnant, mothers-in-law are their primary influencer in issues relating pregnancy, breastfeeding and health-care seeking. Particularly, women did not know about the possibility of expressing milk and suggested adding a card that explained the process and options. The kits help decreasing the practice of old behaviors that can affect the baby's health.

Add call-to-actions to the strategy
In order to guarantee that behaviors associated to this strategy are appropriately improved they have to be measured. Different call to actions can be included in the kit to be able to measure if consultation levels increase as well as the practice of EHHP with the utilisation of the kit and if the EHHPs.


DIENZA DIA
SERUM
SUSPENSION
Colorful

6 Health quizzes in public markets

A series of short quizzes that take place in markets. Since many women have stalls and sell their products in the markets, for many of them it is difficult to obtain information about EHHP. These quizzes facilitate the diffusion of information in a didactic way, allowing women who sell things in the market and also women who go shopping, to participate and learn without having to travel anywhere they would not have to. Quizzes are done orally to avoid barriers of illiteracy. The announcement of the winner is to be done publicly so that winners are recognized by others and they will be awarded a free consultation coupon in the closest health center.

6 Health quizzes in public markets

Prototyping

This concept was comprised of the following components,

Human resources (per testing site)
1 ReCo for the mobilization
1 Market manager for authorizations and mobilization
1 activity leader to coordinate the game, ask the questions and provide answers and explanations
1 note taker to keep track of the participants' answers

Material resources (per testing site)
1 printed questionnaire + 1 score sheet
2 megaphones + 24 batteries
Prizes: 15 soaps + 3 consultation coupons

Total cost (per testing site) = $107.5
Megaphones = $60
Batteries = $7,5
Prizes = $10
Hand washing kit = $20
Mobilization cost (ReCo fee) = $10 per ReCo

Adjustments from Phase I

How was this concept refined based on the results of the first test phase?

- ReCos were involved in the creation of the questionnaires as suggested.
- The quizzes were developed with multiple choice answers and not open questions.
- The prize given to the winner was a reduction coupon but not a free consultation, due to difficulties negotiating with the health center.
- A score sheet was provided to the ReCo to keep track of the participants' answers.
- Additional questions were added to the questionnaires in case of a tie.
- A hand washing kit was taken to the market for a demonstration at the end of the game and each participant was given a soap. The handwashing kit was left to the market manager to be placed at a strategic point in the market.

Testing sites Phase II

The test took place in 4 different locations: Zambia Market (urban), Kikula Market (urban), Karavia Market (peri-urban), and Kilongo Market (rural).

6 Health quizzes in public markets

Results

65 users participated in the quizzes, of which 49 were women (28 pregnant women + 20 breastfeeding women + 1 mother-in-law) and 16 men.

204 people witnessed the quizzes in the different markets.

13 coupons with a 1000 FC reduction were distributed + 70 soaps.

100% of interviewed users (after 1 month) declared to have talked about the activity and what they have learned to at least 4 people and up to 15.

What worked well

- Across all target audiences, the recall of the activity was high. Top of mind topics were hands washing, sleeping under an ITN and the importance of going immediately to the health center in case of fever and cough.
- The market women were very happy to benefit from information on healthcare and EHHPs that they never had before. ***"We are pleased that for the first time someone cares about us; we have learned a lot of new things today, thank you"***
- The handwashing kit and the soaps were highly appreciated because women spend the whole day at their selling stands with no possibility for them to wash their hands, even after going to the toilets. ***"I didn't know that handwashing was so important"***

What did not work

- The ReCos were not known in the markets because they never work there, so the upfront mobilization was not as high as expected and the market manager was key in finally mobilizing the women.
- The relatively low attendance in small markets (rural places) was mostly due to a lack of space.

6 Health quizzes in public markets

Key learnings and recommendations

Markets are critical and strategic intervention points
Men and women who work in markets are never visited by the ReCos or other health-related interventions. This intervention can be adapted anywhere in the DRC as long as there is an open market. Open markets are a key contact point for older and younger women even in the remote villages,

Key intervention to increase awareness but there are service delivery improvements to be done
In rural areas, the community does not go more often to the health center for healthcare because they don't receive a good level of service: the centers are dirty, the health workers are unfriendly and most of the time they don't have the necessary cure packages.

