



SOCIAL IMPACT LAB



DFID Beneficiary Feedback Mechanisms (BFM) Pilot

End-point Review: Synthesis Report

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INTRAC

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Executive summary

Between 2014 and 2016 seven organisations working in six countries piloted a range of Beneficiary Feedback Mechanisms (BFM).¹ These pilots were attached to maternal and child health (MCH) projects funded by DFID's Global Poverty Action Fund (NOW UK AID DIRECT). Implementation was supported by World Vision, Social Impact Lab and INTRAC. This report presents findings from the end-point review.

Three approaches were piloted: 1) mechanisms seeking unsolicited feedback; 2) mechanisms seeking feedback on specific indicators; and 3) mechanisms developing indicators and tools in a participatory way. The pilots were reviewed at three points in time with data collected from beneficiaries, intermediaries (such as health workers) and project staff by consultants based in the countries.

- **Establishment of feedback mechanisms**

All seven pilots were successful in establishing functioning feedback mechanisms. This required **flexibility in the initial design phase** in order to adapt the mechanisms to the project contexts. **Sensitisation of target beneficiaries** to the purpose and process of giving feedback was also critical. Implementation was more straightforward where organisations had an existing presence in the community and had already built up trust. In some contexts, organisations overcame substantial fears and apprehensions about giving feedback:

"... at first, the community did not understand where ADRA was coming from ... Some people believed that this was a trap, trying to identify offenders. As time went on with people airing their views and realising that ADRA is responsive, people realised that it was a genuine desire to meet community needs." – Project volunteer, Zimbabwe

- **Collecting feedback and inclusion of the most marginalised**

A thorough **context analysis** and a **willingness to adapt mechanisms** during implementation ensured that the BFMs were appropriate for the target beneficiaries, and were accessible to them.

These were project contexts with high levels of poverty. There was therefore a preference for mechanisms that did not require literacy, were low cost, and were familiar to beneficiaries in their daily lives. **Face-to-face mechanisms** such as focus group discussions, where available, were used most frequently.²

The provision of **multiple mechanisms aided the inclusion** of different groups. Suggestion boxes in each pilot offered an avenue for confidential feedback.

There are indications that BFMs are valued by beneficiaries as platforms through which they can **exercise voice**, and that BFMs have supported beneficiaries to claim their entitlements.

"[The] community is now closer to the government services because of the project intervention."
– Honorary health worker, Uttar Pradesh, India

¹ ADRA (Zimbabwe), AMREF (Ethiopia), CINI (India), CUAMM Trustees (Tanzania), HPA (Somaliland), MAMTA (India), and Rahnuma (Pakistan).

² An exception is Rahnuma, which operated in a school context, where suggestion boxes were preferred by students primarily because of confidentiality.

- **Responding to feedback at project level**

Frontline staff play a critical role in determining what happens with feedback. A substantial amount of feedback was dealt with at point of service by project staff or volunteers. Some feedback induced organisational responses (such as providing information or referring feedback on to government), while no action was taken on feedback if it was considered **out of scope** (e.g. requests for support unrelated to maternal and child health) or **deemed not actionable** due to lack of detailed information.³

Of the feedback referred upwards from point of service, the vast majority was dealt with at project level in each country. A key advantage of the BFM for the projects and beneficiaries was **real-time adaption of projects** to emerging needs of target groups and their contexts:

“... If they hear our views and concerns on the services here, they will try to change things [for] the benefit of the community.” – Community leader, Sichembu, Zimbabwe

The ability to respond **required flexibility from stakeholders higher up the aid delivery chain**. For organisations not delivering services directly, good **working relationships with government service providers** were important. Changes informed by beneficiary feedback included:

- Construction of Waiting Mothers’ Shelters (Tanzania and Ethiopia)
- Procurement of an ultrasound machine to enable antenatal screening (Somaliland)
- Holding government staff to account for misconduct (Pakistan and Tanzania)
- Holding government and project staff to account for behaviour (Tanzania and Zimbabwe)

The pilot BFMs provided a two-way information channel, whereby feedback from beneficiaries required organisations to communicate back to the feedback-giver what action, if any, would be taken. **Communicating responses** back to beneficiaries was more challenging for mechanisms that were confidential than for face-to-face mechanisms; noticeboards were found to be of limited value except in schools. Direct contact between staff and beneficiaries as part of the BFM facilitated information provision and awareness raising, contributing directly to project outcomes.

- **Use of feedback higher up the aid delivery chain**

Over the course of the pilot, **limited use of beneficiary feedback by pilot organisations’ head offices, the fund manager or the donor** was observed. Few individual pieces of feedback required decisions at these levels, and those that did were primarily for budgeting reasons, indicating projects felt mandated to respond to most feedback. There was evidence that feedback informed organisations’ reporting to the fund manager and also strategic planning processes. However, little evidence of feedback informing strategic decisions or learning above the level of individual projects was found.

The **capacity of organisations to systematically code and analyse feedback** may have limited the provision and usefulness of feedback to stakeholders at higher levels (although it did not appear to significantly affect organisations’ ability to respond at project level).

³ This was particularly the case where traffic light or pictorial formats were used to adapt suggestion boxes to make them accessible for illiterate beneficiaries.

There are early indications that the positive experience of implementing BFM has stimulated pilot organisations to consider how to **sustain current BFMs and scale up the use of beneficiary feedback** within their projects. Pilot organisations have begun developing **exit strategies** for the mechanisms. It is important that this continues in order to avoid disillusionment or dissatisfaction within communities once the pilot ends.

- **Differences between approaches to beneficiary feedback**

The small number of pilots and contextual differences between them limit the possibility of comparison across the approaches. However, some **differences in collecting feedback** were observed. For the unsolicited feedback approach,⁴ where face-to-face mechanisms were not used, organisations struggled to engage illiterate beneficiaries and to sensitise the community to the BFM. Pilots using feedback approaches designed in a participatory way appear to have faced fewer challenges in collecting feedback, although this may be due to their contexts rather than the approach itself.⁵ These differences in relation to collection of feedback did not appear to translate into any systematic differences in how feedback was used or responded to by the pilot organisations.

- **Recommendations for those implementing BFMs in the future:**

- At the outset, ask whether there is sufficient time, resources and flexibility to respond to feedback once the feedback mechanisms is in place
- Conduct a thorough context analysis before deciding on a particular feedback mechanism, poverty and literacy were important factors in marginalised contexts
- Sensitise beneficiaries to the purpose and process of giving feedback, both at the start of the project and on an ongoing basis, and allow time to build trust in the mechanism
- Engage with a range of external local stakeholders (particularly local government agencies and community leaders) about the feedback mechanism and establish referral protocols
- Ensure that there is sufficient scope in the programme design to make changes and respond to requests to increase or reallocate resources; negotiate with the donor if necessary
- Ensure those with 'first contact' with beneficiaries (often project staff) understand the purpose of feedback and the scope for responding
- If feedback is intended to feed into monitoring systems, give careful consideration to how feedback will be analysed and aggregated and the capacity of staff and systems to do that.
- Consider the exit strategy for the feedback mechanism as part of the initial design phase

⁴ Approach 1, employing suggestion boxes, voice calls and SMS feedback mechanisms.

