Breakthrough ACTION DRC

Insights Report

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

Submitted to: USAID

Submitted by: Breakthrough ACTION 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	**PNLP**	Programme National de Lutte Contre le Paludisme
AS	Aire de santé (Health Area)	**PNC**	Postnatal Care
CHW	Community Health Worker	**PNCPS**	Programme National de Communication Pour la Santé
EFP	Essential Family Practices	**PNSR**	Programme National Pour la Santé Reproductive
FOSA	Formation Sanitaire	**PPFP**	Postpartum Family Planning
FP	Family Planning	**PSC**	Post-scholar consultation
HCD	Human-centered Design	**ReCo**	Relais Communautaire
HTSP	Healthy Timing and Spacing of Pregnancy	**SBC**	Social and Behavior Change
LLIN	Long-lasting Insecticidal Nets	**USAID**	United States Agency for International Development
MCH	Maternal and child health	**WHO**	World Health Organization
MCZ	Médecin Chef de Zone (Head of Health Zone)	**ZS**	Zone de santé (Health Zone)
MOH	Ministry of Health		

1. Project background

Breakthrough ACTION DRC

Background and Overview

Care-givers in the DRC may face an array of socio-cultural barriers to seeking care for pregnant women and children ages 5 and under. Care-seeking for pregnant women can include antenatal (ANC) and postnatal care (PNC), including distribution of treatment to prevent malaria in pregnant women, counseling for adoption of post-partum FP (PPFP) and encouragement of exclusive breastfeeding for children up to 6 months old. Current rates of recommended 4+ ANC visits are 49% (MPSMRM, MSP and ICF International 2014). The World Health Organization(WHO) recommends early initiation of ANC and regular visits, as reflected in a 4+ ANC visit indicator, to ensure women in need of care are identified and linked to appropriate interventions such as prevention and treatment for tuberculosis and malaria in pregnant women (World Health Organization 2009). Research has shown that there is a link between women attending 4+ ANC visits and giving birth at a health facility (Starrs 2007). ANC and facility-based births are associated with reduced maternal and child morbidity and mortality (Campbell and Graham 2006, Darmstadt et al 2005, Tura, Fantahum and Worku 2013), as is PNC.
(Campbell and Graham 2006). In the DRC, within the first 48 hours after delivery, 56% of women did not receive any PNC (MPSMRM, MSP and ICF International 2014), suggesting a missed opportunity for identifying and addressing complications for the mother and newborn, encouraging adoption of PPFP, and encouraging exclusive breastfeeding practices (Darmstadt et al 2005, Campbell and Graham 2006).

Indeed, less than 10% of married women use a modern method of FP, and 28% of women have unmet need for FP (MPSMRM, MSP and ICF International 2014). In addition, less than half of children under 6 months are breastfed exclusively (MPSMRM, MSP and ICF International 2014). Understanding the factors that influence these behaviors, including barriers and facilitators at multiple levels, is important to designing effective social and behavior change (SBC) solutions that encourage care-seeking for pregnant women and young children, which affect a cascade of health behaviors and outcomes.

Human-centered design (HCD) approaches have proved useful for fully understanding design challenges from the end user perspective and in developing a broad solution set. With this activity, Breakthrough ACTION aims to uncover a wide range of insights around care-seeking for pregnant women and children under age 5 in two provinces of the DRC: Haut-Katanga and Kasaï Oriental. The final interventions produced by this design challenge will contribute to maternal and child health promotion efforts in the country.

HCD involves participatory co-design with stakeholder groups regarding the best ways to achieve social and health-related goals. The approach emphasizes a rapid discovery, design, apply, and redesign cycle that allows "fast failure" to identify feasible solutions to program challenges and put them into practice using minimum time and resources.

Breakthrough ACTION DRC

Project objectives

1. Institutionalize proven, evidence-based practices to address key barriers and create incentives to positive behaviors.
2. Leverage USAID-supported SBC investments for shared behavioral objectives.
3. Increase capacity of Congolese communication oversight organizations to coordinate, design, implement, and evaluate evidence-based SBC interventions.

Breakthrough ACTION DRC priority behaviors

- Malaria.
- Maternal and child health (MCH)
- Family planning
- Water, sanitation, and hygiene (WASH)
- Nutrition
- Infectious diseases.

The project also includes focused activities addressing social and behavior change priorities within the education and democracy, human rights, and governance sectors.

Geographic scope

A list of interview participants in the various locations can be found in Appendix 1 and 2.

Two teams of researchers made up of local, national, and international researchers conducted interviews in Kasaï Oriental and Haut-Katanga. In each province, the teams visited households, health centers and community influencers (for a total of 201 contacts).

The Discovery Phase of the project was conducted in 5 health zones in each province:

A Kasaï Oriental (Mbuji-Mayi area)

- Bibanga (rural)
- Kasansa (rural)
- Mpokolo (peri-urban)
- Tshitenge (peri-urban)
- Dibindi (urban)

B Haut-Katanga (Lubumbashi area)

- Kafubu (rural)
- Kapolowe (rural)
- Kipushi (peri urban)
- Kalebuka (péri urban)
- Kenya (urban)

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?

Our 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.

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 DRC?

Desired future state

Short-term (1 year):

- Community members enter into dialogue with FOSA providers on topics such as service quality, rumors, and community-FOSA partnership
- When children suffer from cough, fever or diarrhea, parents will apply the recommended household care behaviors and take them to health services.
- Households routinely practice handwashing, use of ITNs, and attendance at ANC, PNC, and PSC. Moms will exclusively breastfeed children for 6 months and vaccinate them.

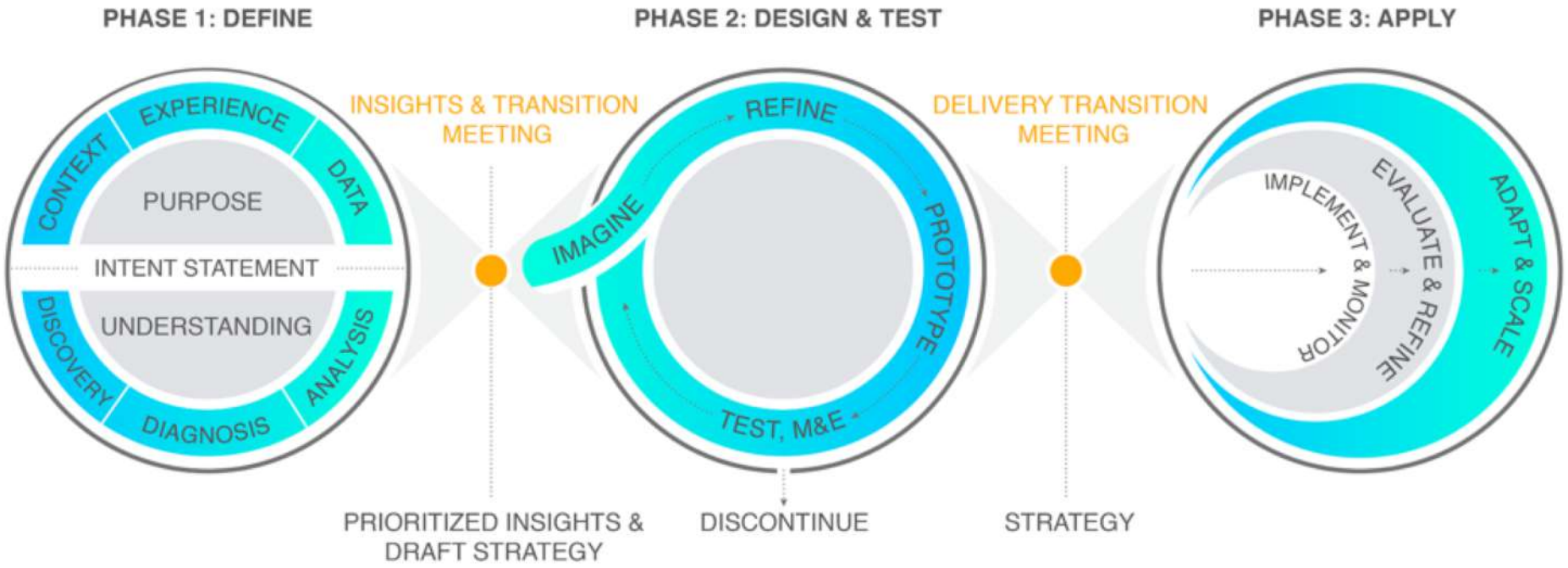
Medium-term (2 – 3 years):

- Couples will discuss pregnancies with each other and understand the usefulness of antenatal care (ANC) and go to ANC as soon as they are pregnant
- The pregnant woman will agree to adopt a modern contraceptive method just after the birth of her baby.
- Couples will plan the times to have children and adopt an MCM to succeed in their plan.
- Tuberculosis' cases will be detected and treated completely.
- Treatments are followed correctly at home: artemisinin-based combination therapies (ACTs) for the treatment of uncomplicated malaria, antibiotics, oral rehydration salts (ORS) etc.

Long-term (5 years):

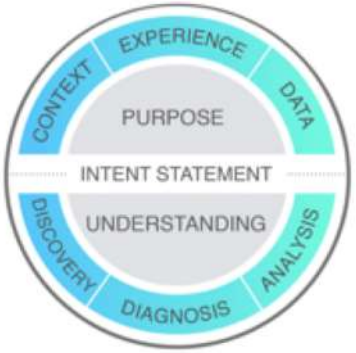
- Quality health services are well attended by parents of sick children of cough, fever and diarrhea.

SBC Flowchart



Breakthrough ACTION's SBC design process integrates research, behavioral sciences and economics, HCD, communication, and community capacity strengthening into a cohesive, flexible approach. In DRC, Breakthrough ACTION uses all components of the process. The SBC process is one of divergence and convergence, iteratively exploring broadly, then deciding how to act. There are three key phases in this process: (1) Define, (2) Design and Test, and (3) Apply. These phases are linked by transitional stages where the strategy is developed and refined.

SBC Flowchart

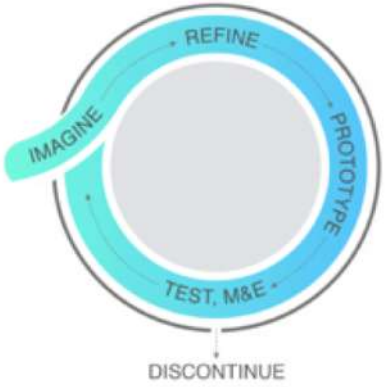


Phase 1: Define

During the Define phase, we examine the definition of the problem and all its facets—environmental, structural, behavioral, cognitive, emotional, and social. The process begins by developing a shared understanding of the project intent and engaging the right research team.

Existing data are then examined and the research team is immersed in the context and community to listen and learn from human experience, discover new insights, and diagnose the problem and behavior.

Identifying SBC opportunities from these insights helps to determine if current activities are effective and can continue as they are ("go"); need refinement ("tweak"); need to move in a different direction ("turn"); or if something completely new is needed to generate change ("initiate").

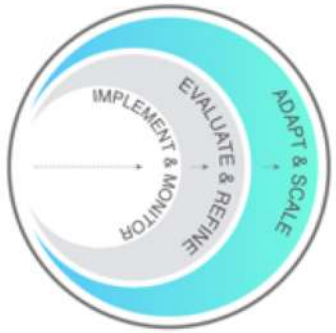


Phase 2: Design and Test

In the Design and Test phase, problems are translated into solutions by generating ideas and prototyping, rapidly testing prototypes with key audiences in their contexts, learning, and improving.

Rapidly building and testing concept prototypes helps gather early user feedback that can help to refine or eliminate the design. This saves investing time and money in solutions that do not meet the needs of users or deliver on the intended outcomes.

The Design and Test phase is highly iterative, allowing the designs to be refined and improved based on user feedback. Design prototypes that show the most merit during testing will be considered for implementation in the Apply phase.



Phase 3: Apply

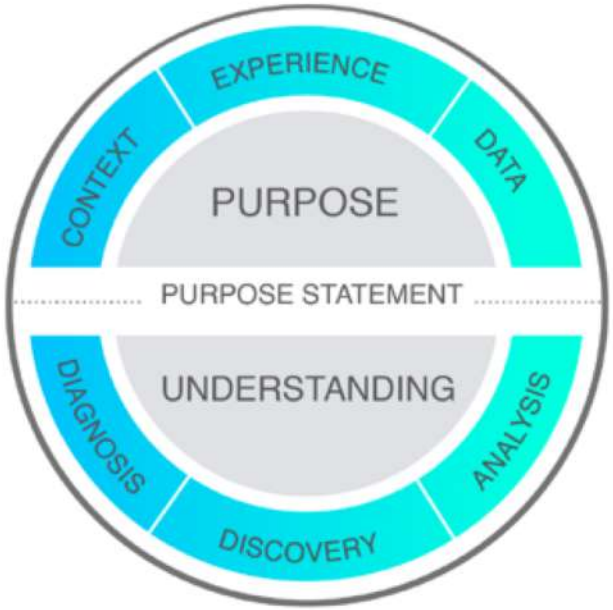
The final phase of the process, Apply, is when high-fidelity solutions are developed, implemented, and monitored and evaluated in context.

If the application solution effective behavior change, it is scaled and further monitored and evaluated for impact.

2. Define phase

Define phase: Purpose and objectives

PHASE 1 | DEFINE



The Define phase aims to establish the project's purpose and develop a deep understanding of the design challenge, with a particular focus on human experiences and perspectives.