Weekly/monthly thematic quizzes
Instead of applying quizzes with questions about different EHHP, there can be weeks or months in which the theme is a specific EHHP related to the outcome indicators. Along with this intervention, health workers could go to the market to provide basic services to women like baby weighting, pregnancy and baby care advice, household hygiene principles, etc.

Conduct briefing sessions for ReCos
It is necessary to empower ReCos and Market Managers with the intervention and involve them as early as possible as they are critical for its success.

7 Health savings club

A structural solution to allow couples to learn to set savings goals and to distinguish between emergency expenses and planned ones. The strategy tackles the resistance of healthcare-seeking due to financial constraints by providing microfinance briefings, individual savings commitments and two saving boxes, one specifically for health services and another one for other household objectives.

7 Health savings club

Prototyping

This concept was comprised of the following components,

Human resources
1 microfinance expert to provide a savings briefing
15 married couples
10 married women
5 married men

Material resources
30 saving boxes for health
30 saving boxes for general needs in the household
30 commitment/agreement sheets
Register sheets to monitor savings

Total cost (per person/couple) = $3
Saving boxes x 2= $2.5
Printed agreement = $0.5

Adjustments from Phase I

How was this concept refined based on the results of the first test phase?

- Tested with couples instead of men and women separately to prevent discussions and issues in households. This issue was reported during phase I as a possible problem if saving boxes were given to only one member of the household.
- Plastic saving bottles were refined and transformed into wooden saving boxes. 60 boxes were built locally in MBM by a carpenter and the cost of each box was $1.
- An agreement was signed by each person and couple that received the saving boxes. Each one made an individual commitment to save a certain amount of money per day/week. This amount changed between participants as they had different income levels.
- 100% of the people who signed-up to be part of the club and received their boxes were gathered 3 weeks after the distribution to make sure saving commitments were achieved or not.
- ReCos were not involved in measuring the saving levels of participants, only the Design & Test team.

Testing sites Phase II

The test took place in 2 different locations in Kasai Oriental: Bibanga (Rural) and Tshishimbi (Peri-Urban)

7 Health savings club

Results

30/30 of mobilized participants signed-up to be part of the savings club. **100%** of them (couples and individuals) saved money in both saving boxes.

575 FC were saved on average per day in Bibanga - **rural** (690 FC for healthcare, 460 for household), for a total of 11,500 FC ($7.2) for health and 8,240 FC ($5.2) for household in a three-week period.

430 FC were saved on average per day in Tshishimbi - **periurban** (460 FC for healthcare, 400 FC for household), for of total of 9200 FC ($5.5) for health and 7200 FC (4,4$) for household in a three-week period.

What worked well

- Using storytelling during the microfinance briefing with examples of real people (people who have fixed salaries paid at the end of the month vs. people who get paid daily).
- Providing users with two different saving boxes.
- Enrolling couples together instead of individually men and women. None of the couples took used their savings during the 3 weeks of testing.
- The amounts saved in each box showed that healthcare is more valued than household objectives. Healthcare savings were not used (except by one) while household savings were used by 4 people.

What did not work

- Briefing sessions lasted 1.5 hours. This made it hard for people to stay focused.
- Not having graphic support to visualize saving efforts in the future during briefing sessions.
- Not giving users a way to track their savings or nudges to save each day.

7 Health savings club

Key learnings and recommendations

Nudging and tracking
As most of the users did not report having any saving habits, to ensure the success of this intervention certain follow-up mechanisms and daily/weekly reminders should be sent to users until saving is perceived as a routinely practice. It might be interesting to engage other Breakthrough ACTION partners, such as VIAMO. In this case a SMS strategy can be designed to provide users with updated information on their savings (if they saved the amounts they initially committed to) and frequent reminders.

Vision and future envisioning is challenging
Objective setting during the briefing sessions was challenging. Even though it is an important part of a savings strategy, participants did not seem to interiorize this task.