⁵ In Approach 3, both pilots employed group discussions and suggestion boxes, following consultation with beneficiaries during the design process. Both Approach 3 pilots were in India, and this context may have shaped some of the differences observed.

List of abbreviations

| | |
|---------|---|
| AFP | Access and Feedback Programme |
| ADRA | ADRA – Pilot organisation in Zimbabwe |
| AMREF | AMREF Health Africa – Pilot organisation in Ethiopia |
| BFM | Beneficiary Feedback Mechanism |
| CINI | Child in Need Institute – Pilot organisation in Kolkata, India |
| CFO | Community Feedback Officer |
| CTOC | Common Theory of Change |
| CUAMM | CUAMM Trustees – Pilot organisation in Tanzania |
| DFID | Department for International Development |
| DMO | District Medical Officer (Tanzania) |
| FGD | Focus Group Discussion |
| GPAF | Global Poverty Action Fund (now UK Aid Direct) |
| HEW | Health Extension Workers (Ethiopia) |
| HPA | Health Poverty Action – Pilot organisation in Somaliland |
| INTRAC | INTRAC – Pilot consortium member responsible for monitoring and review |
| JSY | Janani Suraksha Yojana (India, see page 58) |
| KII | Key Informant Interview |
| KLOE | Key Line(s) of Enquiry |
| M&E | Monitoring and Evaluation |
| MAMTA | MAMTA Institute for Mother and Child – Pilot organisation in Uttar Pradesh, India |
| MANREGA | Mahatma Gandhi National Rural Employment Guarantee Act (India) |
| MCH | Maternal and Child Health |
| MDSR | Maternal Death Surveillance Reporting |
| NGO | Non-governmental organisation |
| OCAT | Organisational Capacity Assessment |
| ORW | Outreach Worker |
| PM&E | Participatory Monitoring and Evaluation |
| RIEC | Research and Impact Evaluation Component |
| SMS | Short Messaging Services (Text Messaging) |
| VFM | Value for Money |
| VHW | Village Health Worker (Zimbabwe) |
| WHC | Ward Health Committee (Zimbabwe) |
| WFP | World Food Programme |
| WV | World Vision UK – Pilot consortium lead |

Contents

| | |
|---|----|
| Executive summary | 2 |
| List of abbreviations | 5 |
| Contents | 6 |
| 1. Introduction | 8 |
| 1.1 Overview of BFM pilot | 9 |
| 1.2 Theory of Change | 9 |
| 1.3 Overview of BFM pilot design | 10 |
| 1.4 Purpose of Monitoring and Review | 11 |
| 1.5 Implementation of the pilot BFMs | 13 |
| 2. Methodology and analytical framework | 17 |
| 2.1 Monitoring and Review design | 17 |
| 2.2 Data collection | 18 |
| 3. Key findings: collecting feedback and inclusion | 25 |
| 3.1 Design, context analysis and adaptation of BFMs [Indicators 1 and 2; KLOE 2 and 3] | 25 |
| 3.2 Sensitising communities to BFMs [Indicators 2, 3, and 5; KLOE 1, 2, and 3] | 27 |
| 3.3 Beneficiaries' awareness of entitlements and confidence to give feedback [Indicators 2, 5, and 8; KLOE 1 and 3] | 30 |
| 3.4 Active use of BFMs [Indicator 6; KLOE 5] | 33 |
| 3.5 Inclusion of target groups in the BFM, including the most marginalised [Indicators 17 and 19; KLOE 5] | 35 |
| 3.6 Use and non-use of different feedback channels [Indicator 17; KLOE 1 - 4] | 40 |
| 3.7 Contribution to empowerment outcomes [Indicators 5 and 10; KLOE 1] | 43 |
| 3.8 Comparing the three approaches and assumptions in the theory of change [KLOE 2] | 45 |
| 4. Key findings: project-level feedback loops | 49 |
| 4.1 Point of service feedback loops [Indicators 7 and 12; KLOE 4, 6 and 7] | 49 |
| 4.2 Project level feedback loops [Indicators 7, 13, 14, and 15; KLOE 4, 6, and 7] | 52 |
| 4.3 Closure of feedback loops at project level [Indicator 13; KLOE 4, 6, and 7] | 56 |
| 4.4 External feedback loops [KLOE 6 and 7] | 57 |

| | | |
|-----|---|----|
| 4.5 | Contribution to improvements in programme quality [Indicators 8 and 18; KLOE 4, 7 and 10] | 59 |
| 4.6 | Value for money [Indicators 21, 22, and 23; KLOE 8] | 60 |
| 4.7 | Comparing the three approaches and assumptions of the Theory of Change | 61 |
| 5. | Key findings: upper feedback loops | 63 |
| 5.1 | Decisions at higher levels on individual pieces of feedback [Indicator 16; KLOE 4 and 7] | 63 |
| 5.2 | Integration with existing M&E systems [Indicator 1; KLOE 3] | 68 |
| 5.3 | Feedback informing donor reporting and strategic planning [Indicators 4, 7, and 16; KLOE 7] | 70 |
| 5.4 | Evidence of change at higher levels | 71 |
| 5.5 | Comparing the three approaches and assumptions in the Theory of Change | 73 |
| 6. | Conclusions | 74 |
| 7. | Recommendations | 78 |
| 7.1 | For the seven partner organisations | 79 |
| 7.2 | For organisations considering implementing BFM's in the future | 80 |
| 7.3 | For donors and policy-level stakeholders | 81 |
| | Annex 1: Common Theory of Change | 82 |
| | Annex 3: Design changes during inception | 90 |
| | Annex 4: Indicators | 93 |
| | Annex 5: Methodology – supporting tables | 94 |
| | Annex 6: Meta-analysis of Organisational Capacity Assessment Tool (OCAT) Results | 96 |

I. Introduction

This report presents findings from the end-point review of a pilot implementing beneficiary feedback mechanisms (BFM) in seven aid projects, funded via DFID's Global Poverty Action Fund (now and hereafter referred to as UK Aid Direct). The pilot ran from 2013 to 2016, and sought to gather evidence and practical learning on three different approaches to implementing BFMs tested across the seven pilot sites. The approaches varied in terms of whether feedback collected was solicited or unsolicited, the intended level of resources required to implement them, and level of participation by targeted users in their design/use. Each approach followed the same 'closed loop' definition, described in Box 1.