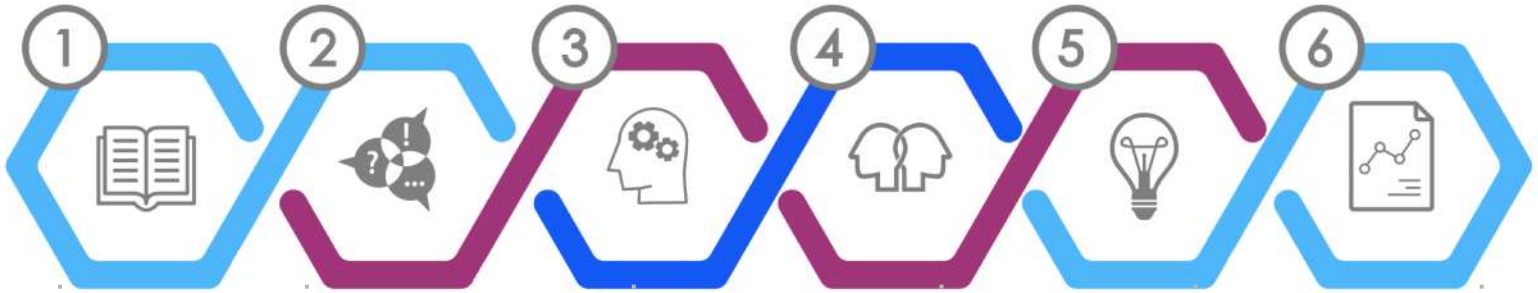
The main objectives of the Breakthrough ACTION DRC Define phase are to:

1. Establish a shared vision for the activity's intent, a common understanding of the challenges and opportunities, and collective action towards a shared solution.

2. Obtain deep insights into social, cultural, and behavioral barriers and facilitators to EFP and health seeking behaviors and apply them to innovative program design.

3. Strengthen the capacity of staff and partners to carry out HCD.

Define phase: Approach and methods



Literature review & project planning

A comprehensive literature review summarized knowledge, attitudes, practices, behavioral determinants, and the social and cultural context of healthcare seeking and Essential Family Practices (EFP) in DRC. The literature review established a strong knowledge base to guide the project.

Intent workshop

An intent workshop brought key stakeholders from the Ministry of Health (MOH), United States Agency for International Development (USAID), Breakthrough ACTION, and other partner organizations to determine the parameters of the project and align expectations.

Capacity strengthening

Breakthrough ACTION DRC facilitated a two-day capacity strengthening workshop in each research locations to build knowledge, skills, and confidence in qualitative research approaches and techniques. Topics covered all methods and techniques required throughout the Define phase, including research ethics, elements of a good interview, how to conduct observations, empathetic listening.

Discovery fieldwork

Two research teams, including Breakthrough ACTION staff, MoH National Program for Communication for Health (PNCPS) staff, MoH National Program for Reproductive Health (PNSR) staff and Save The Children staff conducted research activities in Haut-Katanga and Kasaï Oriental.

Insight harvesting & sharing

Insight harvesting occurred in Kinshasa. However, the two teams generated their own insights and then came together to combine and refine the themes emerging from the research. Next, an insight sharing workshop was held to share the insights with key project stakeholders and obtain their feedback.

Insights report

Persona and journey maps were developed to summarize who and what was heard during the fieldwork. The insights report provides an overview of all activities completed during the Define phase. Key findings are consolidated and presented alongside opportunities for the Design and Test phase.

Discovery fieldwork

What were we trying to understand?

The objective of the qualitative research interviews was to understand the experiences of each stakeholder group around EFPs and healthcare seeking, particularly in cases of fever, cough and diarrhea for children under five and pregnant women.

A separate line of inquiry (or interview guide) was developed for each stakeholder group so that conversations would be relevant to each context. Lines of inquiry consisting of suggested questions helped the research team build rapport and ask opened-ended questions to understand latent motivations and needs.

The methodology focused on gaining deep user understanding and providing a truly outside-in perspective. The research approach was generative, so as to provide a platform for identifying opportunities for the future.

The goal of the discovery fieldwork was to obtain authentic user insight and then express this in accessible, meaningful and impactful ways

Who was in our research team?

Each research team consisted of the following individuals:

- **Save the Children**
  Six Mbuji Mayi Office staff
- **Ministry of Health**
  Two PNCPS members
  Two PNSR members
- **Breakthrough ACTION**
  Two lead designers
  Four members of the Breakthrough ACTION team
- **Other partners**
  Four local partner NGOs

20 people

Participants

How were participants selected?

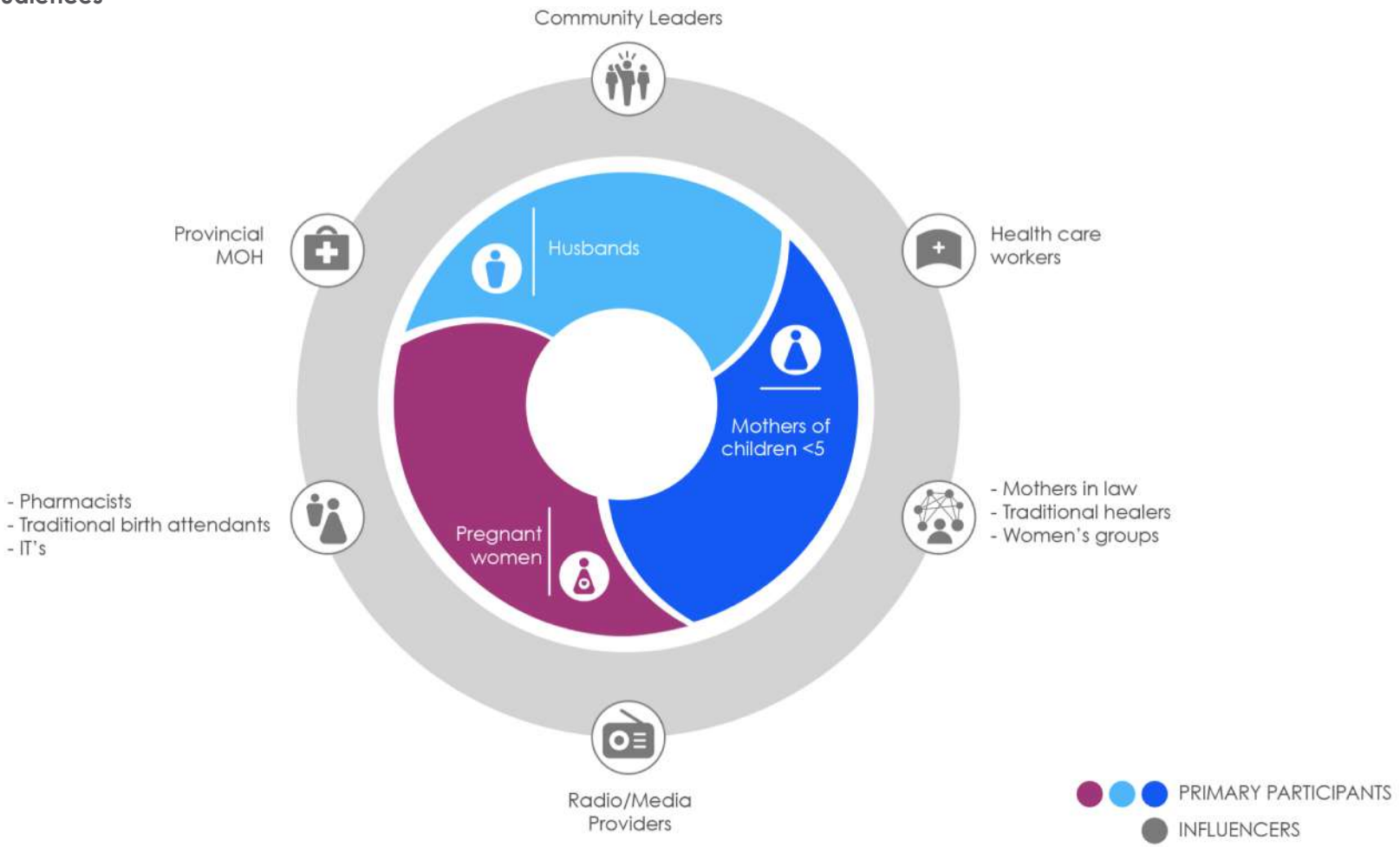
A defining characteristic of an HCD process is that one of its priorities is to speak and collaborate through the process with people who will probably be impacted by the interventions that will be created. The observation of contexts focuses on describing a culture and its practices through understanding the social group; for this, HCD uses different tools, with observation and interviews being the most used instruments. Insights from HCD tell how an intervention can be best designed so that it is inherent and useful for the target group.

Local partners, with the support of the MOH, mobilized and screened participants according to specified criteria to ensure that they represented likely targets of the design challenge.

The discovery process focused on understanding behaviors of households with pregnant women and children under five. The team made sure that important considerations were taken into account, such as the distance between selected households for interviews (making sure they were not located in close proximity to each other), ensuring that no one from the same household was interviewed, and distance to health centers. This provided the team with a diverse mix of backgrounds and life situations. Influencers of household health practices were also engaged in the process - including mothers in law, community leaders, healthcare workers, and traditional healers, among others.

Participants

Target audiences



Prioritized Social Behavior Change Factors

The interviews focused on knowing a wide spectrum of behavioral factors from each target group. The team that worked in Kasaï Oriental conducted a review of different SBC theoretical models, among which were: the theory of reasoned action, planned behavior and ideation. Subsequently, the team prioritized different factors to be understood for each population and adapted the line of inquiry to the theories, thus creating an adapted model for DRC.

PRIMARY PARTICIPANTS			INFLUENCERS					
Mothers of children <5	Pregnant women	Husbands	Health care workers	Community leaders	Mothers in law, women's groups, trad.healers	Radio/media providers	Pharmacists, trad. birth attendants, IT's	Provincial MOH

PRIORITIZED SBC FACTORS

Internal Motivation
Emotion - Attitudes - Beliefs - Values

External Influence
Social Influence - Subjunctive and Social Norms - Stigma

Perceived risk - knowledge
Effectiveness of the solution

Self efficacy
Independence

Motivation
Emotion - Beliefs

External Influence
Social Influence - Subjunctive Norms - Stigma

Perceived risk - knowledge
Evaluation of consequences

Self-efficacy to facilitate changes in favor of healthy behaviors

FOCUS IN DISCOVERY	
104 Interviews (55 Kasaï Oriental + 49 Haut-Katanga)	97 Interviews (39 Kasaï Oriental + 58 Haut-Katanga)
6 Focus Group Discussions	2 Focus Group Discussion

Insight harvesting approach

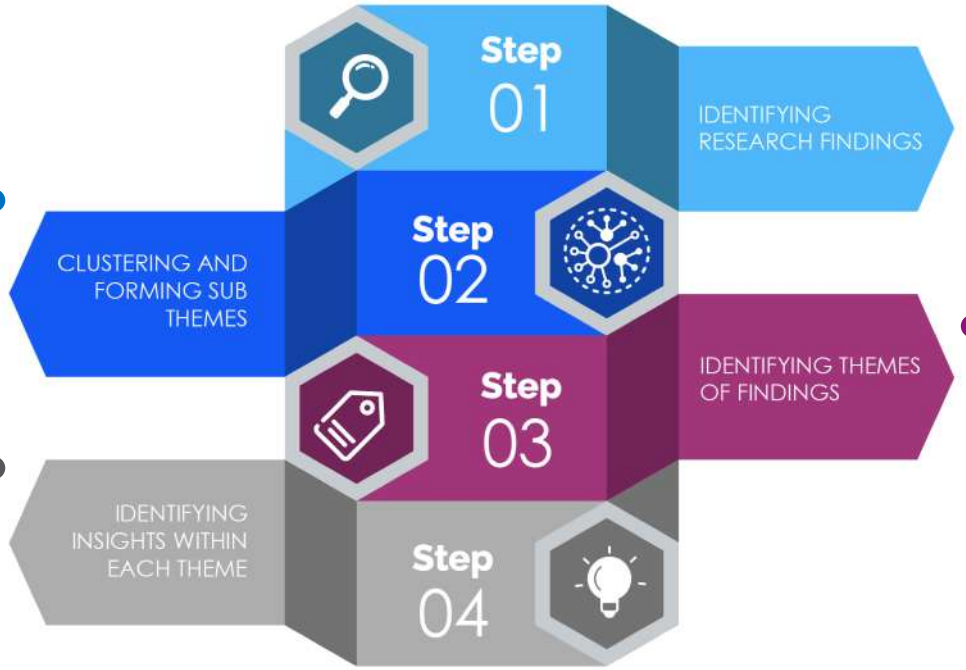
An insight harvesting approach was used to access and managing the complexity of human experience that was observed during the discovery phase without over simplifying it. To mine for themes and opportunity areas, research notes and photos were reviewed repeatedly in order to get a sense of the whole picture and to search for common themes.

What was this about?

After harvesting the data, the two research teams grouped the conclusions into themes and sub-themes.

What was this about?

After completing the themes, the two provincial research teams worked in pairs to examine the results and generate preliminary insights.



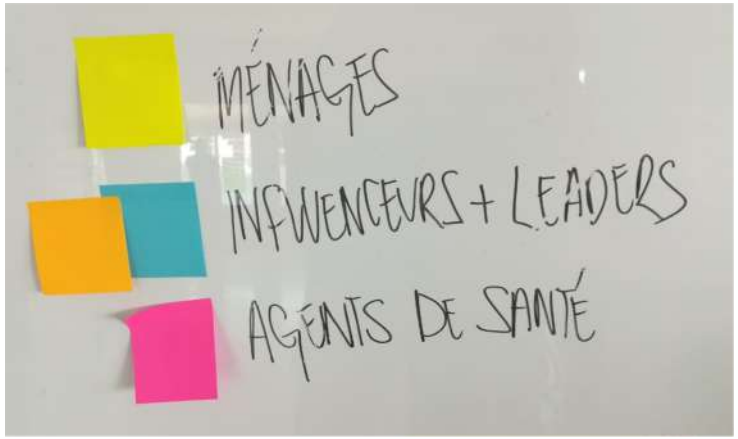
What was this about?

The team reviewed notes, observations, and recording and captured discoveries on post-its. This information captured included significant quotes, syntheses and observations. The objective was to document as much information as possible. Different colors were used to differentiate the target audiences that we interviewed.