Designing tools and support materials for briefing sessions
It is necessary to equip the strategy with didactic materials that can make the understanding of the strategy easier for populations of low educational levels.

Two saving boxes instead of one
Equipping the intervention with one saving box specifically for healthcare seeking is crucial. This demonstrated being an effective way to prevent people spending their savings.


DILAMA DIA MAKUÏA
BUA BUÑOLA BUA MUBIDI
USAID
DILAMA DIA MAKUÏA
BUA BUÑOLA BUA DIKU
USAID
USAID

8 Portable baby basket

A basket designed with locally sourced materials equipped with an impregnated mosquito net to allow mothers of children under six months to take their babies along with them to fields, markets, etc. in order to be able to breastfeed them during the day while protecting them from bites, snakes and the sun.

8 Portable baby basket

Prototyping

This concept was comprised of the following components,

Human resources (per testing site)
1 ReCo for the mobilization
1 Team member to explain the importance of exclusive breastfeeding and explain the intervention
10 mothers of children under-five

Material resources (per testing site)
10 plastic basins (10-15 Lts)
10 small bed nets with an adjustable elastic

Total cost (per baby basket) = $7.45

Adjustments from Phase I

How was this concept refined based on the results of the first test phase?

- Custom-made bed nets with adjustable elastics were manufactured in Kinshasa.
- During the briefing, there was a short session on how to keep safe and clean the bed nets from the baby baskets.

Testing sites Phase II

The test took place in 2 different locations: Kabeya Kamuanga (rural) and Tshishimbi (peri-urban).

8 Portable baby basket

Results

On average, during a two-week period the baby baskets were used in **8** days. The woman who used it the most reported using it every day for two weeks and the woman who used it the least mentioned using it in 3 days.

On average, the baby basket was used during **4** nights per week, allowing babies to sleep safely under an ITN. Results were similar between urban and peri-urban settings.

100% of women reported increasing the number of times they breastfed their babies during the three weeks of testing. There was a larger increase in the rural setting vs. the peri-urban setting.

What worked well

- Differently from Phase I, after three weeks of use, the nets of the baby baskets were well preserved and clean.
- This is a cost-effective intervention with locally sourced materials. Costs can be reduced more if purchasing bigger amounts or if women are encouraged to use their own baskets.
- According to women, having RecOs frequently nudging women to use the baskets helped them remember the importance of using it for their own comfort and the benefit of their children.
- Prior to the briefing and distribution sessions, most women reported not knowing the importance of exclusive breastfeeding.

What did not work

- The briefing and the distribution of the baby baskets were done at two different health centers. This affected negatively the way in which women responded to their actual breastfeeding practices as they were afraid health providers would be upset due to their bad responses. For next iterations, it is suggested that these sessions are reserved to the community level.
- The interior of the basket was uncomfortable for many babies.

8 Portable baby basket

Key learnings and recommendations

The challenge is not improving breastfeeding but preventing complementary feeding before 6 months of age
During the briefing and distribution sessions, women were asked about their daily breastfeeding practices. Some women mentioned having challenges breastfeeding their babies when they had to go to work, so they usually decide to leave their babies with other family members or older children. Since they are not able to provide breast milk to the baby they give regular food to the baby and this is not perceived as a problem. Ignorance of the importance of exclusive breastfeeding for the first 6 months and the indifference to the risk of not breastfeeding exclusively, allows the proliferation of false beliefs about infant nutrition within the community.

In addition to improving breastfeeding practices, the baby basket also prevents malaria cases

Add other components to the basket to create an integrated intervention
There are challenges to be targeted with this intervention. Firstly, women should be able to understand why is exclusive breastfeeding fundamental for their babies' growth to ensure the use of baby baskets. Hygiene practices relating to breastfeeding are ignored and/or unknown, These along with other complementary information relating how to appropriately take care of the net, wash it and restore it is key.

Map out and design the baskets' strategy, from fabrication to distribution and reparation
To prevent gaps in the product distribution process, it is necessary to map the different resources needed in each stage of the product cycle to identify different ways to optimize the resources of the strategy.