Box 1: Definition of Beneficiary Feedback Mechanism used in the pilot

"A *beneficiary feedback mechanism* (BFM) is a context-appropriate mechanism which a) solicits and listens to, collates and analyses feedback, b) triggers a response/action at the required level in the organisation and/or refers feedback to other relevant stakeholders, c) communicates the response/action taken where relevant back to the original feedback provider and if appropriate, the wider beneficiary community. In this definition (a), (b) and (c) must all be present/true and a feedback mechanism is not functional if just one of them is present/true."⁶

Seven pilot feedback mechanisms were implemented in six countries (Ethiopia, India, Pakistan, Somaliland, Tanzania, and Zimbabwe) with civil society organisations that were carrying out maternal and child health projects funded via the UK AID DIRECT.⁷

The review assessed progress of the BFM pilot against a series of indicators and key lines of enquiry and analyses changes observed that were brought about by the BFM feedback since the baseline, but is not an evaluation of the pilot as whole, the projects themselves nor the organisations implementing the pilot beneficiary feedback mechanisms.⁸ This synthesis report draws on the findings from seven project-level reports (available on request), each informed by data collection by in-country consultants at three key moments in the monitoring and evaluation cycle. It supplements the findings of these reports with additional interviews with stakeholders in the aid-delivery chain, as well as a review of project documentation.

The purpose of this report is to analyse the experiences of the seven pilots, draw common themes, and highlight relevant learning for audiences with an interest in how beneficiary feedback can inform development aid programmes. A shorter summary briefing, based on the findings in this report is available at: www.feedbackmechanisms.org.

⁶ Jean, I. (2013, June) 'Desk Review on Existing Evidence CDA and Development Initiatives.'

⁷ Pilots in Tanzania, Ethiopia and India (CINI) are due to end in March 2016, and Pakistan and Zimbabwe in April 2016.

⁸ See Section 3.1 for key lines of enquiry.

1.1 Overview of BFM pilot

In April 2013, DFID commissioned World Vision UK (WVUK), the International NGO Training and Research Centre (INTRAC) and Social Impact Lab (SIMLab) to design, monitor and implement a Beneficiary Feedback Mechanism pilot in seven UK Aid Direct maternal and child health projects in six countries.⁹ The overall objectives of the pilot were:

- To enhance understanding and responsiveness between beneficiaries, grant holders (including their project partners) and DFID in order to: improve the appropriateness of projects in making positive change to poor people's lives; and increase the adaptability of projects to unintended consequences (good or bad)
- To provide information to DFID and the external Fund Manager on beneficiary views of the performance of projects to hold the grant holder accountable.
- To contribute to the evidence base of how, and under what conditions, beneficiary feedback improves development results and the level of resources required to design and manage a BFM for meaningful impact. This will enable DFID to roll out tried and tested mechanisms across their programmes in the future and share this approach with civil society organisations and other donors.¹⁰

The pilot formed part of DFID's Access and Feedback Programme (AFP).¹¹ The AFP was designed to increase transparency on aid spending and test the effectiveness of a range of beneficiary feedback mechanisms (BFM) in allowing poor women and men to hold aid implementers and donors accountable for the delivery of aid projects. The overall hypothesis was that increased aid transparency together with beneficiary feedback will lead to greater oversight in how aid is used, and therefore greater accountability in donor decision-making, and influence better development results.

The overall ambition for the BFM pilot was adjusted during the design phase, as the number of implementing organisations participating was lower than originally expected. A learning approach was proposed and agreed in April 2015, shifting the focus of the pilot from evaluation, building on the existing Monitoring and Review processes and supporting the partners in their own learning and contribution to pilot-wide learning.¹²

1.2 Theory of Change

A Common Theory of Change (CTOC) was developed by Itad¹³ as part of a wider evaluation of feedback mechanisms implemented under the AFP (which was later cancelled). The CTOC was retained for these pilots (see Annex 1).

The overall hypothesis for the pilot was that increased aid transparency together with beneficiary feedback will lead to greater oversight in how aid is used, and therefore greater accountability in

⁹ The original design was for nine pilots in eight countries; two projects pulled out during the design phase.

¹⁰ DFID (2012) 'PO6076 Invitation to Tender - Terms of Reference: Supplier for the Global Poverty Action Fund pilot for design, implementation and monitoring of the Beneficiary Feedback Mechanisms.'

¹¹ See: <https://devtracker.dfid.gov.uk/projects/GB-1-203316/>

¹² Learning approach paper, April 2015

¹³ Itad were contracted to manage the Research and Impact Evaluation Component (RIEC) for the BFM GPAF Pilot

donor decision-making and influence better development results.¹⁴ A more detailed Common Theory of Change (CTOC) was developed during the inception phase (see Annex 1), which posited three longer-term outcomes:

1. People are empowered to claim entitlements and hold projects and others to account.
2. Improvements in project quality.
3. Scale up and institutionalisation of feedback loops.

These were underpinned by a set of intermediate outcomes, which saw operational feedback loops at point of service, project level, strategy/policy level and DFID/development partner level. The intermediate outcomes were, in turn, underpinned by short-term outcomes reflecting appropriate levels of understanding and confidence for beneficiaries and capacity of staff to use the BFM to generate relevant feedback. Although the purpose of the monitoring and review was not to assess the Theory of Change, the data collected are relevant linkages and assumptions. Where relevant these are discussed in the key findings (chapters 4 – 6).

1.3 Overview of BFM pilot design

This section summarises the BFM pilot design, and key decisions made during the inception phase (May 2013 – May 2014).¹⁵ Three overall approaches for the design of the pilot BFMs were agreed during the inception period, which informed the subsequent design of the seven individual pilots. A summary of the approaches are outlined in Table 1. More detail about how these were expected to operate is given in the Theory of Change for each approach (Annex 2).

Table 1: Summary of the three approaches

| Approach | Summary |
|------------|---|
| Approach 1 | Provides an unsolicited feedback mechanism using low-cost, accessible mobile technology (SMS and voice). This was intended as a low resource approach. |
| Approach 2 | A social research approach soliciting feedback from target beneficiaries using pre-determined questions determined by the partner organisation. Beneficiaries participate in the method used to feedback, using a range of methods including client satisfaction surveys and beneficiary reference groups. This was intended to represent a medium resource approach. |
| Approach 3 | A beneficiary-led feedback approach (with partner support) in which beneficiaries decide on what, how, and when they provide feedback. This was intended to represent a high resource approach. |

The three approaches therefore structured the solicitation and collection of feedback differently. However, during the inception period, significant changes were made to the pilot design, including the three general approaches (see Annex 3). Changes, including those agreed at very early stages of

¹⁴ World Vision (2014) 'Design, Implementation and Monitoring of Beneficiary Feedback Mechanisms: GPAF Pilot Project PO 6076: Inception Report, Period: April 2013-May 2014.'