What was this about?

Data from the two research regions and was reviewed defined together insights from the themes and sub-themes identified.

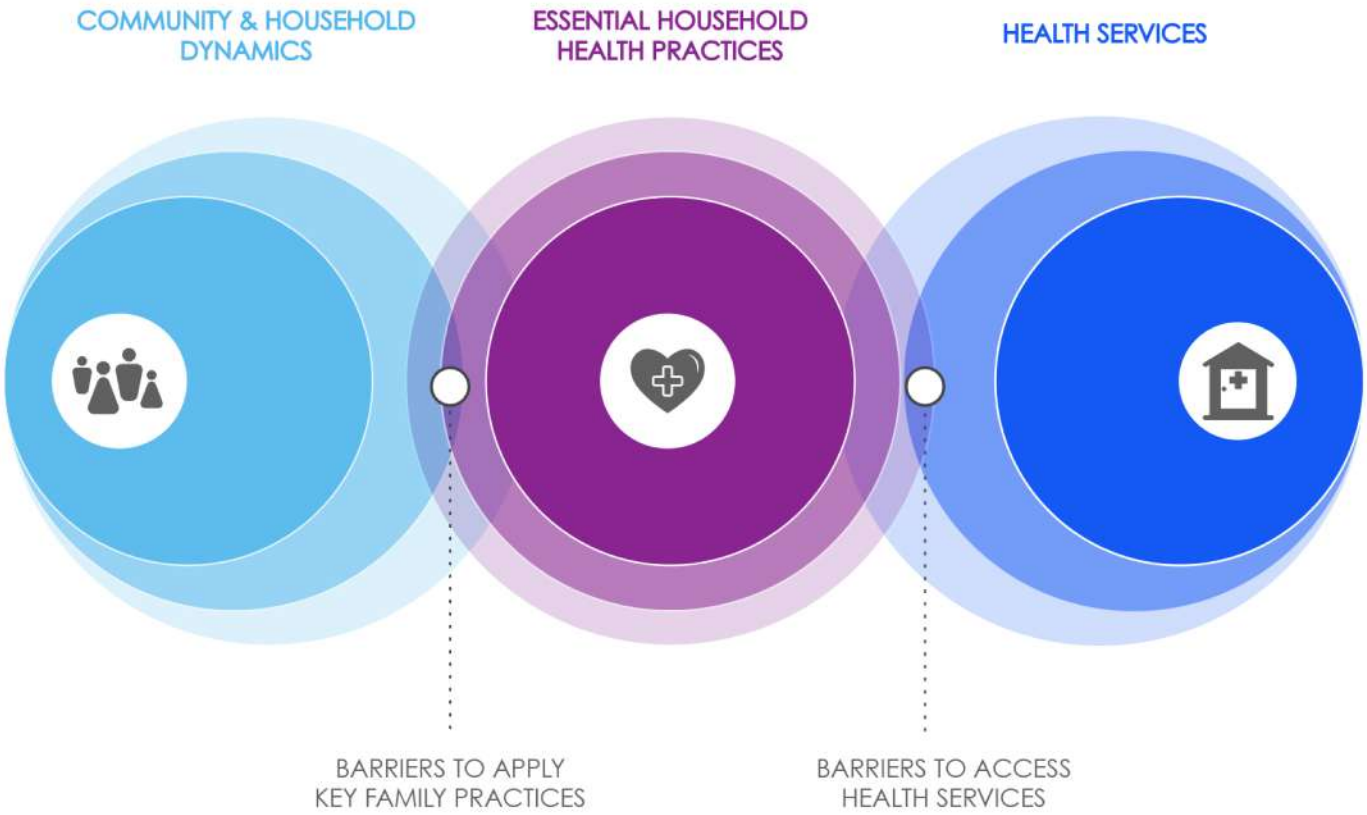
Insight harvesting approach



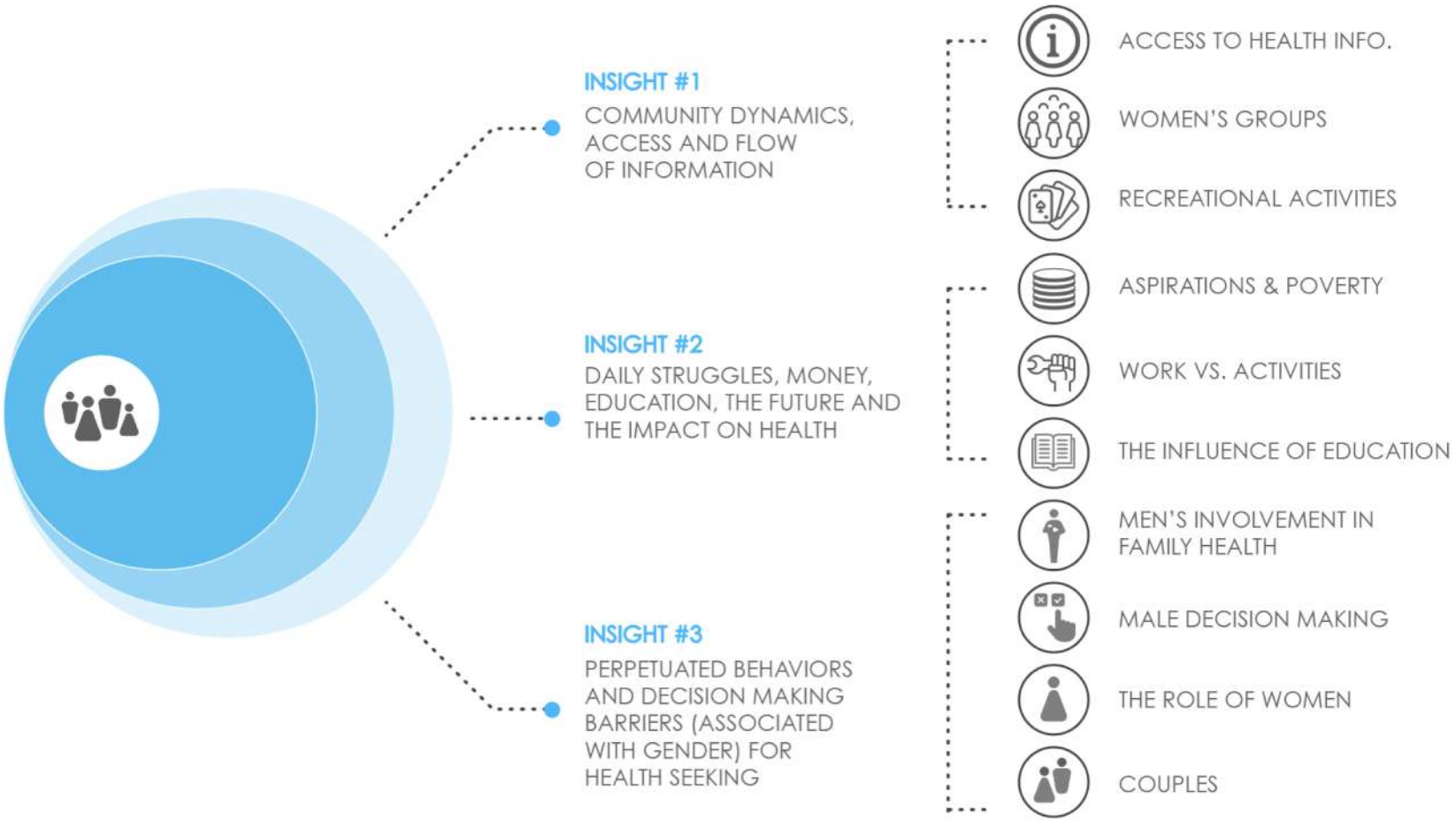
3. Research findings

Insights within the system

Part of the potential of HCD is that it uncovers people-level insights that have systems-level impact. The discovery process uncovered certain perceptions, aspirations, fears, and mindsets, which were mapped into the following diagram to understand their influence level on the key family practices and health seeking behaviors. The team corroborated the influence of some members of the community towards adapting behaviors that put children and pregnant mothers at risk. The lack of knowledge is sometimes filled by rumors and this transforms into a series of barriers to the adoption of essential household health practices and the search for health services.



Insights overview: Community and household dynamics



INSIGHT 1

Community dynamics, access & flow of information

1 Women's groups

Women that are part of women's groups are more empowered and confident about their role in the community. These women know the importance of their autonomy and are dissatisfied with several aspects of their responsibilities. Even though they have higher knowledge of family planning, they do not necessarily practice it. These groups provide a basis for generalized knowledge or for myths and misconceptions surrounding health.

> ***I have faith in the capacity of women. If we were in positions of responsibility society would be better managed.***
>
> Member of mama moziki group, Kasaï Oriental.

IMPLICATIONS

Usually women's groups gather once per month, though meeting places shift. Participation is voluntary and regular financial contributions are often collected to be able to support other members when they face a challenging moment and/or for small commerce. Women's groups are formed usually around the church and older empowered women are seen as leaders who guide and influence the behavior of younger ones.

1 Access to health information

Knowledge about health is limited to 'sensitization' provided from the *ReCos*. Households that have been reached or have contact with ReCos have more knowledge of healthy behaviors. However, the lack of motivation of ReCos (due to the absence of a formal salary) creates that their efforts do not always lead to the systematic use of health services.

I feel demotivated, because I don't receive a salary and being a ReCo is a hard work.
ReCo. Kasaï Oriental

IMPLICATIONS

Although there are social reasons such as helping those who have less and some other altruistic aspects in becoming a ReCo, currently, being a ReCo only reveals benefits for others and the community. There are personal feelings of disappointment because of the lack of recognition of their own role and impact.

The lack of recreational activities (particularly for women) and lack of access to electricity in rural and peri-urban areas provide opportunities for filling time with unconventional activities related with health education (provided by Recos or other sources) that leads to the adoption of healthy behaviors.

1 Emerging opportunity areas

HOW MIGHT...	HOW MIGHT WE...	HOW MIGHT WE...
...other established male and female groups convey health risks and education?	...identify the myths and misconceptions being shared in women's groups and ensure that these groups provide a good basis for generalized knowledge surrounding health?	...unleash the potential of ReCos and guarantee that they provide accurate information at tactical moments for the community to lead to the systematic use of health services?
PRIORITY FOR DESIGN & TEST: LOW	MID	MID

INSIGHT

2

Daily struggles, money, education, the future and the impact on health

2 Aspirations & poverty

Household's goals are short-term. The future seems distant and is a concept difficult to imagine since present needs are so pressing. Prevention is hard to conceive if there are not tangible associations seen in the present. Healthcare expenses are secondary or tertiary behind food and education.

> ***Money does not circulate here.***
> Mother of child under 5 years, Kasaï Oriental

> **At home, the priority is food.**
> Mother of child under 5 years, Kasaï Oriental

> **If you gave me $1000 I wouldn't know what to do with them. I'd probably give them to my husband.**
> Young pregnant mother, Kasaï Oriental

IMPLICATIONS

Many people live lives that are dictated by immediate needs, what is happening now and not what might happen in the future. People seek to reduce expenditures on all goods and purchases, and limit expenses to just the essential. Agriculture is seen as a subsistence activity, not as an avenue to get ahead. Many await (formal) employment as their sole means out of poverty. Until then, cash flow is a daily struggle.

2 Work vs. Activities

Women's work is not considered work since these tasks do not represent any economic benefit for the household. Women labor is often referred to as "activities". However due to the multiple tasks and responsibilities women have to complete each day, childcare for the infants is filled with risk and this responsibility is not shared with the husband of the household.

We cannot let our men know we do economic activity. Otherwise they will take our money and spend it on cigarettes and drink.
Woman representative of a women's group, Kasaï Oriental

Here, around 80% of women practice prostitution. They have to provide for their own children. Men here are just parasites.
Father of children under 5, Kasaï Oriental (urban context)

The woman's activities do not allow her to take good care of her children. She has to leave them at home without anyone who can take care of them.
Mother in law, Kasaï Oriental

IMPLICATIONS

Infants are left at home to be taken care of by older siblings, who may be only a few years older than the babies, putting at risk nutrition, hygiene and safety practices. The need to entrust the care of infants to their siblings, combined with ignorance of the importance of exclusive breastfeeding, in the context of poverty, pushes women to choose the activities that generate some income to the detriment of wellbeing, for themselves and their children.

2 The influence of education

Lack of experience and ignorance provide a fragile environment for young women who are recently married, and who become pregnant. Their education about pregnancy and childbirth comes from in-laws, who may not know much more, and whose desires for grandchildren may put women at risk.

> ***We do not consider girls because they contribute to the well-being of a family other than theirs.***
> Mother in law, Kasaï Oriental

> **The dowry is not the direct right of the biological father of the girl, but for the rest of the family according to custom and tradition.**
> Pregnant woman., Kasaï Oriental

> **Girls leave their homes to join their husbands before learning how to become a mother**
> Member of women's group, Kasaï Oriental

IMPLICATIONS

Women who have been able to access education are better-informed about risks factors surrounding pregnancy and late ANC attendance. However, due to the lack of opportunities for women and that education is only accessible at schools, young mothers are left to fill in the knowledge gaps on their own and are vulnerable to be influenced by their in-law's health habits. Due to cultural factors in which women get married while being adolescents, young mothers have a fragile awareness for risk factors surrounding health and pregnancy.

2
Emerging opportunity areas

HOW MIGHT WE...

...make prevention behaviors tangible to assure that they become a priority in the household?

HOW MIGHT WE...

...reframe women's tasks and responsibilities to make men more aware of their contributions to the household?

HOW MIGHT WE...

...create safe spaces/arrangements for women to be able to work and complete their tasks while knowing their children are safe?