Do-it-yourself portable baby basket sessions
These sessions can be key to the sustainability of the solution in the long term.


mars
journée de la fe

9 Health Round-Table —

This concept brings together the community influencers and the health workers to gain a better understanding of each other's role regarding health care, and create a frame of collaboration for the traditional healers and religious leaders to systematically refer their clients to the health center when they present symptoms like fever, cough and diarrhea. Each influencer receives a number of discount coupons to distribute among their clients for services at the health center.

9 Health round-table

Prototyping

This concept was comprised of the following components,

Human resources (per testing site)

1 ReCo for the mobilization of influencers
1 Community Agent (AC) to take care of the logistics
1 health center manager to host the meeting
1 health worker (IT)
1 head of Health Zone to validate the idea
1 moderator to facilitate the discussion
3-5 traditional healers
3-5 religious leaders
3-5 pharmacists
3-5 community leaders

Material resources (per testing site)

1 discussion guide
200 discount coupons

Total cost (per testing site) = $229 (printing and mobilization)

Adjustments from Phase I

How was this concept refined based on the results of the first test phase?

- The round-table was extended to pharmacists and civil society representatives.
- The steering committee was constituted at the end of each meeting with a clear commitment from its participating members, and a planning for the next meetings was agreed.

Testing sites Phase II

The test took place in 6 different locations in Haut Katanga:

- Mamba Health Center in the suburban area of Ruashi
- Munua – Cité Karavia (Lubumbashi urban area)
- Kikula in the city of Likassi
- Kinsevere Health center in Kilongo (rural)
- Lumata (Kipushi Health Zone - rural)
- Malambwe (rural)

It was evaluated after a month, in 4 locations out of the 6

9 Health round-table

Results

122 people participated in the different round-tables, including traditional healers, religious leaders and other influencers.

12/170 discount coupons were used during a 4-week period, 2 of them from religious leaders, 4 from traditional healers and 6 from pharmacists.

34% was the average increase in the number of consultations of children under 5 from August 2019 to September 2019 in five of the six health centers that participated in the round-table.

What worked well

- All health centers confirmed an increase in the number of consultations during the month following the round-table.
- In Kilongo, the stakeholders held another meeting to pursue collaboration. In Lumata, the health center agreed to extend the price reduction to coupons made by the Recos for the community.
- In all locations, traditional healers, religious leaders and pharmacists claimed to have referred patients to the health center and were willing to continue.
  The coupons were well received as a means to encourage the influencers to refer their visitors to the health center.
- All health centers were happy to participate by giving a 1000 FC reduction on the price of the consultation, for a given period of time.
- All the traditional healers and religious leaders accepted to sign commitment forms agreeing to refer their clients to the health centers.

What did not work

- In some locations, it was difficult to have all the stakeholders at once. Traditional healers were the hardest to reach.
- The majority of health centers forgot to record the number of coupons used.
- Some stakeholders seemed to have misunderstood the coupon strategy. They did not understand the coupons were linked to a specific health center, so they did not refer their clients to the right facility.

9 Health round-table

Key learnings and recommendations

This prototype was well received in both provinces and was suggested to be an extension of the existing framework in Haut Katanga

Similar round-tables already exist in different communities in Haut-Katanga. These discussions aim at dealing with general community issues and include health workers, the CAC, the CODEV, the traditional chiefs, the religious leaders and NGOs/Associations. However, they do not address health matters specifically and usually do not include traditional healers nor the pharmacists.

The health centers were pointed out by influencers for their low quality of service delivery that they consider to be the main cause for the community not to seek healthcare

In both provinces this demonstrated being a challenge. According to the majority of the traditional healers, even when they recommended their visitors to go to the health centers, a lot refused by fear of a bad experience. Some also mentioned that they often receive patients that could not be healed at the health center and therefore turned to them for a solution.

The meetings triggered constructive discussions between the participants that had never had the opportunity to openly talk to each other about health

The influence from participants of the round-table in health care seeking in the DRC cannot be ignored. Even though these discussions represent a high effort in resources (time, money and human) these stakeholders could drastically improve health care seeking behaviors around the country. It would be useful to provide the traditional healers, religious leaders and pharmacy vendors with a list of arguments for them to talk the community into seeking healthcare without losing their credibility.