¹⁵ The main source for this section is the Inception Report, June 2014.

the design process such as the utilisation of suggestion boxes,¹⁶ muddled the distinction between unsolicited (Approach 1) and solicited (Approaches 2 and 3). Partner organisations received advice and templates from World Vision to support them in analysing and responding to feedback. However, the pilot did not seek to test alternative approaches to analysing or responding to feedback. Some feedback collection methods were also associated with certain response analysis channels (e.g. SMS involved Frontline cloud, and focus group discussions (FGDs)/community meetings provided easy opportunities for face-to-face responses).

The pilot consortium worked with partner organisations to identify the most suitable approach for each particular project, informed by a detailed context analysis. Other key design criteria included:

- **Selection criteria:** purposeful allocation, according to context, of specific projects to implement a single approach (i.e. not random selection or implementation of more than one approach per project).¹⁷
- **BFM pilot target area:** the implementation of the pilot in a sample of locations of the project and not the entire project area.
- **Integration with UK Aid Direct project logframes:** outcomes and indicators for the pilot would not be integrated into existing logframes.¹⁸ Given that many of the partners had already agreed their logframes with the fund manager when they agreed to be part of the pilot, this was deemed inappropriate. Instead, the integration of the pilot into the existing projects was outlined in MOUs signed with each partner.
- **Definition of 'beneficiary':** "beneficiary" referred to the "end" beneficiary of a project (service user) and not implementing partners, Government health staff, or intermediaries, even though they may benefit from the project or be stakeholders.¹⁹

I.4 Purpose of Monitoring and Review

Monitoring and Review support for the implementation of the BFM pilot was provided by INTRAC. The objectives of this support were to:

1. Provide an assessment of whether the three BFM approaches were being implemented as planned, through monitoring the implementation process against plans, targets and objectives.
2. Provide an assessment of the information flow between beneficiaries, UK Aid Direct partners, the UK Aid Direct fund manager and DFID.
3. Provide a review of the performance, effectiveness and efficiency of the BFM approaches in relation to how they affected the ability of the projects to make positive changes in peoples' lives.

¹⁶ The purpose of utilising suggestion boxes across the three approaches was to provide a confidential mechanism for beneficiaries.

¹⁷ There is therefore a potential bias that limits comparison of the three approaches, as organisational characteristics and contextual factors co-vary with the choice of approach.

¹⁸ For CINI (India), beneficiary feedback was integrated into their logframe and monitoring system.

¹⁹ In AMREF (Ethiopia) however, the BFM pilot targeted health sector political leaders at Zonal and District level, in addition to direct beneficiaries of the GPAF project.

4. Provide learning for projects, stakeholders, WV/SIMLab and DFID in order for them to adapt project activities in response to beneficiaries; and in order to improve subsequent decision-making and programming.²⁰

These objectives have informed the implementation phase of the BFM, to make real-time changes to the pilots, and also support learning from the pilot by documenting individual project experiences and capturing learning around common themes.²¹

The Monitoring and Review process involved an interconnected set of activities carried out by:

- The seven individual pilot organisations (UK Aid Direct partners) relative to their projects;
- The consortium overseeing the implementation of the pilot (World Vision and SIMLab, working through Community Feedback Officers at the project level);
- Independent Monitoring and Review consultants, collecting and reviewing data at intervals throughout the BFM implementation period (INTRAC);
- Linkages to the Research and Impact Evaluation Component (RIEC) (led by Itad) which was originally planned to carry out a larger evaluation of beneficiary feedback mechanisms. This component was discontinued during the course of the pilot.

²⁰ World Vision (2014) 'Design, Implementation and Monitoring of Beneficiary Feedback Mechanisms: GPAF Pilot Project PO 6076: Inception Report, Period: April 2013-May 2014.'

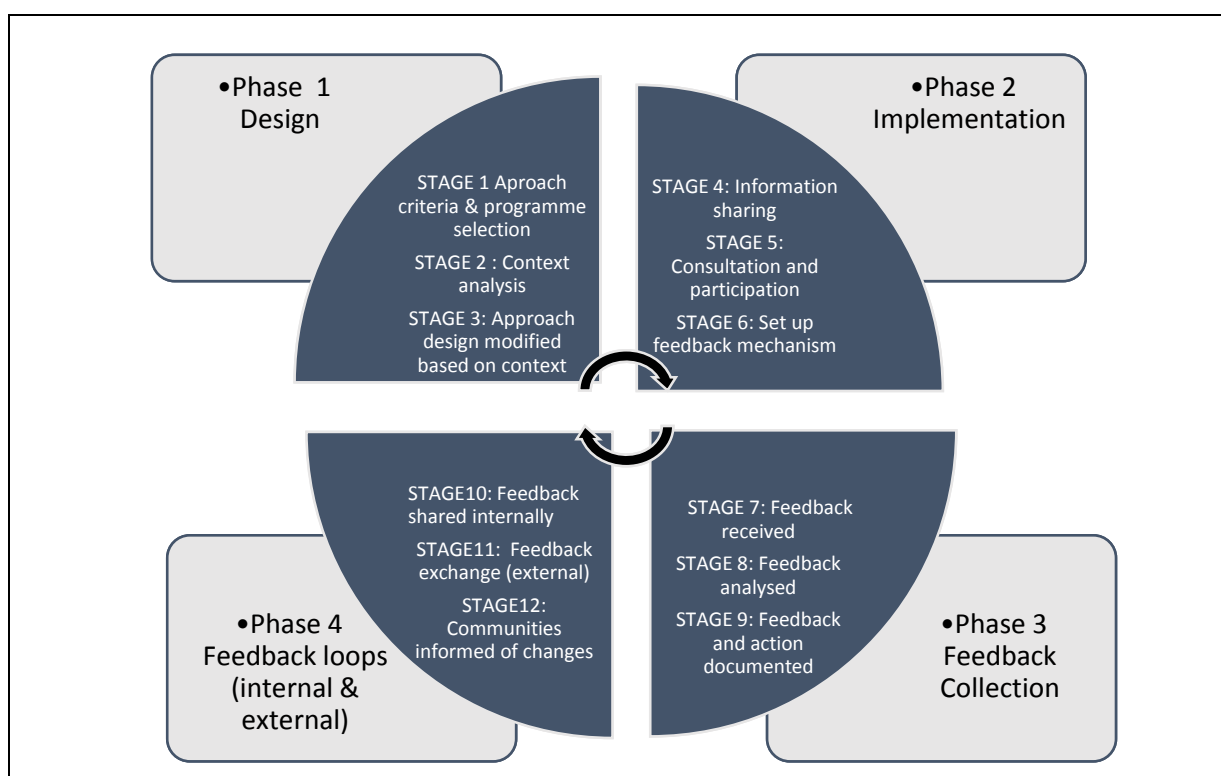
²¹ See: World Vision UK in conjunction with INTRAC and Social Impact Lab (2015, April) 'Learning Approach Paper in conjunction with DFID GPAF Beneficiary Feedback Mechanisms Pilot.'