PRIORITY FOR DESIGN & TEST

HIGH

LOW

MID

INSIGHT 3

Perpetuated behaviors and decision making barriers for health seeking

3 Male involvement in health seeking behaviors in the household

Men are rarely involved in health practices within the household and assume that this is a responsibility of women. Nevertheless, when a child or a pregnant woman is sick, the husband is the principal decision-maker for seeking treatment or care. He is not well equipped to decide between therapies - traditional, religious or modern, and acts as a barrier to any care.

Husbands refuse to have their wives deliver their babies by a man at the health center. They still prefer a matron.
Health provider, Kasaï Oriental

The husband has all the power of decision on the health of the child and the health of his wife during childbirth.
Health provider, Haut-Katanga

Children grow up like the wind.
Husband, Kasaï Oriental

IMPLICATIONS

Men take for granted the health of their families. Prevention is not practiced as it is seen as unnecessary, and an expense that can be avoided. Men don't use services since being seen at the health center represents a threat to the image of the strong man. However, treatment seeking is a decision made by men, as it includes a decision about spending money. As a result, women have to ask men to seek treatment and go alone. Men may recommend traditional healers or religious therapies since they are thought to be cheaper.

3 The role of women and men

Gender expectations are socially accepted and shared with children from an early age. Harmful gender stereotypes that favor boys over girls are perpetuated in adult relationships – within the couple, in social life, and in the community. Since men are the stable points in the community, investment in daughters is considered as investment in another family's daughters-in-law.

> ***The responsibility of providing for the family rests on the shoulders of the man.***
> Married man, Kasaï Oriental

> ***A woman who didn't have children (or who is sterile) is considered to be useless in society. When she dies, she must be stabbed in the neck and back by her husband's family, as a punishment.***
> Married man, Haut-Katanga

> ***Men are the most important person in the household.***
> Pregnant woman, Kasaï Oriental

IMPLICATIONS

Male children are the means to ensure the old age of the parents. From a very young ago, girls are disadvantaged in relation to boys. Girls are subject to early marriage, most of them do not have equal education opportunities as boys, they must stay at home, as that should be their role and since they constitute a wealth for another family. Gender norms are introduced from early ages, meaning that roles are pre-determined and hard to fight once children grow older.

3 Couple's reality

The lack of couple's conversation and interactions are a threat to empathy and understanding between them.

A family that has progressed is a family where there is dialogue, sharing of ideas, transparency and the growth of God (love).
Mother of children under 5, Kasaï Oriental

Women have secrets.
Father of children under 5, Kasaï Oriental

Men do not know the role of the woman next to them.
Mother of children under 5. Haut-Katanga

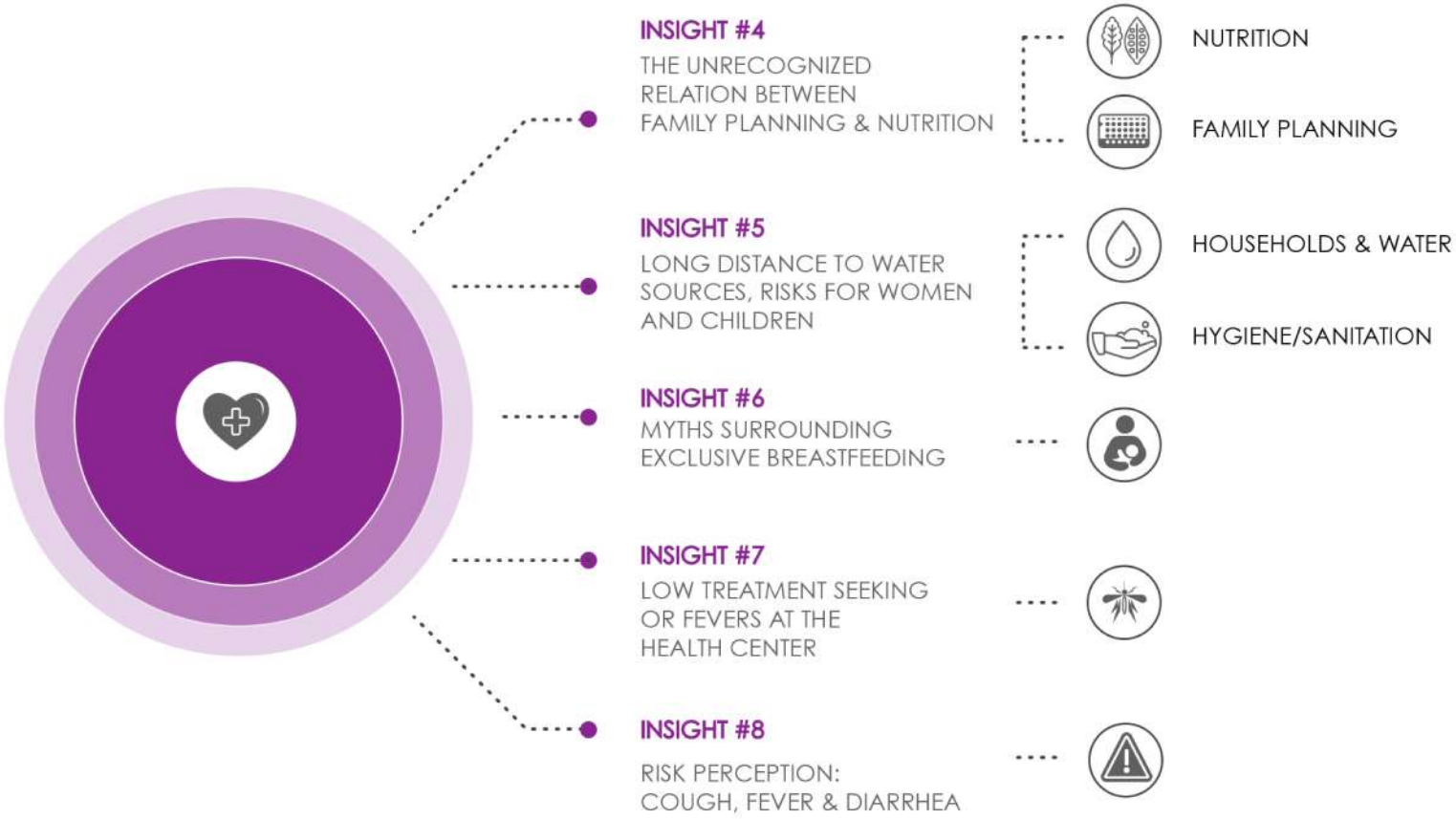
IMPLICATIONS

Acknowledging and imagining different roles and archetypes of households may disrupt what is socially approved within the community. Stepping out of what is acceptable seems like a rocky path for women but could uncover opportunities for a healthier relationship. Harvested product sales provide the money for children education and healthcare. Men keep most of their money and do not tell their wives how much they earn.

3
Emerging opportunity areas

HOW MIGHT WE...	HOW MIGHT WE...	HOW MIGHT WE...	HOW MIGHT WE...
...motivate men to be more involved in health practices within the household to make this a shared responsibility with women?	...equip men to understand the risks of not using health centers and not using household health practices?	...transform conversations and interactions within couples and create more empathetic relationships?	...transform harmful gender stereotypes from a young age to be able to reframe the role of girls in their houses and their communities?
PRIORITY FOR DESIGN & TEST: HIGH	MID	LOW	MID

Key insights: Essential household health practices



INSIGHT

4

The unrecognized relation between family planning and nutrition

4 The unrecognized relation between family planning and nutrition

There is an inconsistency between the number of children and the ability to feed them properly in the context of poverty. Parents decide to have children without being prepared to offer them and to offer themselves a good quality of life.

It's God who gives children, we do not make calculations.
Mother of children under 5, Haut-Katanga.

Malnutrition is as widespread as malaria, but some are not even aware of its existence.
Health provider, Kasaï Oriental

Malnutrition is a consequence of another "internal wound" disease.
Mother of children under 5, Kasaï Oriental

IMPLICATIONS

Many people think that children are given by god and should be accepted as a blessing. Similarly, God will also provide parents with ideas/intelligence to raise them. As part of a pronatal society, health is not a priority and there is a generalized desire for birth spacing, but not for birth control.

4
Emerging opportunity areas

HOW MIGHT WE...	HOW MIGHT WE...	HOW MIGHT WE...
...evoke the relationship between family planning and quality of life in a way that is relevant for men and women?	...guarantee that decisions to conceive more children are linked to a previous examination of the household's financial health?	...challenge traditional uses of regularly consumed ingredients (or ignored resources) to entitle women to create healthier dishes?
PRIORITY FOR DESIGN & TEST: MID	PRIORITY FOR DESIGN & TEST: MID	PRIORITY FOR DESIGN & TEST: LOW

INSIGHT

5

Long distance to water sources, risks for women and children

5 Long distance to water sources, risks for women and children

Limited access to safe water sources reduce the amount of water that is used for hygiene in the household; the most important consideration is to have drinking water. This is a considerable risk factor for moderate-to-severe diarrhea. Fetching water is time consuming, and means less time for other household activities.

Drilling points and water towers are places of attraction for women and children.
Village chief, Kasaï Oriental

As you can see, in our community children play on the ground. Many babies put things in their mouths and mothers or caretakers do not notice.
Mother-in-law, Kasaï Oriental

If families don't have money to spend buying jugs of water, women must go to fetch water. This is time consuming and means that women don't have time to come to the health center.
Nurse, Kasaï Oriental (peri-urban)

IMPLICATIONS

Women and female children are generally responsible for water collection. A shorter time spent in water collection would permit women with education opportunities, more rest per day and fewer risks for their children. The longer the distance to a water source, the higher the negative childhood health outcomes. Households that have bicycles rely on these for water transportation and men support this task.

5
Emerging opportunity area

HOW MIGHT WE...

...create a model to access water in which time, distance and community support are optimized to decrease time invested each day, effort and to guarantee that water is also available to be used for hygiene?

PRIORITY FOR DESIGN & TEST

MID

INSIGHT

6

Myths surrounding exclusive breastfeeding

6 Myths surrounding exclusive breastfeeding

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. Where there is mystery and lack of knowledge, there is room for myths. Women look and receive personal support from a select few women in their intimate social circle.

When we eat my baby looks at me with insistence because he's hungry, so I give him some porridge.
Mother of children under 5, Kasaï Oriental

During the heat it is necessary to give water to the baby as soon as he is one week old.
Mother of children under 5, Haut-Katanga.

Malnutrition is caused by having sex while breastfeeding.
Traditional healer, Kasaï Oriental

IMPLICATIONS

Usually mothers-in-law, neighbors or older family members provide advice about child feeding practices; even if they are not always correct, they are accepted. Additionally, the need to entrust the care of babies to their older siblings, combined with ignorance of the importance of exclusive breastfeeding, in the context of poverty, pushes women to choose activities that generate income over providing appropriate care for their children. Women prefer not to carry the infants with them because they believe they will be safer at home, leaving foufou (solid food) for infants. Lack of understanding of alternative foods for babies forces this decision.

6
Emerging opportunity areas

HOW MIGHT WE...

...normalize exclusive breastfeeding (for the first 6 months) while acknowledging the existence of false beliefs about infant nutrition within the community?

HOW MIGHT WE...

...leverage the influence of mothers-in-law to improve exclusive breastfeeding practices?

PRIORITY FOR DESIGN & TEST

HIGH

MID


BOSS

INSIGHT 7

Low treatment seeking for fevers at the health center

7 Low treatment seeking for fevers at the health center

Households that have access to ITNs use them consistently. However, nets need to be cared for and nets that are old or destroyed do not protect users. Treatment seeking for fever is low because people don't feel they are at risk unless a neighbor or family member has suffered from malaria/fever.

> ***In case of malaria, an enema of plants called Kanga Bakishi and Lwenyi / Lufwa nyoka in case of measles is done.***
> Traditional healer, Haut-Katanga

> ***People think malaria is a disease that everyone will have, but they don't perceive it as fatal.***
> Health provider, Kasaï Oriental

IMPLICATIONS

People do not perceive malaria/fever as an important health threat. As a result, treatment seeking for fever is not prevalent. Rather people prefer to self-medicate with products purchased at the pharmacy or use traditional plant based treatments. Seeking treatment in the health center is considered only as a last resort if the self treatment and plant based therapies are ineffective.

7 Emerging opportunity areas

HOW MIGHT WE...	HOW MIGHT WE...	HOW MIGHT WE...
...ensure that ITNs are being routinely cared for (washed and repaired) and old nets are appropriately replaced?	...increase the awareness of the dangers of seeking late treatment and acquiring medication in pharmacies without a previous malaria diagnosis?	...make practical and effective use of the influence of pharmacists to secure safe and effective malaria treatment?
PRIORITY FOR DESIGN & TEST: LOW	PRIORITY FOR DESIGN & TEST: LOW	PRIORITY FOR DESIGN & TEST: MID

INSIGHT 8

Risk perception: Cough, fever and diarrhea

8 Risk perception: Cough, fever and diarrhea

Often, caretakers are not capable of recognizing when symptoms become severe enough to seek treatment at a health facility. This causes a delay in treatment seeking, increased costs as multiple solutions are tried and higher pressure for health facilities to treat very sick children and adults.

> ***The treatment of children is done traditionally. It is only when complications arise that people go to the health center.***
> Health provider, Kasaï Oriental

> ***The leaves of papaya with sugar are very good for the cough.***
> Mother of children under 5, Haut-Katanga.

IMPLICATIONS

Caretakers reported knowing and understanding the signs of recurrent diseases such as malaria and diarrhea. When in doubt about treatment they fill the knowledge gaps by gathering information from experiences of others and trying to avoid unnecessary costs. For example, mothers reported managing fever and diarrhea with Paracetamol, as this will likely be among the drugs prescribed at the health center for treatment of adults and children.

8
Emerging opportunity area

HOW MIGHT WE...