ReCos don't have enough leadership to bear the project on their own

Facilitators of the sessions should be senior people and well-respected in the community (i.e chief of villages)


1000

10 Health center, quality center

A health center evaluation system that allows the community, with the help of ReCos, to give their appraisal of the health facilities on the basis of three criteria: Politeness, availability and cleanliness in an anonymous way. These 3 criteria are represented by three compartments of a small portable box, accompanied by green, orange and red voting cards be used by the community to according to their most recent experience at the health center. The box is handled and kept by the ReCos. The boxes are opened at the end of each month, at the Health Zone's monthly meetings to lead to corrective measures in the health center.

10 Health center, quality center

Prototyping

This concept was comprised of the following components,

Human resources (per testing site)

10 ReCOs
2 AC
2 IT
2 MCZ

Material resources (per testing site)

10 wooden boxes with three separate chambers
10 padlocks
Paper of 3 different colors to cut for the "vote" of the members of the community
List of ReCos participating in the activity with their contact information
List of participants to give to each ReCo to contact members of the community during the evaluation of the prototype

Total cost (per testing site) = $50

Adjustments from Phase I

How was this concept refined based on the results of the first test phase?

- Boxes were refined and carefully built by a local carpenter in Kinshasa.
- Branded stickers and icons were designed and added to the voting boxes.
- Instead of only providing green and red cards, orange cards were introduced to make the evaluation less binary.
- ReCos were given a longer period of time to collect votes.

Testing sites Phase II

The test took place in 2 different locations in Kasai Oriental: Bonsola (urban) and Bibanga (rural)

10 Health center, quality center

Results

In both locations, ReCos were able to successfully collect the feedback from **100%** of the users they were tasked to.

1.5 days was the average time to collect 10 votes per ReCo.

10/10 of participating ReCos mentioned being interested in participating again in a similar intervention.

Health providers rated their engagement in improving their behaviors after being evaluated by users on a scale of 1 to 10, being 10 absolutely engaged. Their average engagement was **6.2** .

44% of participating health providers were not interested in being involved again in the evaluation.

What worked well

- ReCos were actively engaged in the evaluation strategy and agreed in the need of gathering anonymous feedback in the community.
- The prototype was able to gather the opinion of 100 people from the community in only 2 days. It is a simple concept easy to understand for users and ReCos.
- In general terms, the evaluation of both health centers in the three different categories was positive. In the rural health center, cleanliness, and welcomeness received some red votes, but the majority were green and orange.

What did not work

- The engagement of the AC, was positive in both health facilities, however the level of interest was very different in the rest of the staff. Some health providers mentioned that the strategy was interesting but to improve it would be needed an investment from the government in infrastructure and their salaries.
- There have been similar strategies previously implemented by Save the Children and the Ministry of Health.
- There was not enough time to measure if the different services improved at the health facility level and no specific criteria was built to evaluate improvement.

10 Health center, quality center

Key learnings and recommendations

There have been similar interventions implemented by Save the Children and the Ministry of Health
Although these types of strategies have been tried in the past and by other partners, this strategy is simpler and guarantees user privacy in the votes.

Introduce a recognition system for health centers that are able to improve their performance after the evaluation
The strategy was very well received on the demand side and for the users, it was positive to have the opportunity to give their opinion. However, things were not the same on the supply side. The health providers felt attacked and for the strategy to succeed it is necessary to empower them as agents of change and happiness in the community.

Personal commitments among health providers and other personnel in the health center
Such strategies cannot be forced to be implemented by health centers. Each health center must be aware of the benefits that a solution such as this can bring to them and its members must commit to improving the quality of the service in the three most important criteria for users: Cleaning, welcome and availability.