1.5 Implementation of the pilot BFM

The overall implementation of the pilot began in May 2013 with an inception period. This was extended from an original four month period to one year (ending May 2014) as a result of including country context analyses to inform the design of each of the pilots (not just Approach 3 pilots as originally envisaged).

The design of the seven project-level pilot BFMs was based on the following four-phase process in Figure 1.

Figure 1: Four-phase model for project-level BFMs



The design phase, including context analysis and subsequent adaptation, took longer than expected for several projects (ADRA, AMREF, CINI, MAMTA and Rahnuma), with knock-on consequences for start-up and implementation (Table 2). Community sensitisation and gaining buy-in from key stakeholders was planned for a two-to-three month period, but in reality took much longer. In some contexts the idea of a feedback mechanism had negative connotations due to previous experience, or was not a known concept. BFM was also an added component of the project, so sensitisation had to be repeated.

Table 2: Implementation setbacks²²

| Pilot/Country | Reasons for delays | Examples of knock-on consequences of delays |
|------------------|---|--|
| CUAMM/Tanzania | Community sensitisation took time as it had to cover 18 villages and partner had limited staff at field level; local government elections in brought in new leaders at village and sub-village level. | Sensitisation process slowed down roll out. By the end-point, some communities still didn't have a clear understanding of the feedback process because they had less regular contact with project staff. |
| HPA/Somaliland | Issues with scheduling and implementing project during launch stage (pilot relaunched in June 2014). | Impacted upon community confidence in the BFM, with knock-on effect on feedback given, as initial enthusiasm waned. |
| AMREF/Ethiopia | Diphtheria outbreak; local elections; a longer than anticipated process for hiring the Community Feedback Officer (CFO); security situation from October 2015. The project location was very remote and project manager based over 80kms away and poor communications infrastructure leading to delays in closing feedback loops and escalation of feedback | Delays to installation of suggestion boxes; under-performed on key strategies for gathering feedback through FGDs and KIs; delays to systematic analysis and response to feedback meaning that issues were not able to be addressed quickly or adaptations made in real time |
| ADRA/Zimbabwe | Obtaining clearance from district hospital to implement BFM; politically sensitive context slowed progress and led to apprehension by various stakeholders. | No consequence specifically due to implementation setback, but due to scepticism the procedure for opening suggestion boxes had to be adapted. |
| Rahnuma/Pakistan | Security and longer than anticipated processes (e.g. finalising sample of schools for BFM pilot; finalising pre-determined questionnaire; hiring of CFC). | Suggestion boxes were not attractive enough to students at time of baseline (due to delays in finalising Information Education and Communication material to be displayed around the boxes). Implementation of suggestion boxes and pre-determined questionnaire was not in parallel. |
| CINI/India | Longer than anticipated planning processes, including changing from Approach 1 to 3; local municipal elections in May – June 2015. | Delays to start-up. However planning is part of implementation process (as per cycle of Approach 3) so may not be a delay in the real sense; BFM activities could not take place during |

²² Source: Baseline, mid-term, and end-point country-level and synthesis reports

| | | |
|-------------|--|---|
| | | election time; there were challenges in sensitising new officials |
| MAMTA/India | Longer than anticipated planning processes due to awareness raising. | Less time available for implementation of BFM activities. |

Table 3 shows the implementation dates of the BFM in comparison to the UK Aid Direct-funded projects. The projects were not concurrent with implementation of the BFM pilots.

Table 3: Operational period of UK Aid Direct projects and BFM pilots

| Project/Country | Operational period of UK Aid Direct project | Operational period of pilot BFM |
|------------------------|--|--|
| ADRA/Zimbabwe | November 2013 – October 2016 | May 2014 – March 2016 |
| AMREF/Ethiopia | April 2013 – March 2016 | September 2014 – March 2016 |
| CINI/India | December 2012 – February 2016 ²³ | February 2014 – March 2016 |
| CUAMM/Tanzania | April 2013 – March 2016 | March 2014 – March 2016 |
| HPA/Somaliland | January 2013 – December 2015 | February 2014 – December 2015 |
| MAMTA/India | December 2012 – November 2015 | December 2013 – November 2015 |
| Rahnuma/Pakistan | July 2013 – June 2016 | April 2014 - March 2016 |

The Monitoring and Review support to the pilot BFMs began in March 2014 with the design of a Monitoring and Review plan. A baseline assessment was conducted between September 2014 and January 2015,²⁴ a light-touch mid-term review between May and June 2015, and an end-point review from October to January 2016. Validation workshops were held in-country between November 2015 and February 2016. Table 4 (overleaf) provides a summary of participating projects, contexts, and BFMs implemented.

One important contextual distinction to draw is the different ways in which organisations were operating. Rahnuma/Pakistan delivered services directly, and sought feedback about their own services. ADRA/Zimbabwe, HPA/Somaliland, AMREF/Ethiopia, and CUAMM/Tanzania, were working together with government service providers to varying degrees; some such as ADRA focussed feedback on their own activities, while in others feedback was related to government services. CINI/India and MAMTA/India operated more social accountability or ‘advocacy’ based projects, with feedback focussed on government service provision.

²³ The timeframe for CINI’s GPAF project was extended from November 2015 to February 2016.

²⁴ The timing of the baselines was determined by the GPAF partners, based on the implementation schedules of the BFM projects; fieldwork for the baseline assessment for Rahnuma/Pakistan was delayed.

Table 4: Summary of projects, contexts and BFM implemented

| Country | Host organisation | UK Aid Direct-funded project | BFM approach | Scope/focus of BFM pilot |
|------------|--|--|---|--|
| Tanzania | CUAMM Trustees | Enabling access to improved mother and child health services for 101,632 women and new-born children in two districts of Tanzania | <u>Approach 1</u> : Mobile technology based 24-hour access to a two-way feedback system through SMS and voice | Four wards (18 villages) in Iringa district |
| Somaliland | Health Poverty Action (HPA) | Improving mother and child health for 116,744 internally displaced women of child-bearing age, as well as 10,116 infants and 50,580 children under five years of age | <u>Approach 1</u> : Mobile technology based 24-hour access to a two-way feedback system through SMS and voice | Women attending three health facilities: Abdi Idan (population 20,000); Sheikh Noor (population 30,000); and Hawadle (population 40,000) |
| Pakistan | Rahnuma – Family Planning Association of Pakistan (FPAP) | Integrating education, health and income generation services for 14,000 school students and their mothers in Pakistan | <u>Approach 2</u> : Participatory research model using pre-determined questions | Punjab Province (Ralawpindi and Attock District), six schools and two health clinics |
| Ethiopia | African Medical & Research Foundation (AMREF) UK | Improving maternal, reproductive and child health services for 285,760 people in southern Ethiopia | <u>Approach 2</u> : Participatory research model using pre-determined questions | 15 targeted Kebeles (villages) in two clusters of Konso District ; 21,920 women of reproductive age (15-49 years) and 14,867 children under-five |
| Zimbabwe | ADRA | Improved maternal health care services for 7,500 women of childbearing age in three wards of Gokwe | <u>Approach 2</u> : Participatory research model using pre-determined questions | Two wards in Gokwe North |
| India | Child Hope (implemented by local partner, CINI) | Improving access to health and social welfare opportunities for 41,900 vulnerable women and children in West Bengal, India | <u>Approach 3</u> : Beneficiary-led feedback approach with partner support based on contextual adaptation | Kolkata slums Borough VII |
| India | MAMTA | Improving maternal and child health services and livelihood opportunities for 15,855 poor women in Kaushambi district of Uttar Pradesh, India | <u>Approach 3</u> : Beneficiary-led feedback approach with partner support based on contextual adaptation | 36 women's groups in four villages |