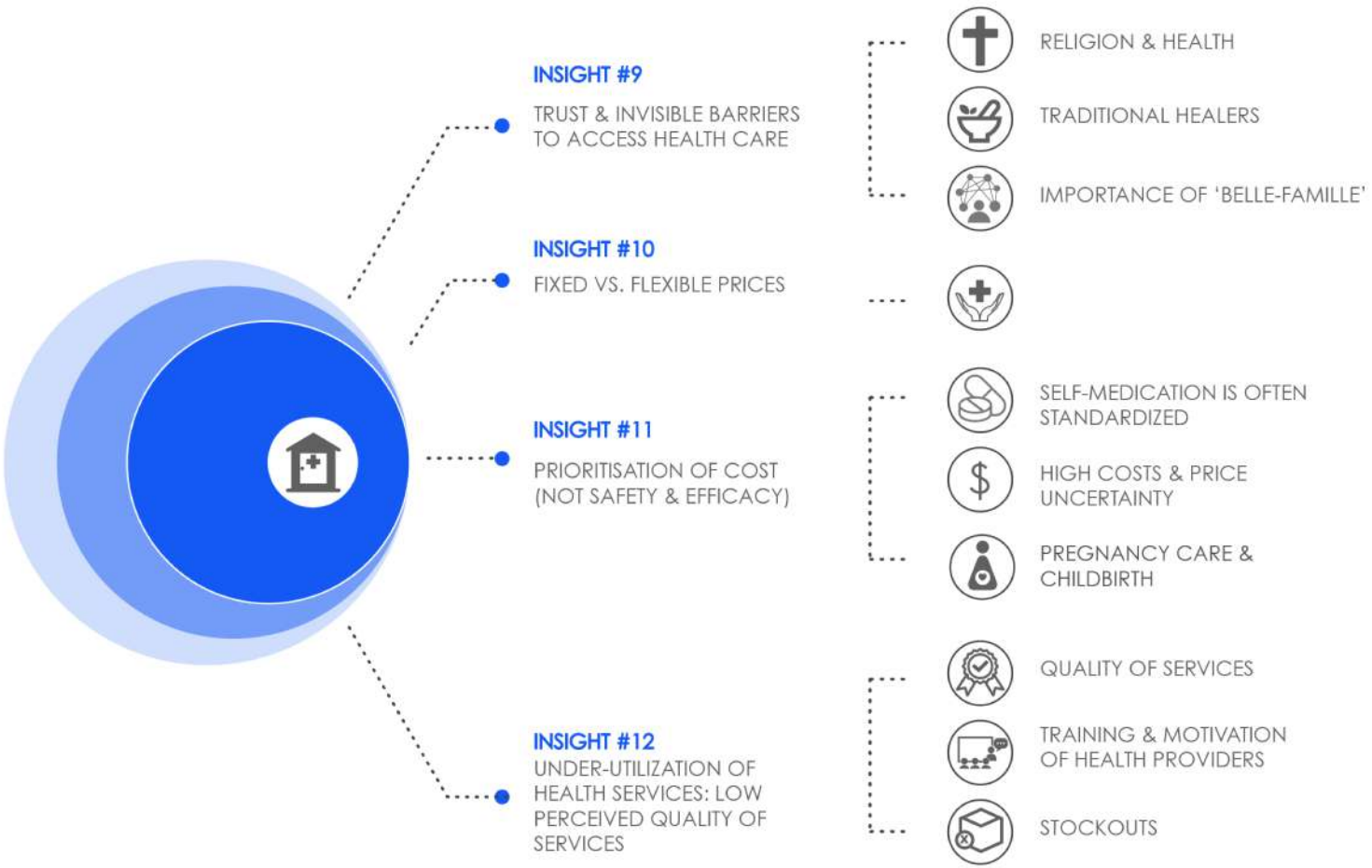
… ensure people understand and are able to recognize when cough, diarrhea and fever symptoms become severe enough to seek treatment at a health facility?

PRIORITY FOR DESIGN & TEST

HIGH


THE HEART
DIAGRAM OF CIRCULATORY SYSTEM
CEFATAX

Insights overview: Health services



INSIGHT 9

Trust and invisible barriers to access healthcare

9 Trust and invisible barriers to access healthcare

Although all religious leaders and traditional healers are not trained in health, people trust and rely on them for guidance in care. Even though they could be bridge for safe healthcare, they are, in most cases, an obstacle. If the religious leader decides to treat an illness, the person will no longer go to a health facility.

> ***Before going to the hospital I have to ask the pastor.***
> Mother of children under 5, Haut-Katanga

> ***There are diseases for the health center and others for traditional healers.***
> Traditional healer, Kasaï Oriental

> ***As a religious leader I treat diseases and I can detect through my religious ceremonies. For other illnesses I ask people to go the hospital.***
> Religious leader, Kasaï Oriental

IMPLICATIONS

The level of trust put into traditional healers and religious leaders is notorious and can be barely compared to services provided at health facilities. Women prefer to report to their Pastor for the ANC and pastors will advice them for the next steps in their pregnancies or deliveries. As a result, in most cases, people are too late to seek health services in case of illness.

9 Emerging opportunity areas

HOW MIGHT WE...

...transform the role of traditional healers and religious leaders to become bridges for safe healthcare and adequate pregnancy care?

PRIORITY FOR DESIGN & TEST

HIGH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INSIGHT 10

Fixed vs. flexible prices

10 Fixed vs. flexible prices

Price uncertainty is a source of worry and anxiety, and ultimately a barrier to formal health service use. In many cases, people approach health facilities without knowing the exact price of the services that will be provided to them. This creates a feeling of unease and a preference towards sticking to what is known to them, or the option of paying in kind.

> ***Childbirth at the health center is too expensive (10,000FC). You have to ensure food.***
> Pregnant woman, Kasaï Oriental

> ***Sometimes we agree the payment in installments, but you do not refuse care to those who cannot afford.***
> Health provider, Kasaï Oriental

IMPLICATIONS

In communities in which there has been a dialogue (to understand willingness to pay, schedules, etc.) between health areas and people, visits to health centers have increased. Health workers are open to seek solutions to the financial barriers of access to services and do not like to retain patients or women in services when they have no means to pay.

10
Emerging opportunity areas

HOW MIGHT WE...

...reduce the anxiety and worry of not knowing the total price people have to pay for services before approaching the health facility?

PRIORITY FOR DESIGN & TEST

HIGH

HOW MIGHT WE...

...uncover the risk and consequences of using traditional medicine or automedicating and make them relevant to different households?

HIGH

HOW MIGHT WE...

...ensure common understanding of needs and expectations between health centers, village chiefs and the community are frequently shared?

HIGH


DEPOT

INSIGHT 11

Healthcare decisions based on cost (not safety and effectiveness)

11 Health care decisions based on cost (not safety or effectiveness)

The lack of financial means causes couples to minimize the risk of not being treated well and not delivering their babies in a health center. Families are making health care decisions based on cost, access, cultural considerations and close proximity, rather then on quality of health outcomes.

> ***At the pharmacy they do not ask questions, they give me the medicine I ask for.***
> Mother of children under 5, Kasaï Oriental

> ***I prefer to go directly to the drugstore, it is closer to me because the transport to go to the health center is too expensive.***
> Mother of children under 5, Haut-Katanga.

IMPLICATIONS

In the decision making process of taking action to seek treatment, cost is the most important factor when weighing the different available options. As an example, the cost of safe deliveries and ANC visits are constantly compared to the cost of feeding the household per day. As a consequence they disregard the adequate risk assessment of their choice (fake medicines, side effects, etc.)

The cost of healthcare is considered excessive compared to traditional practitioners, birth attendants and medicines available at the pharmacy, so people will choose whatever is easier and cheaper to access.

11 Emerging opportunity areas

HOW MIGHT WE...	HOW MIGHT WE...	HOW MIGHT WE...
...inspire people to make healthcare decisions based on quality of health outcomes rather than on cost, access, cultural considerations and close proximity to health centers?	… encourage pregnant women to complete the four ANCs during pregnancy regardless of their income level?	...build relevant cost comparisons to help households consider the longer term costs and risks associated with the adoption of other culturally accepted practices for healthcare?
PRIORITY FOR DESIGN & TEST: HIGH	MID	HIGH


Pharmacie
PHARMACIE

INSIGHT 12

Under-utilization of health services: Low perceived quality

12 Under-utilization of health services: low perceived quality

People would consider paying for services as long as the services are not disappointing. Information about a bad experience with health providers/ health facilities spreads as fast as viruses. Trust between the community and the health zones is often missing.

The nurses they treat you badly when you are poor so we do not go to the center.
Pregnant woman, Haut-Katanga

We are just demanding that the nurses be transparent in the management of CODESA.
ReCo, Haut-Katanga

We don't learn anything during the ANC appointments.
Mother of two children under 5 and pregnant, Haut-Katanga

IMPLICATIONS

Despite the intervention of ReCos and community leaders trying to maintain the link, fighting against shared negative perceptions of health services is overwhelming.

Some health personnel do not have the standards of care and are not able to convey important advice to patients. Even the most basic information is not shared with women as it should be. There is questioning about the skills of health workers.

12
Emerging opportunity areas

HOW MIGHT WE...

...motivate and train health personnel to provide empathetic services in order to regain the trust of the community?

HOW MIGHT WE...

...make positive experiences at health facilities more relevant than bad ones?

PRIORITY FOR DESIGN & TEST

MID

HIGH

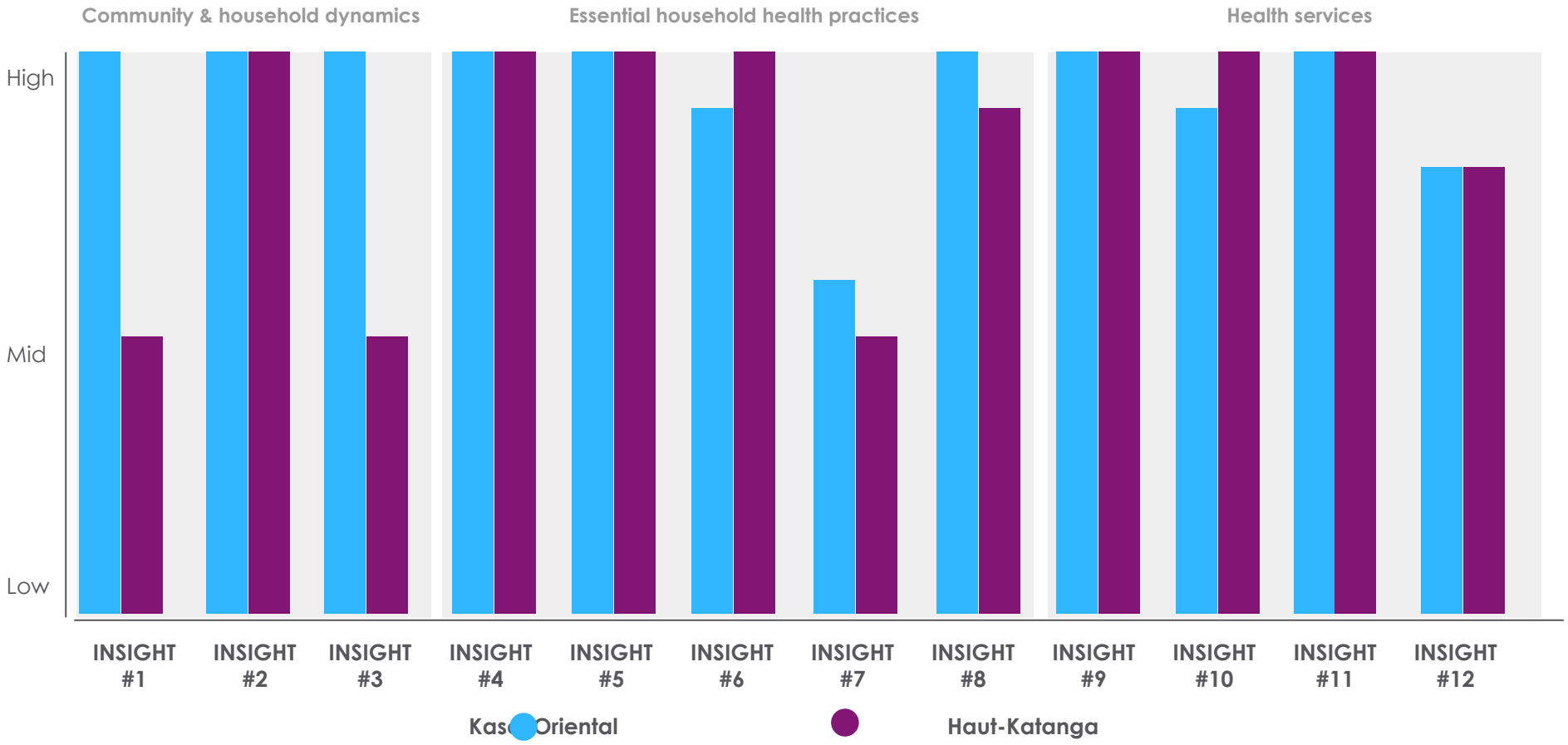
REPARTITION DE LA POPULATION TOTALE PAR VILLAGE

ANNEE 2019

N°	VILLAGE	POP. TOT	ENFANTS DE 0-59Mois											FEMME 15-49 ANS	0-1A	0-5A
			1,5%	3,5%	7,5%	2%	5,5%	11%	15%	1,2%	11%	19%	4%	21%	4,8%	81,1%
1	KASUMBI CENTRE	1967	37	69	148	39	112		295	24		372		413	944	1595
2	KANTALAJA I	1420	27		107	28	81		213	17		268		298	682	1152
3	KANTALAJA II	2404	46		180	48	137		361	29		454		505	1154	1950
4	M.IMPOMPO I	3275	62		245	66	187		491	39		619		688	1572	2656
5	M.IMPOMPO II	1859	35		140	37	106		279	22		351		390	892	1508
	POP. TOTALE	10 325	207	382	830	218	623		1639	131		2064		2294	5244	8861

Comparative insight's relevance per location

Since the discovery phase was simultaneously carried out in two different locations, the following graph helps to illustrate the relevance of each insight in each province.