Implement a mechanism to accredit the best health centers and generate demand
As done previously in the DRC and in other neighboring countries this evaluation system can go hand in hand with a national accreditation system where health centers are encouraged to improve their services to be accredited.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KANEMU NE
(MUAKIDILU MULENGA)
MANKENDA

11 Family fidelity cards —

A loyalty scheme for the community to be encouraged to visit the health centers more often when needed, without constraining themselves because of the foreseen cost. The program creates a compelling link between the community and the health center. Loyalty cards are distributed by RECOs to families entitling them to a free medical consultation or ANC (which is previously approved by the health center) after 4 visits to the same health centre.

11 Family fidelity cards

Prototyping

This concept was comprised of the following components,

Human resources (per testing site)
3 ReCos
1 AC
1 IT
1 MCZ

Material resources (per testing site)
30 fidelity cards (each ReCo received 10)
List of participating ReCos
List of participants to give to each ReCo

Total cost (per testing site) = $17

Adjustments from Phase I

How was this concept refined based on the results of the first test phase?

- Increased the number of required visits to be able to receive a prize (free consultation or discount).
- Introduced a briefing session done at the health center with the AC and ReCos to explain the financial benefits of the card for the health center and was understood as a new marketing opportunity for them.
- Enlarged the fidelity cards and branded them with Breakthrough ACTION, USAID and MOH logos.
- The cards were tested for a longer period of time (3 weeks).
- ReCos were asked to identify families that barely visited health centers and usually consult traditional healers.

Testing sites Phase II

The test took place in 2 different locations in Kasai Oriental: Bonsola (urban) and Bibanga (rural)

11 Family fidelity cards

Results

100% of users kept their fidelity cards

All the mobilized ReCos distributed successfully the fidelity cards. The mean time it took them to identify, select and distribute 10 the cards was 4 days.

7/30 cards were used in the urban setting vs. **6/30** in the rural environment in a period of three weeks.

The average appointments registered per used card was **2**

What worked well

- Both selected health facilities agreed in the positive benefits of this intervention for both, users and providers.
- It is a cost effective intervention for the project that requires minimum supervision.
- Explaining the value of the intervention to ACs and ITs was done taking into account a business perspective. All of them easily understood that the family fidelity cards could be a marketing investment and a good way to prevent people from going to the traditional healer instead of seeking care at the health center.

What did not work

- Whereas for one health facility it was easy to decide to award one free consultation after families completed four visits, for the health facility in the rural setting the decision was not that simple. Since not all the decision-makers in the health center were invited to the briefing session, one person could not decide alone. It's important to take this into account as well as the different operational models different health facilities might have.
- The cost of the 5th consultation was mentioned as a potential drawback to the adoption of the program by the health centers.