2. Methodology and analytical framework

This chapter outlines the overall methodology and analytical framework for the Monitoring and Review (M&R) process, the rationale for the methodological choices made, and the limitations implied by those choices.

2.1 Monitoring and Review design

The M&R was designed with reference to a Common Theory of Change (CTOC, Annex 1) for beneficiary feedback mechanisms and the revised learning approach²⁵ agreed in April 2015. To test the CTOC, and generate evidence in relation to key questions of relevance, effectiveness, efficiency, and impact of BFM, 10 key lines of enquiry were developed (Box 2), underpinned by 24 indicators (Annex 4).

Box 2: Key Lines of Enquiry²⁶

1. How do **contextual factors** affect the implementation and performance of beneficiary feedback mechanisms?
2. How does the **design** of beneficiary feedback mechanisms affect the results and participation by different groups?
3. What are the **optimal steps** and sequence for design, implementation and feedback generation?
4. What are the most appropriate **information channels**? How is information flowing between beneficiaries, partners, the fund manager and DFID?
5. Who is **using** the BFM, why and how? (including **access/inclusion by different groups** e.g. gender, age, disability, intended/unintended beneficiaries)
6. How useful is the **format** in which the information is gathered, and how likely is it to induce a response closing the feedback loop? (Usefulness)
7. How **effective** are the beneficiary feedback mechanisms in terms of **closing the feedback loop and improving the quality of project decision-making and implementation**? (Effectiveness and Responsiveness)
8. What are the **costs** of implementing BFMs (Economy, VFM) for beneficiaries and grant holders?
9. How **efficient** are the BFMs? (Efficiency)
10. What **evidence** is there that additional BFMs are contributing to project objectives? (Impact)

During the course of the end-point review, additional information regarding the sustainability of BFMs also came to light and is reflected in the analysis.

A pre-test/post-test design was agreed, with a light-touch mid-term assessment and a more in-depth baseline and end-point review. Since the purpose was to provide Monitoring and Review support,

²⁵ World Vision UK (2015, April) 'Learning approach paper: in conjunction with DFID GPAF Beneficiary Feedback Mechanisms Pilot.'

²⁶ Ibid. The KLOEs were modified based on feedback from BFM Pilot Project Steering Group in January 2014.

rather than evaluation, a control/comparison group was not included the methodological approach at baseline, nor the subsequent mid-term and end-point reviews.

The design allows assessment of the contribution of the BFM for short-term and intermediate outcomes under the CTOC, as the pilot BFM is likely to be a major underlying plausible factor underlying any changes observed between baseline and end-point reviews.²⁷ For the longer-term outcomes, particularly empowerment of beneficiaries to claim entitlements and improvements in programme quality, it is plausible that the maternal and child health programmes themselves were a major contributing factor to observed changes at an aggregate level. Therefore the contribution of the BFMs can be established only where specific linkages are identified between, for example, the feedback received and specific improvements in programme quality.

2.2 Data collection

Data were collected using a range of methodological tools, and appropriate sampling methodologies relative to the indicators (Annex 4 and 5) and key lines of enquiry (see Chapter 5) that were agreed by the pilot steering group, within the resources available. The key challenge for the M&R process was ensuring that the monitoring process was appropriate to the contexts and purpose (given that each project had different types of beneficiaries and different social dynamics), while also delivering robust data for the purposes of comparative analysis and the review. In light of this, while overall guidance and draft tools were provided by INTRAC to country-based consultants, the exact mix of methods and tools, questions, and sampling designs were contextualised and piloted by the local consultants in the project locations.

Data were collected from three main groups/levels at which the BFM was working: project beneficiaries, implementing organisations, and the upper feedback loops (partner headquarters, fund managers and donor).

2.2.1 Beneficiary level

The M&R process as a whole reached beneficiaries at baseline, mid-term and end-point through a variety of tools. The light-touch nature of the mid-term review meant small numbers of beneficiaries were engaged. The definitions of beneficiary target groups (target populations) varied across the pilots, and thus different sampling approaches were required in each pilot.

Focus group discussions (FGDs) formed the main formal primary data collection vehicle for understanding the views of direct beneficiaries about the BFMs. Sampling varied according to context. In some cases beneficiaries were randomly sampled from appropriate sample frames; in those where a sample frame was not present, purposive sampling was necessary to reach direct beneficiaries. For most pilots, FGDs were also conducted with indirect beneficiaries. A visual empowerment tool was used at baseline in all pilots and repeated at end-point, where appropriate.

²⁷ Although the added value of the piloted approaches is more complicated to assess for pilots with pre-existing BFMs, such as Rahnuma or MAMTA.

Key informant interviews (KIs), purposively sampled, were also used in some of the pilots to gather richer information from direct beneficiaries using the BFM.²⁸ This was particularly relevant where only a small number of BFM users could be identified,²⁹ but also in other contexts where it was felt that individual interviews would add value over FGDs. For both FGDs and KIs, local consultants developed their own topic guides, based on a question bank developed by INTRAC.

A survey of beneficiaries was used at the end-point, with the objective of reaching a wider set of users and non-users of the BFM, rather than reproducing quantitative estimates/comparisons. In most cases a household survey was conducted,³⁰ either using an existing sample frame (e.g. register of pregnant women) or screening for MCH users from a general household survey where a relevant sample frame could not be established. Sample sizes were in the range 140-224, with stratified random sampling according to context.³¹ In ADRA/Zimbabwe the logistics of a household survey of a dispersed population over difficult terrain in rainy season meant it was not feasible; instead beneficiaries participated in FGDs at a central location.

A question bank was developed by INTRAC and contextualised to individual contexts. In some cases, the survey corroborated findings from the FGDs, while in others it revealed somewhat different results, suggesting it reached a different subset of beneficiaries than the FGDs.