Comparative insight's relevance per location

Community & household dynamics

In Kasaï Oriental the evidence and emerging insights confirmed a highly patriarchal society in which behaviors and gender gaps are preventing the systematic search for health services and creating barriers for women in accessing timely treatment for themselves and for their children.

These behaviors were less noticeable in Haut-Katanga, where slightly more nuanced gender perspectives were found regarding prevention and health care.

Essential household health practices

In both provinces, women had many closely spaced births, which impacted the nutritional status of the children. Some people expressed knowing family planning methods, but there was little use and variable interest for it.

Lack of education and ignorance in rural areas in the two provinces facilitate the generation of false beliefs regarding the adoption of essential household health practices.

In Kasaï Oriental, gender inequality creates higher pressure for women who have to make decisions between the general well-being of their families and successfully completing their work.

Health services

Barriers in accessing health services were similar between Kasaï Oriental and Haut-Katanga. Health centers face similar challenges relating the negative perception of the quality of services, elevated prices and anxiety from patients due to the lack of knowledge of services that will be provided to them and the total prices they will have to pay once treatment is finalized.

Both locations evidenced a high trust level and preference in traditional healers and religious leaders due not only to cost but also faith.

4. Empathy tools

Segmentation and empathy tools

Personas

Personas are key archetypal users that represent the needs, goals, values, and behaviors of larger groups of people. In this case, they allow us to understand our target audiences in a real and human way. Personas allow us to make evidence-based decisions, which means that all persona information is derived directly from our discovery fieldwork.

In short, personas are vehicles for design and not a simple segmentation of the market or a catalog of all the roles within an ecosystem. Acting as stand-ins for real people, personas are tools that help guide design teams in asking the right questions, generating insights, and ultimately making decisions about the functionality of a solution. They also serve an essential function as a tool for the continuation of empathy and allow us to remember the human element of the people with whom we are working.

Multiple personas identified for each of the stakeholder groups are shown here.

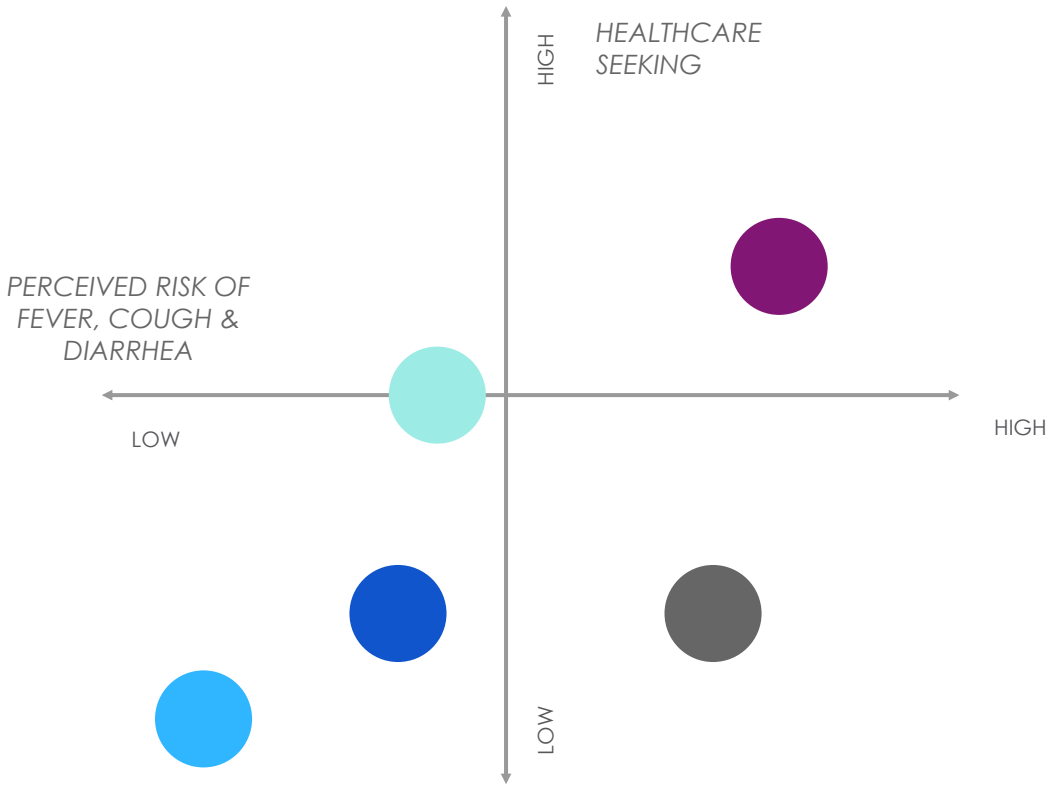
Journey Maps

Journey maps illustrate the experience pathway or journey of a persona from their individual perspective and allow us to highlight pain points and opportunities for intervention. Journey maps tell the important stories of our personas in a way that places them within a broader ecosystem of interactions between people and systems; they help us to consider our personas within their unique context, rather than in isolation.

The content of a journey map varies depending on the subject matter and context of the project. Most journey maps include a timeline, opportunities for intervention, and elements of the persona such as pain points, thoughts, and feelings.

Journey maps are useful during the Design phase because they help us to keep the experiences and interactions that influence behavior at the forefront. This design tool helps contextualize the situation that each stakeholder faces in their role.

Audience segmentation
Healthcare seeking vs. perceived risk



Annie & Jean-Paul: The young ignorant couple
"When my children are not feeling well they don't eat much, I don't know what to do so Jean-Paul's mom tells me which plants or medicine I should buy"

Mbuyi & Safi: The struggling but united couple
"Although I lack financial means, I am willing to do anything for the health and well-being of my children. Children are wealth "

Giresse and Mamie: The commanding husband and the religious fatalist wife
"I don't trust the health workers so I forbid my wife to take the children to the health center"

Pascal & Bilonda: The traditional extended family
"I can't take any initiative on my child's health without consulting my husband or my in-laws."

Mado: The single mom and confident caregiver
"No need to go systematically to the Health Center because I already have experience with my other children"

Annie and Jean-Paul: The young and ignorant couple

Annie, 19, is pregnant for the third time. Already a mother of two children aged 3 and 5 months. She lives with her husband, Jean-Paul, 21, and her mother-in-law, in a village by the main road to the big city. She attended school until 6th grade, but had to stop because her parents did not want to keep investing in her studies and wanted her to get married. Jean-Paul is a motorbike taxi driver. However, they do not have enough resources to support all of their needs, including those of health. They go to church together on Sundays. Annie's mother in law gives them advice on home management and child health and tells them which plant to give in case of fever or cough. They always rely on her because she knows best and they don't have much experience of life. Whenever they don't understand what is going on with their children's health they ask for the opinion of the pastor. Jean-Paul still wants to have a lot of children because it is a wealth and he wants to please his mother.

SBC FACTORS

INTERNAL MOTIVATION

Low — High

EXTERNAL INFLUENCE

Low — High

PERCEIVED RISK - KNOWLEDGE

Low — High

SELF EFFICACY

Low — High

RELEVANT INSIGHTS

- 1-2-3
- 4-5-6
- 9

ASPIRATIONS

Annie wants to have several children, as much as God will give her. She wants them to be able to go to school, but she thinks this is a decision that Jean-Paul should make. Jean-Paul's mother encourages them to keep having children.

MOTIVATIONS

She wants to please Jean-Paul's mother and sees herself staying with him forever and being considered as a good wife. He wants to keep enjoying life as he believes he is still very young.

OPPORTUNITIES

Annie has a small radio where she often listens to music or theatre, while Jean-Paul prefers playing football in the village. During the moments shares with cousins they discuss many things and exchange advice on the management of the husband, the home and children. Annie is thirsty for knowledge but can't access it.

KEY PAIN POINTS

Annie understands that breastfeeding is important but does not know the importance of doing it exclusively. She breastfeeds because the traditional birth attendant told her to do so. Annie does not know how to read or write and the only moments she spend with Jean-Paul are during the night and on Sundays.

KEY BEHAVIORS

- She doesn't know how to recognize when a child is sick and can't decide to take her to the health center on her own. If the fever is mild, she makes plants boiled with sugar, based on the advice of her stepmother.
- She buys drugs at the pharmacy because they are cheaper than going to the health center.
- She lives far from a health facility and her husband drives a taxi moto. If the child is very very sick, they can access the health center..
- She breastfeeds but not all the time because she has to go to fetch water and she believes that when her child cries it's because he is thirsty so she gives him water.

VALUES

Annie and Jean Paul believe in God and in the power of prayer. They think that family values are important as well as respect for elders.

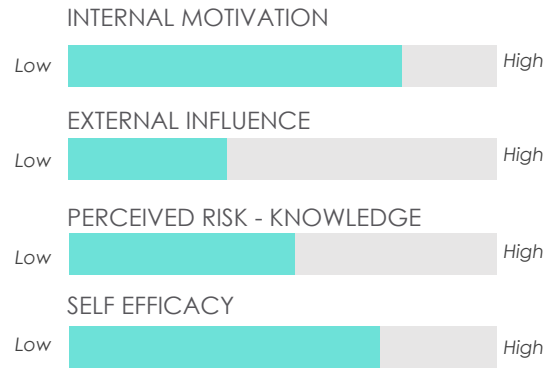
Journey map: **Annie & Jean Paul**

STAGES	SYMPTOMS	RESPONSE	SEEKING FURTHER HELP	TREATMENT	OTHER BEHAVIORS
	When one of our children is sick, Annie is the one taking care of it. Jean-Paul is almost never aware of the situation.	If the child coughs or has diarrhea, I tell my mother-in-law who tells me what to do with the plants. For diarrhea, we give guava leaves that are boiled and for coughing it is papaya leaves with sugar.	If it's not better after two or three days, then we talk to Jean-Paul's mother and we decide together if we're going to take the child to the health centre. As my husband has a motorcycle, it's easy to get there.	At the health centre, if we are given a prescription, my husband will give me money to pay for the medicine at the pharmacy. Once we didn't have enough money to pay for my child's treatment and I had to remain in the clinic until my Jean-Paul gathered all the money.	Annie has a low awareness about risks. Due to her age and her lack of experience she relies on the advice that her mother-in-law can give her.
THOUGHTS	I wonder why my children often have fever when they all sleep under the mosquito net. And we give them the porridge so they can have strength but they still get sick.	Cough and diarrhea are less severe than fever. That's why we can treat them with plants. My mother-in-law knows very well the plants that must be given for each case.	The fever is serious because it means that the child has malaria. In this case, we prefer to go to the health centre because malaria care is free.	Malaria medications are free at the health center For the other drugs, we buy them at the pharmacy.	Annie was visited once by a ReCo. He gave her some advice on how to prevent malaria, but he never visited her again.
PAIN POINTS	If our child is sick, I will ask Jean-Paul's mother. I will follow the instructions she gives me because she knows a lot about children.	It is sometimes difficult to find the right plants. We can ask the traditional practitioner but I do not like to go there. Sometimes I wish I could take my child to the health facility, but Jean-Paul thinks it's very expensive.	You have to wait for my husband to come back with his motorbike so we can take the children to the health center. We are always nervous because we don't know how much we will have to pay at the health facility.	Sometimes when you arrive at the health centre, there are no more medications so you have to come back while the child is having a high fever.	She still remembers some of the things the ReCo taught her. He gave her some advice, but she forgot what he said, and never heard anyone else talk about this same information.
OPPORTUNITIES	How might we motivate men to be more involved in health practices within the household to make this a shared responsibility with women?	How might we equip men to understand the risks of not using health centers and not using household health practices?	How might we reduce the anxiety and worry of not knowing the total price people have to pay for services before approaching the health facility?	How might we ensure common understanding of needs and expectations between health centers, village chiefs and the community are frequently shared?	How might we unleash the potential of ReCos and guarantee that they provide accurate information at tactical moments for the community to lead to the systematic use of health services?

Mbuyi and Safi: The struggling but united couple

Mbuyi, 38 and Safi, 34, have been married for 20 years. He feels that they married too early but they had parental pressure because Safi was pregnant at 15. At first, her parents threw her out of their house and he had to find a job to take care of them both. His mother accepted the whole family in her house so now she still wants to rule their life and the life of their six children.
Mbuyi takes all the decisions regarding the children but not without consulting his wife and always taking her opinion into account. The same is done for the household expenses that they plan together. For the last 3 years Mbuyi, who used to work in a mine, is now unemployed, so Safi is the only one providing for the family by selling vegetables and seeds at the market. Only two of their children go to school but it is sometimes difficult to find enough money to pay for their supplies. The other children work in the field so she can go and sell in the market in the nearest city.

SBC FACTORS



RELEVANT INSIGHTS

- **3**
- **10-11-12**

ASPIRATIONS

Mbuyi and Safi would like to have more money to put all their children in school and also afford to rent their own house one day to be free from Mbuyi's mother's influence. For that, Mbuyi needs to find a job soon.

MOTIVATIONS

The well-being of their children and their education are the two most important things for them both. They strongly believe that by investing in their children they will go out of poverty one day as one of them could emerge and get a well paid job in the city in a few years.

OPPORTUNITIES

Although they don't have much disposable income, Mbuyi and Safi still trust the health center's capacity to provide the necessary treatments for their children and they remain optimistic about the future.

KEY PAIN POINTS

The husband is unemployed and has no clear perspective of finding a job in the near future.

KEY BEHAVIORS

- Apart from their first child, who was born at home for shame of going to the hospital without being married and at 15, all their children were born at the hospital and Safi attended ANC for most of them except the last two because she claims she already knows everything they will tell her and she doesn't have time anymore as she now has to work to provide for the whole family.
- When children are sick Safi will ask her husband to take them to the health center that is located at half an hour walk.
- Most of the time, Mbuyi's mother gets mad because they don't listen to her advice about child care and she would prefer that they take the children to the traditional healer who she believes is more competent that the nurses at the health center.
- However, when they don't have enough money to pay for the medicine, they will give the children plants and local roots until they can find the needed money.