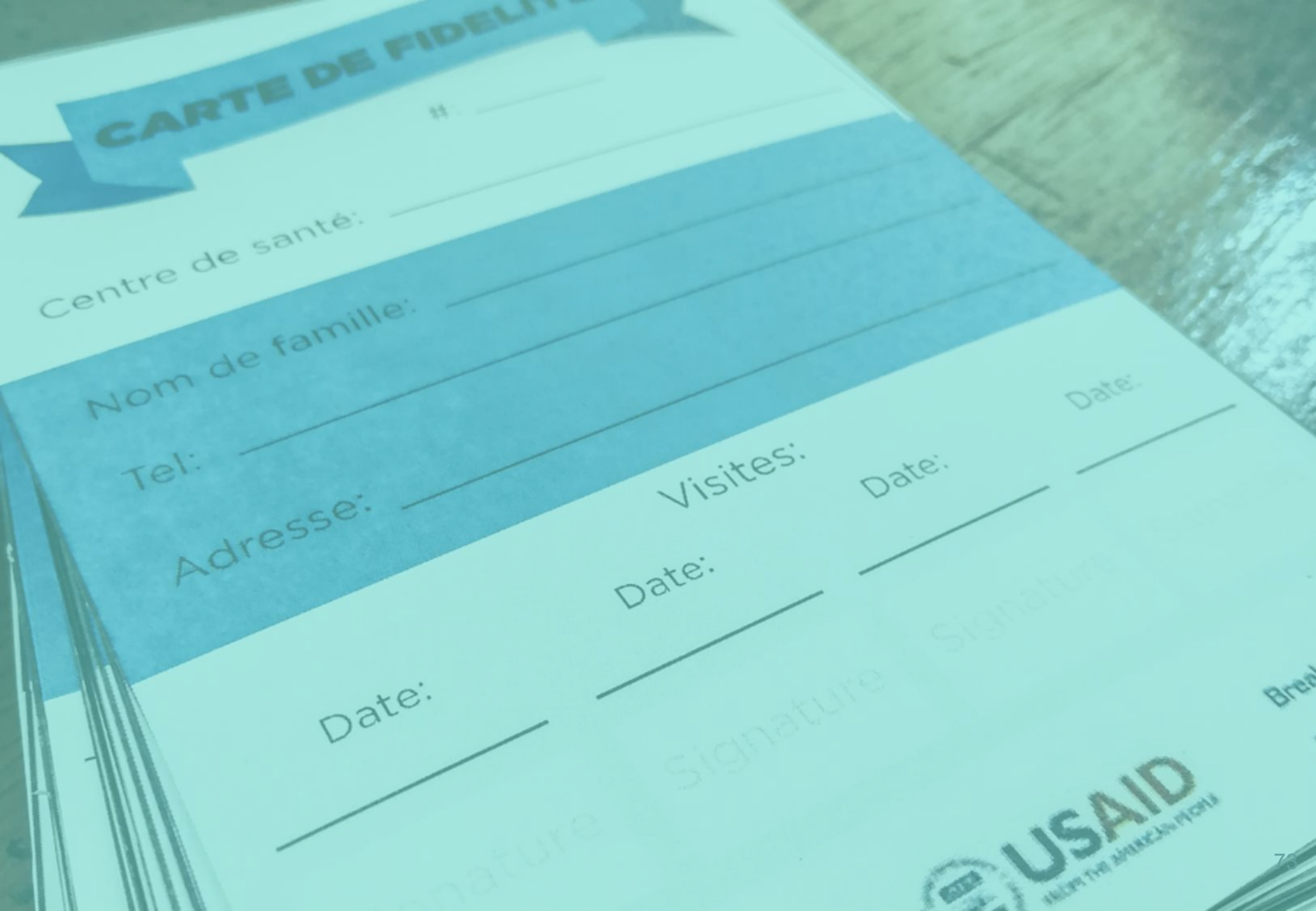
11 Family fidelity cards

Key learnings and recommendations

Present the intervention to more health centers
Prototyping this solution for a longer period of time and in more health centers can provide more information about the barriers that a concept like this can bring. Since the time to measure the intervention has been short, almost no family has been able to reach the award and the attitude of the health centers is unknown when this happens.

ReCos helped reaching families that do not visit health centers frequently
Through this distribution strategy, the risk of handing out cards to families that already visit the health center decreases.

Allow health centers to decide whether they want to be part of the intervention or not
During the first two stages of testing, most health centers agreed to be part of the strategy. However, since the decision was requested immediately, this generated some discomforts for some leaders of the health centers. It is possible to give them a few days to internally decide if they want to be part and if they agree to give a free consultation or other type of prize with the fidelity card.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3. Next steps

Looking ahead: Piloting

Adaptation and piloting

The first two testing sprints represented the start of a highly creative and action-oriented journey in which meaningful evidence towards different interventions in the DRC context has been gathered. Moving forward, this journey requires active participation from key stakeholders, especially local authorities, partners and communities.

What is Piloting?

The 'Pilot' stage is where the ideas and concepts which surfaced from previous stages are further developed so that the shape of what needs to be made becomes well defined and stable.

Why Piloting?

By the end of this phase, the design team will have a clear, well-documented understanding of the high-level architecture of the thing(s) that must be delivered – be they a service, a product, a program or a policy. In this project, we have developed detailed prototypes and design specifications to move forward with. Piloting the design of the solution means articulating in detail:

- The users and their characteristics
- The different interventions, including a breakdown of its components (e.g. channels, processes, workforces, technologies) and how they fit together
- The experience that will emerge as user and solution interact with each other
- The evaluation framework

This is also an ideal point to think critically and ask questions. Do the interventions deliver on the intent? Is it really the intersection between desirability, possibility and viability? Does it work for users?