2.2.2 Intermediary level

Intermediaries were defined as frontline staff who were positioned between the project and the beneficiaries. They included project staff, volunteers and outreach workers, but also included government health workers, particularly in those pilots that took a social accountability approach.

Semi-structured key informant interviews were the primary vehicle for engaging with intermediaries, with the exception of CINI where a larger number of 'change agents' meant group interviews were considered more appropriate. Sampling was purposive (such as based on respondents' knowledge of, and participation in, the pilot BFM in their locality) in all cases, given the limited numbers of intermediaries. Broad topic guides were developed by INTRAC and contextualised to each pilot.

2.2.3 Organisation level

Organisation level respondents included in-country project staff within each of the partner organisations.

²⁸ In the case of AMREF/Ethiopia this also included GPAF project staff (such as project managers and CFOs) and government staff (such as health authorities, health workers and health extension workers) as these were regarded as direct beneficiaries.

²⁹ This was the case for the HPA end-point review. All feedback was anonymous, so no sampling frame of users could be ethically constructed, thus users were identified via the survey and where the CFO could identify and obtain consent from known users.

³⁰ In Pakistan the partner organisation was not comfortable with a household survey (with the aim of reaching indirect beneficiaries, users and non-users); the survey was therefore conducted only at clinics. In Ethiopia (AMREF) a household survey was conducted with women who were directly involved in the pilot BFM (participants of women's focus group), thus the extent and reasons for non-use could not be established via the survey.

³¹ Sampling designs varied according to context; stratifications generally applied to ensure coverage of the different geographies in which the project was operating (e.g. village, clinic, school).

In each pilot organisation, an Organisational Capacity Assessment Tool (OCAT) was used to facilitate a discussion with project staff about their organisation's capacity at baseline and end-point. The purpose of the OCAT was for the organisation to self-assess their capacity with respect to different aspects of developing and implementing the BFM. Seven capability categories (see Annex 6), were pre-defined, in line with the Theory of Change. Within these capability categories, different capacities were identified by staff themselves, and then scored. The capacities identified varied across the pilots, but were retained from baseline to end-point.³²

Semi-structured key informant interviews were also conducted with project staff, including:

- Community Feedback Officers
- Project Managers of the AK Aid Direct-funded projects
- M&E officers/coordinators
- Senior staff, including Country Directors and Regional Directors

Interview topic guides were developed and contextualised by local consultants, based on a question bank supplied by INTRAC.

2.2.4 Upper feedback loops

While the main data collection activity was at project level, the Theory of Change also required information pertaining to how feedback was flowing up the aid-delivery chain, from the partner organisations, to:

- Their headquarters/the fund holder
- The fund manager (Triple Line)
- The donor (DFID)

INTRAC staff conducted interviews with staff at headquarters/fund holder level in each of the pilots, concurrent with the project-level mid-term reviews. Interviews were written up and triangulated with project-level findings. A workshop was also conducted with staff of the fund manager for the UK Aid Direct (then known as GPAF) fund, although it was discovered that only two staff were relevant to the seven pilots. The donor was not interviewed at mid-term, as no relevant issues were reported from the other stakeholders.

At the end-point it was decided to conduct these interviews after the project-level findings were available, enabling follow-up of issues identified at end-point. The project-level findings were written up and compared with transcripts of interviews at mid-term. At that stage it became clear that few changes had occurred during the limited time between mid-term and end-point reviews, so a lighter touch follow-up with each of the stakeholders was pursued via correspondence using the transcripts of the mid-term review. The senior responsible Officer for the UK Aid Direct fund was also interviewed at the end-point.

³² With the exception of Rahnuma, where staff felt the need to reflect and make adjustments based on their experience.

2.2.5 Stories of change

Cross-cutting the different levels, particular change stories were identified that related to how specific pieces of feedback had informed decision-making. These stories were identified by local consultants from beneficiaries, intermediaries and staff, and triangulated across the groups to form a more detailed picture of how information was flowing. They were also followed up in upper feedback loop interviews conducted by INTRAC staff.

2.2.6 Validation and sense-making

Validation workshops were held in each country after the end-point review data collection process. These brought together partner organisations, communities and other key stakeholders that closely participated in the pilots (such as Ministry of Health officials). The primary objectives were to:

- Validate emerging findings from the end-point review.
- Close feedback loops with participants of end-point data collection in order that they knew and understood the findings.

After both the mid-term and end-point data collection processes, sense-making webinars were held with consultants based in-country to draw out lessons learned and enable additional reflections.

2.2.7 Limitations

A number of limitations within the planned methodology were encountered and discussed in more detail in country-level reports. However, issues that impacted on data availability and quality overall were:

- At baseline, challenges included small sample sizes for beneficiaries relative to total populations. Issues with the use of the Community Process Mapping tool were also experienced. However, in most projects the consultants did reach target population groups.
- The mid-term exercise was very light-touch, based on a relatively small number of interviews and observation, plus document/database reviews. Few points were verified through discussions with beneficiaries.
- Beneficiary surveys were not possible for the end-point review in all contexts. In Zimbabwe (ADRA) the transport difficulty during rainy season, and the requirement to be accompanied by a community health worker, meant a household survey was not feasible. In Pakistan (Rahnuma), a household survey of indirect beneficiaries could not be agreed with the partner organisation, so a survey at point-of-service (clinics) was conducted instead.
- For AMREF, although a household beneficiary survey was conducted, it was only possible with targeted beneficiaries of the project, hence it was not possible to ascertain the experiences of non-users.
- In some contexts, availability of certain groups (particularly men and youth) meant a smaller sample than expected.

2.2.8 Synthesis approach

The synthesis at end-point follows a narrative approach, structured around key findings within the broad themes of: 1) collecting feedback and inclusion; 2) project-level feedback loops; and 3) upper-level feedback loops. It is supported by meta-analysis at indicator and key lines of enquiry level. Where relevant, specific indicators and key lines of enquiry are referred to in the key findings.

Meta-analysis at the level of tools was not pursued, partly because a standardised approach was not followed, but also because triangulation of different tools was done at project level. The exception is the OCAT, where the tool corresponds directly to an indicator: meta-analysis is presented at Annex 6.

2.2.9 Levels of analysis

In the M&R Plan of June 2014, we proposed to focus the analysis on three different levels:

- Level 1: A contextualised understanding of the implementation of each of the seven BFMs, exploring the contextual variations affecting the BFM relative to the geographic area in which it was being implemented and the partner organisation involved.
- Level 2: An appraisal of the seven pilot BFMs against the common indicators, providing an overall reflection on what works, where, and under what conditions.
- Level 3: An appraisal of the three approaches, to tease out lessons concerning the different BFM methodologies piloted.