VALUES

The couple is open to discussion and prioritize their children. Mbuyi gives his wife a key role in the household decisions and values her financial contribution.

Journey map: **Mbuyi & Safi**

STAGES	SYMPTOMS	RESPONSE	SEEKING FURTHER HELP	TREATMENT	OTHER BEHAVIORS
	Safi is able to recognize the signs of sickness among her children. But as she works most of the day out of home, she has to trust her mother-in-law and her unemployed husband to identify anything wrong with the children.	Mbuyi doesn't work but he will wait for his wife to come back home to make a decision about the children. His mother will give boiled roots or plants in case of diarrhea or fever. She would like him to go to the traditional healer but he would rather take them to a health facility.	In case of high fever or diarrhea both parents agree to take the children to the health center but it is relatively far. They may not always go to the health center in case if a cough. When short of money, they can borrow from the neighbors to pay for care at the health center.	They will follow the treatment recommended by the healthcare professional unless they don't have the necessary money to buy the medicine.	The fact that Safi works outside the house prevents her from exclusively breastfeeding as she has to leave the children at home. Everyone in the household sleeps under a torn mosquito net that they received during an ANC consultation at the health center. They don't have water nearby so their 17 years old daughter is in charge of getting water from the village fountain.
THOUGHTS	I always wonder if my children are safe while I'm not home.	I don't like that my mother-in-law gives the children plants and roots that I don't know but I have no other choice.	I wish I'd always have enough money available to take my children to the health center or the hospital.	I wish we could receive free medicine immediately at the health center or to be able to buy them at credit somewhere.	I would like to take better care of my younger children but I need to work to support the family until my husband finds a new job.
PAIN POINTS	The mother-in-law and the husband know less about children's sickness symptoms but the wife stills needs to rely on them during the day.	Mbuyi's mother has higher trust in the traditional medicine than in the modern one.	The couple is willing to provide the best healthcare to their children but have little disposable income so sometimes they are not able to pay for a consultation.	Although they trust the health workers to consult and diagnosis children's' illnesses, they can face situations where they will have to wait before they can provide proper treatment to their child, due to lack of money.	Having an income generating activity is key for Safi but it means less time for her children and the household chores.
OPPORTUNITIES	How might we create safe spaces/arrangements for women to be able to work and complete their tasks while knowing their children are safe?	How might we work together with traditional healers and religious leaders in the adoption of health seeking behaviors without threatening his legitimity in the community?	How might we inspire household members to seek safe healthcare even if they perceive it as expensive and unattainable?	How might we build relevant cost comparisons to help households consider the longer term costs and risks associated with the adoption of other culturally accepted practices for healthcare?	

Giresse and Mamie, the commanding husband and the religious fatalist wife

Giresse, 31, works in a mine, 120 km from his house. He is absent two months then comes back home for a week. He is married to Mamie, 29 and they have 5 children; 4 girls and 1 boy. Giresse wants Mamie to have more children because it is important to have a lot, and more boys, to show the community that he is a "strong man."
Giresse has a total of 12 children, 7 from his first wife, Vivi. They all live in the same compound except a few of the older children who don't live with them anymore because there's not enough space. They only come during the day to eat with the family. Mamie strongly believes that God will provide and she will therefore do nothing to stop having children although she is tired.

SBC FACTORS

INTERNAL MOTIVATION
Low — High

EXTERNAL INFLUENCE
Low — High

PERCEIVED RISK - KNOWLEDGE
Low — High

SELF EFFICACY
Low — High

RELEVANT INSIGHTS

- 2 - 3
- 7 - 8
- 9 - 12

ASPIRATIONS

Giresse is convinced that one day he will find a better job, maybe in town, so that he can buy a car and become a taxi driver.
Mamie dreams of having a bigger house to accomodate all the children from both marriages.

MOTIVATIONS

Mamie believes that God will help for anything, even health and that one day he will improve the family's situation by providing a better job for her husband so that he can spend more time with the family and get to know his children better.

OPPORTUNITIES

The husband has a paid job and could save money for healthcare. Besides her husband, Mamie could be positively influenced by her religious leader if the latter is aware of the appropriate health and household savings messages to convey to the couple.

KEY PAIN POINTS

The husband doesn't trust the healthcare facilities of the area because he thinks the health workers are incompetent and costly. He believes prayer is strong enough, and prohibits his wife to go there or take the kids.

KEY BEHAVIORS

- Giresse brings money home when he comes back from the mine but leaves very little when he goes back to work. Despite that, he is the absolute chief of the household and demands much respect from his wife. He is the first to eat and gets the best parts because he is the provider, and sometimes the children don't get enough to eat.
- He will not send his girls to school because they will get married as soon as they are women and will leave the family. His wife can buy the food that she needs to cook but he is the one who buys everything else.
- Mamie goes to church every Sunday and listens to what her pastor says. She will not try to stop getting pregnant because the number of children is God's will.
  She usually breastfeeds during the first three months approximately but also gives red tea and water to the baby for fear of dehydration due to the heat.
- When the children are sick, she calls the pastor and he comes and pray on the children. Sometimes, when it gets bad, she goes to the pharmacy to ask for medication but she will not go to the health center against her husband's will.

VALUES

God is everything but respect for traditions (and the husband) is also important

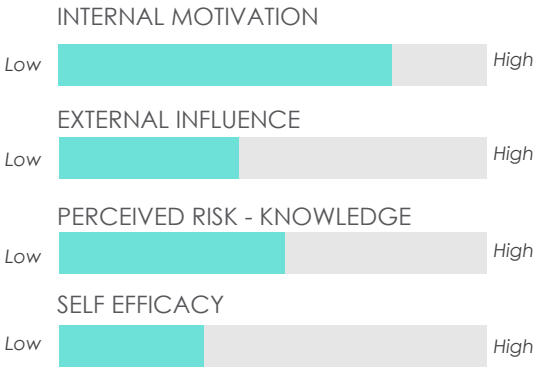
Journey map: **Giresse & Mamie**

STAGES	SYMPTOMS	RESPONSE	SEEKING FURTHER HELP	TREATMENT	OTHER BEHAVIORS
	Mamie knows well how to differentiate between non harmful symptoms and more serious situations. With her first children, she used to panic for anything but now she knows that she does not need to worry as much. She learned from previous illnesses among her children.	Now, when a child is apparently sick, Mamie will wait and see if he gets better by himself. After a few days, if the situation worsens, she will take the child to see the pastor so that he can pray on him. If it's cough or diarrhea, she knows some plants that stop them, but for fever it's only the prayer.	Giresse forbids Mamie to go to the health center. He believes that the health workers are not trustworthy and will do more harm than good before they often go against God's will by doing blood transfusions for example or practicing surgery although they don't have good materials.	God will help them and prayer will treat anything. No need for medication apart from plants and natural roots than they find in the fields.	The baby needs to drink water and tea because it's too hot. Breastfeeding is good but if the baby only drinks his mother's milk he will die of hunger.
THOUGHTS	No need to panic for a simple cough or diarrhea. Fever can be dangerous but it can also end after a few days with a wet cloth on the baby's head.	*"Prayer heals everything"*. They believe in the power of prayer and will of God to solve any issue including health.	*"I don't trust the health workers, they are mostly too young and not experienced"*	Modern medication can be dangerous. We don't know what they give to our children.	The baby has to eat and drink to grow healthy because mother's milk is not sufficient to feed him.
PAIN POINTS	Low awareness of risks linked to cough, diarrhea or fever leads to poor decision-making.	Low awareness of risks linked to cough, diarrhea or fever leads to poor decision-making.	Religious beliefs are a strong barriers to the adoption of proper behaviors.	Religious beliefs are a strong barriers to the adoption of proper behaviors.	Lack of information on the importance of exclusive breastfeeding leads to dangerous behaviors.
OPPORTUNITIES	How might we ensure people understand and are able to recognize when cough, diarrhea and fever symptoms become severe enough to seek treatment at a health facility?	How might we build relevant cost comparisons to help households consider the longer term costs and risks associated with the adoption of other culturally accepted practices for healthcare?	How might we transform the role of traditional healers and religious leaders to become bridges for safe healthcare and adequate pregnancy care?	How might we involve religious leaders and traditional healers to encourage their followers to use health facilities as soon as the first signs of disease appear?	How might we normalize exclusive breastfeeding (for the first 6 months) while acknowledging the existence of false beliefs about infant nutrition within the community?

Pascal and Bilonda, the traditional extended family

Pascal, 49 and Bilonda, 42, have 10 children. He has some crops and sells his harvest at the village market. He is also a village chief. They live about 20 km from the city. In addition to the couple and their children, Pascal's two young brothers of 22 and 19 years old and his mother live with them. Pascal's days start very early in the field and he only arrives back home after he has had a drink with friends at the only shop in the village. Bilonda grows cord, peanuts and some soy in a small family plot far from the house. She cooks for all the family, and fetches water every morning. When Pascal and Bilonda are out of the house, the younger children stay at home with their grandmother. Only two of the children go to school.

SBC FACTORS



RELEVANT INSIGHTS

- 1 - 2 - 3
- 4 - 5 - 7
- 10 - 12

ASPIRATIONS

Pascal: Save enough money to buy more land and take good care of his entire family (good health, good education)

Bilonda: To be able to put all her children to school, to allow them to have enough to eat everyday and that they are all in good health.

MOTIVATIONS

Pascal wants to have a good reputation in his village, so having children in good health and who go to school is a factor of pride. He doesn't want to have more children but he doesn't know of any family planning methods and is afraid Bilonda will suffer side effects.

OPPORTUNITIES

They value the importance of having a good health to be able to move forward in life. The level of influence Pascal has in the community. People trust his advice.

KEY PAIN POINTS

Since there are so many family members living with them, not all of them have access to bed nets. Men usually sleep without bed nets and the ones that they have are old and torn. The responsibilities at home are not evenly distributed. Bilonda does not have much time available to share with her children or to rest. Bilonda doesn't have time left between her work in the fields, fetching water and going to the market Her husband is seldom at home.

KEY BEHAVIORS

- Although her children's health is a priority for Bilonda, she doesn't recognize the benefits of going to the health center because "*they don't know more than me and the cost is high for nothing*".
- "*Sometimes you will still go and wait there for hours and when you see the nurse or the doctor he will prescribe paracetamol or anaflam and make you pay for the "fiche". I'd rather go direct to the pharmacy*".
- However, if after a few days their condition has not improved, she will take them to the hospital after consulting her husband who has to agree and also give the money for the consultation and treatment.
- She always exclusively breastfed her babies for the first weeks but after that she had to go back to the fields and the market and she can't take them with her so they start eating porridge.

VALUES

Family values, tradition, hard work

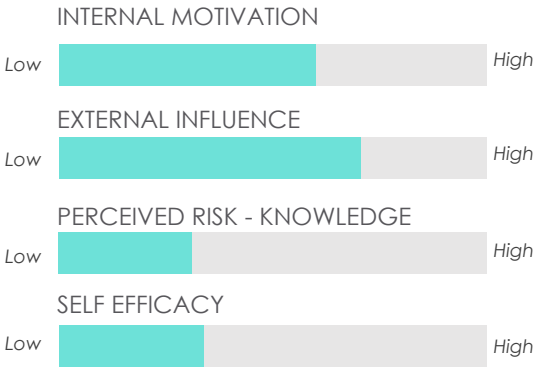
Journey map: **Pascal & Bilonda**

STAGES	SYMPTOMS	RESPONSE	SEEKING FURTHER HELP	TREATMENT	OTHER BEHAVIORS
	Bilonda might know that her child is not well but sometimes misinterprets the signs and neglects the severity of the situation. Since they have 10 children, they can't control that everyone is healthy.	She will go to the nearest pharmacy to ask for a drug she already knows because she or a neighbor previously used it in a similar case.	Pascal and Bilonda don't trust the health workers to solve their problems because of their apparent incompetence. They think care at the health center or the hospital is too expensive and the return is very poor.	They'd rather buy drugs at the pharmacy than to seek treatment at the health facility.	Although Bilonda knows the benefit of breastfeeding she has to work in the fields and cannot carry her babies with her.
THOUGHTS	All children get sick ; its normal. But if we have more children we will be at risk of not being able to provide a good life to them.	"I have to work and don't have much time. If you go to the hospital you will wait there for hours and when you finally see the nurse or the doctor he will prescribe you paracétamol or anaflam and make you pay for the "fiche". I'd rather go direct to the pharmacy". "At the health center, they don't know more than me and the cost is high for nothing".			I know it's good for my baby to get the mother's milk, I don't have the time for that.
PAIN POINTS	She doesn't spend enough time with her children to be able to genuinely identify signs of severe condition.	The lack of time and money favors self medication	Strong mistrust for health workers is a huge barriers to healthcare seeking.		Lack of time for herself and her children is a barrier to exclusive breastfeeding. Also, mothers don't know what else to feed infants.
OPPORTUNITIES	How might we guarantee that decisions to conceive more children are linked to a previous examination of the household's financial health?	How might we inspire people to make health care decisions based on quality of health outcomes rather than on cost, access, cultural considerations and close proximity to health centers?	How might we motivate and train health personnel to provide empathetic services in order to regain the trust of the community?		How might we create safe spaces/arrangements for women to be able to work and complete their tasks while knowing their children are safe? How might we offer valid child feeding options?

Mado, single mom and confident caregiver

Mother, 34 of nine, Mado got married to a farmer at 14 and her oldest son is now 19 and has his own child. She spends most of her mornings in the field to be able to feed her family. Her husband left a year ago, leaving her alone with the 9 children. When she comes back from the field, she takes care of the house and cooks. The older children alternate between the field and the house to look after the younger ones (5, 3 and 8 months). Only 1 out of 9 children goes to school and it's her 10 years old daughter because, according to Mado: "she is smart and willing to learn." Mado thinks that she doesn't need to go to any healthcare center because of her extensive experience with children that allows her to know well about fever, cough, diarrhea treatments, and what is best for pregnant women. She makes sure that her family, friends and neighbors benefit from her knowledge by providing advice and guidance anytime she can.