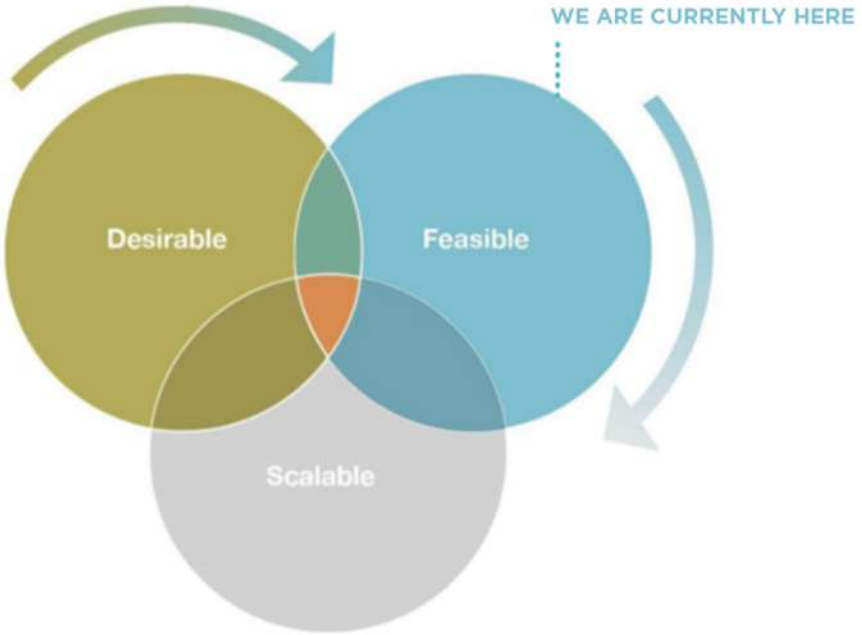
From feasibility to scalability

The first two testing sprints represented the start of a highly creative and action-oriented journey in which meaningful evidence towards different interventions in the DRC context has been gathered. Moving forward, this journey requires active participation from key stakeholders, especially local authorities, partners and communities.

Design & Test Phase I: Desirability - To test whether the innovation is solving the right challenge

Design & Test Phase II: Feasibility - To ensure that the innovation makes operational sens and risks are managed

Design & Test Phase III - Scalability - To ensure that the innovation reaches the maximum amount of users/clients.



Decision making during the piloting phase

Breakthrough Action will prioritize and continue testing selected interventions to capture meaningful evidence regarding health-care seeking and the adoption of EHHP. Moving forward, this journey requires:

1. Refining desirable + feasible prototypes from Phase II
2. Building capacity from local team members who will be in charge of conducting Phase III
3. Conducting a 4 month testing phase in different provinces
4. Generating final designs to hand-over to the Implementing Partner of the project.

Critical decisions during the transition to the scalability phase will be based on these four factors:

Risk: How can possible risks during this phase be mitigated.

Capacity: What kind of resourcing will be needed to carry out the testing of the different interventions.

Cost: How much will it cost to execute these interventions.

Capability: What skills and expertise are required to ensure the effectiveness and sustainability of the interventions.

4. Appendices

Appendix 1: Discovery Phase report

https://www.dropbox.com/s/9gbb047rsdcfvhr/BA-DRC-Insights-Report-Final.pdf?dl=0

Appendix 2: Design & Test Phase I report

https://www.dropbox.com/s/26yhgalmfytomdg/BA-DRC%20Design%20%26%20Test%20I%20Report%20%28Low%20Fidelity%29.pdf?dl=0

Appendix 3: Design and test: Phase I workplan (Kasai Oriental and Haut Katanga)

https://docs.google.com/spreadsheets/d/1M-FHQXRpnETxj0dd33rGU9IhOjyRb16gRsmv0s4T0Dg/edit#gid=0

Appendix 4: Co-design resources

https://www.dropbox.com/sh/l4snujdddi05rh3/AAAfKtTEUf6b2HE85hEID-lTa?dl=0

Appendix 5: Geographic scope

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Get in touch!

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