SBC FACTORS



RELEVANT INSIGHTS

- 1 - 2
- 5
- 10 - 11

ASPIRATIONS

Her 10 years old daughter is the only one going to school, hoping that one day she will take care of her brothers and sisters and take the family out of poverty. Her children are her only wealth and she will do whatever it takes to raise them properly, even without a man by her side. She hopes that they will grow healthy and she will be able to send more to school with the help of God.

MOTIVATIONS

Being seen as a good mother to her children and a valued member of the community and her women's group are key drivers for Mado. She likes helping out other women and sharing her experience and knowledge regarding children and household care.

OPPORTUNITIES

She strongly believes that education can take her children out of poverty but she can't afford sending them all to school. She has been part of a women's group for the last 5 years. Most of her health 'knowledge' come from her own experiences or the ones shared at the group meetings.

KEY PAIN POINTS

She doesn't have any spare time for revenue generating activities. She spends all her time between house chores and field work. He doesn't trust men.

KEY BEHAVIORS

- She doesn't have time to take care of herself or go to the hospital so when the children have fever, she boils papaya leaves with sugar or she takes them to the traditional healer who leaves nearby. Most children sleep under a bed net in the house but not all night, so they suffer from frequent bouts of malaria, without seeking proper treatment.
- She breastfeeds only in the morning before going to the field and leaves some porridge or fufu at home for all the children, depending on what she can afford.
- She helps other women from her neighborhood dealing with fever or other child sickness by giving them plants that she grows in her field and providing advice to prevent malaria like sleeping under a bed net or not keeping water stored inside the house.

VALUES

God and prayer are important as well as being a good mother

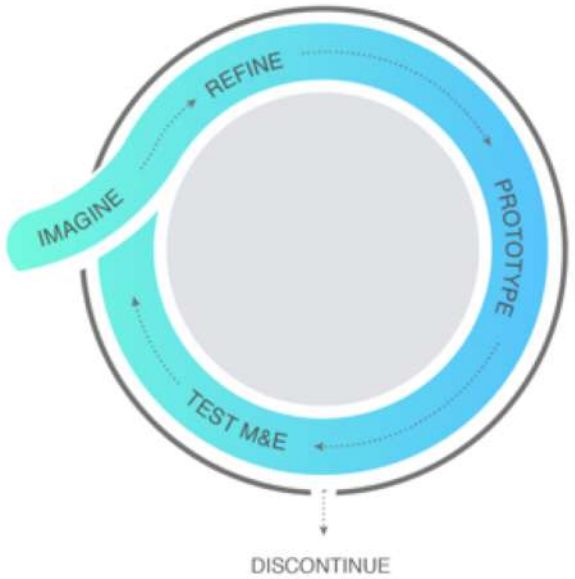
Journey map: **Mado**

STAGES	SYMPTOMS	RESPONSE	SEEKING FURTHER HELP	TREATMENT	OTHER BEHAVIORS
	Mado is able to detect if a child his moderately or severely sick because she had 9 children and now even has a grandchild so she has the experience. However some of the knowledge she has is incorrect and was shared in the women's group she is part of.	She will give plants and other traditional treatments that she knows of and often recommends to her friends and neighbors.	If the child's conditions worsens, Mado will visit the traditional healer and ask him for advice. Most of the time he is able to cure the children in a few days. Modern health care is useless and expensive and she doesn't' have the time nor the transport money to go.	She doesn't have time to take care of herself or go to the hospital so when the children have fever, she boils papaya leaves with sugar or she takes them to the traditional healer who leaves nearby.	She didn't attend any ANC visits and gave birth of all her children at home, with the help of the traditional matrone who is now her close friend and gave her advice on how to go through pregnancy nand how to take care of the babies. Everybody sleeps under a bed net in the house but the whole still suffers a lot from malaria, without seeking proper treatment
THOUGHTS	My children are getting sick because of the bad quality of the water in the village. But that's the only option we have	*"We women do not have much time because we are always between the field and the house and the children"*			I know it's good for my baby to get the mother's milk, I don't have the time for that.
PAIN POINTS	She doesn't spend enough time with her children to be able to genuinely identify signs of severe condition	The lack of time and money favors self medication	The health center is far away and expensive for Mado who has to raise 9 children on her own. She relies on her past experience to provide the best care to her children.		The risks of not exclusively breastfeed are not well known even though she has 9 children.
OPPORTUNITIES	How might we identify the myths and misconceptions being shared in women's groups and ensure that these groups provide a good basis for generalized knowledge surrounding health?	How might we uncover the risk and consequences of using traditional medicine or automedicating and make them relevant to different households?	How might we transform the role of traditional healers and religious leaders to become bridges for safe healthcare and adequate pregnancy care?		How might we encourage pregnant women to complete the four ANCs during pregnancy regardless of their income level?

5. Next steps

Design and Test phase overview

PHASE 2 | 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.

Imagine and Prototyping workshops
Imagine and Prototyping workshops will be held in Mbuji Mayi and Lubumbashi to generate multiple ideas to address the insights and opportunities. This will be an interactive and collaborative workshop with stakeholders, partners, and target audiences. The workshops will refine their ideas and select the most promising to prototype and test.

Capacity strengthening
Capacity strengthening sessions will be build in to the Imagine and Prototyping workshops for the Design and Test fieldwork teams.

Rapid prototyping
After the Imagine and Prototyping workshop, rapid low-fidelity prototypes of the selected ideas will be developed to test with target audiences.

Prototype and test sprints
A four-day prototype and test sprint will be held in Mbuji Mayi and Lubumbashi. This will include one day of capacity strengthening and three days of testing prototypes with target audiences. At the end of each day, the prototypes will be refined based on the feedback received.

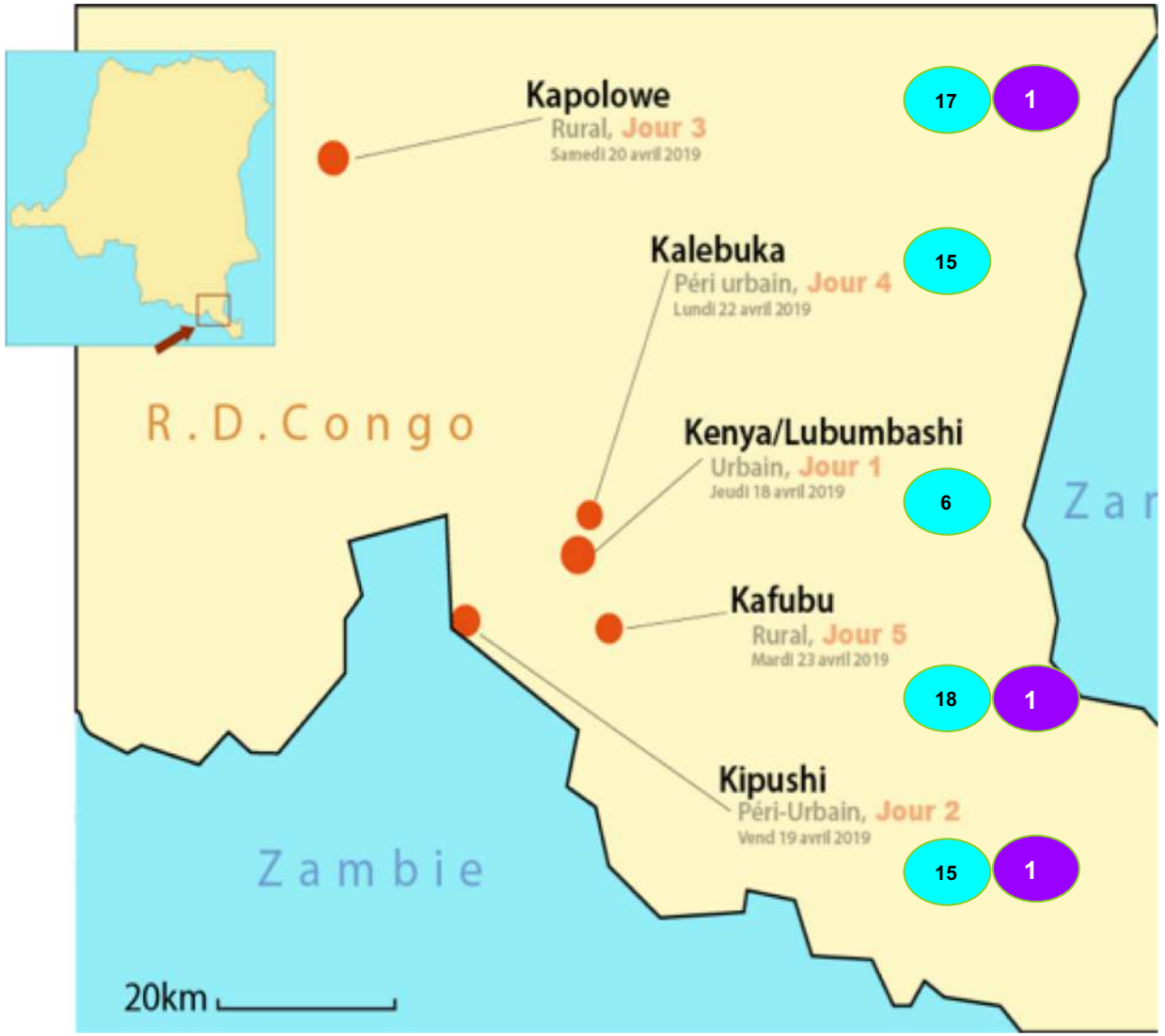
Consolidation workshop
After testing, the Design and Test fieldwork teams will share their findings and consolidate the refined prototypes.

Prototype prioritization
Prototypes will be prioritized based on their feasibility, usability, and desirability. The prioritized prototypes will then be considered for transition to the Apply phase.

6. Appendices

Geographic scope

Appendix 1: Haut Katanga interview locations and distribution



Appendix 2: Kasaï Oriental interview locations and distribution

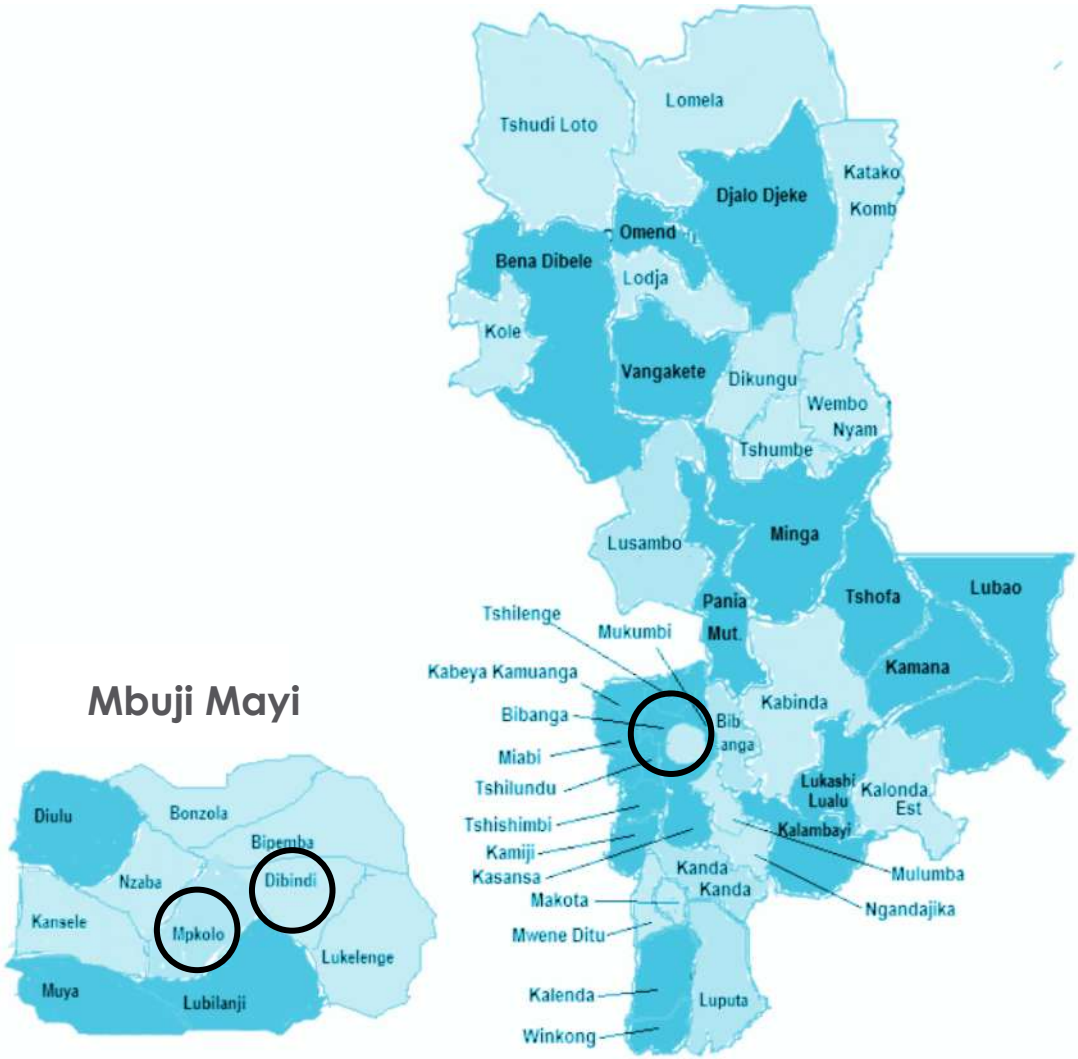
Tshitenge: 15 interviews + 1 FCD

Dibindi: 14 interviews + 1 FCD

Bibanga: 16 interviews

Kasansa: 12 interviews + 3 FCDs

Mpokolo: 16 interviews



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