Given the adaptation of approaches used by partner organisations (identified in the mid-term review), and the wide range of context-specific factors influencing the BFM implementation, an important part of level 1 analysis was to understand the changes made to approaches by BFM partners and their rationales for doing so. Given the small pool of projects, and the potential variations due to context-specific factors, there are significant limitations to what we can robustly attribute to differences in project implementation (level 2) and choice of approach (level 3), vis-à-vis other factors. The analysis at these levels was primarily qualitative and aimed to explore common themes or emerging patterns.

2.2.10 Confounding factors and generalisability of the results

A further limitation in drawing meaningful and reliable comparisons is the degree to which organisational contexts are observed to vary in ways that might plausibly affect the results of the pilot (Table 5). In short, there are more plausible confounding variables than there are cases (seven) – which very much limits the ability to draw comparisons, since each organisation encompassed a wide range of observed and unobserved variables.

Table 5: Differences in organisational contexts

| Observed differences in organisational contexts | Potential effects on outcomes |
|--|---|
| Pilot: Unsolicited (feedback on any issue) vs. solicited (pre-determined issues) vs. participatory (pre-determined by beneficiaries) | Difference in quality and relevance of feedback; difference in awareness of entitlements. |
| Pilot: Low, medium, high resource BFM. | Differences in results, costs, sustainability prospects. |
| Feedback was sought about organisations' own services vs. feedback about government providers, supported by Partner organisations | Difference in closure of feedback loops and requirement and use of external referral mechanisms. |
| Pilot organisation already operating in BFM pilot community vs. organisation new to community. | Difference in investments required in sensitisation and time to build trust; differences in the scope for feedback to influence the project. |
| BFM integrated into project from outset vs. BFM treated as pilot- i.e. add on (with various levels of buy in and support). | Difference in use by senior management (and buy in/prioritisation/support). |
| South Asia vs. African contexts | Differences in how feedback is viewed in society plus how community organisation is done. |
| Implementer granted UK Aid Direct funds directly vs. granted via fund holder (HQ) | Differences in how information flows in upper feedback loops |
| Organisational structure and responsibilities of staff vis-à-vis the BFM (particularly whether networks of volunteers are present, and the position of the CFO within organisation). | Differences in number and the level of staff initially screening feedback and making decisions about routing feedback internally or externally. |

Finally, in considering the broader lessons that can be drawn from the pilot, it was important to bear in mind that specifics of the pilot itself may also have affected the outcomes observed. In particular:

- The pilot involved considerable technical support from the consortium members, particularly World Vision and SIMLab, to the implementing organisations. For example, World Vision was able to work with partners to overcome challenges identified, and provide guidance such as on tools, adaptation, documentation and analysis of feedback. Whether or not changes observed would have occurred in the absence of this support is difficult to establish.
- All pilot projects were focussed on maternal and child health; different policy contexts may have different incentives for learning from feedback at policy/donor levels.
- All pilots were in highly marginalised communities, a condition of the UK Aid Direct fund. Most projects targeted vulnerable women who were also found to be the least literate and empowered, potentially affecting confidence and ability to give feedback.
- The timeframe of the pilot was relatively short and was further decreased as additional time was taken in context analysis and design.

- The BFMs were operating on relatively small scales; different challenges apply to operationalising BFMs at larger scales.
- The BFM pilot was managed separately from the UK Aid Direct fund at the global level and sometimes at project level. It was also implemented after the projects had started, leading to varying levels of integration between BFM pilot and the projects themselves.

3. Key findings: collecting feedback and inclusion

This chapter presents findings in relation to the establishment of the pilot BFM, collection of feedback and inclusion of most marginalised beneficiaries in the pilot. It is relevant to the first two phases of implementation (of the four-phase model presented in Chapter 2): design and implementation of the BFM. It is also relevant to “Step 1” of the Common Theory of Change, which covers the linkages from activities through to short-term outcomes.

3.1 Design, context analysis and adaptation of BFMs [Indicators 1 and 2; KLOE 2 and 3]

Key finding: A thorough context analysis for the feedback mechanisms, flexibility in the initial design phase and further adaption of the mechanisms during implementation were critical to the establishment of functional feedback mechanisms.

Each of the pilot BFMs the design phase included a context analysis which involved modifying some of the initial pairing of approaches with projects. At baseline, it was observed that considerable adaptations to the three approaches occurred at project level as a result of contextualisation of the BFMs during the design phase. The mid-term and end-point reviews note that many of the pilots continued to adapt the mechanisms as the BFMs were bedding in (Table 6).

These adaptations were deemed appropriate in order to maximise the relevance and effectiveness of the BFM design in particular contexts. However, the time and resources used during the design and roll out phase could potentially have been reduced, had a full context assessment been planned at the inception of the BFM pilots or if the BFM component been integrated with the design and context assessment of the projects themselves. While further adaptation and design of the mechanisms would still have been necessary, it is likely that the process would have been considerably shorter.

Table 6: Adaptations made to original BFMs

| Project | Intended approach and mechanisms | Adaptations (and when made) |
|---------|--|---|
| CUAMM | Approach 1: SMS and suggestion box | <ul style="list-style-type: none"> Voice call (via missed call) added due to literacy levels (early design phase) |
| HPA | Approach 1: SMS and suggestion box | <ul style="list-style-type: none"> Voice call via missed call added due to literacy (early design) Pictorial formats developed for suggestion box due to literacy (implementation) Toll-free voice calls introduced due to perceived cost of voice calls (implementation) Short code SMS (also toll free) |
| ADRA | Approach 2: Pre-determined questionnaire, suggestion box | <ul style="list-style-type: none"> Mobile feedback box (implementation) Women-only FGDs (implementation) Quick feedback form (implementation) Adolescent Training of Trainers (ToTs) (implementation) |

| | | |
|---------|--|--|
| AMREF | Approach 2: Pre-determined questionnaire, suggestion box | <ul style="list-style-type: none"> • Coloured cards introduced for suggestion box due to low literacy levels (implementation) • Volunteers to help administer feedback surveys to overcome geographical and security challenges (implementation) • Use of an existing feedback mechanism – public forum (not in design) |
| Rahnuma | Approach 2: Pre-determined questionnaire, suggestion box | <ul style="list-style-type: none"> • Feedback collection forms developed (implementation) • Male CFO accompanied by female staff to feedback meetings to respond to gender dynamics (implementation) |
| CINI | Approach 3: Beneficiary-led feedback approach with partner support based on contextual adaptation and suggestion box | <ul style="list-style-type: none"> • Originally considered for Approach 1, but this was rejected due to fit with context (non-availability of personal mobile phones and low literacy levels to read or write SMS) • Pictorial forms introduced to give feedback for the suggestion box; these were distributed at meetings |
| MAMTA | Approach 3: Beneficiary-led feedback approach with partner support based on contextual adaptation and suggestion box | <ul style="list-style-type: none"> • Eight new noticeboards and 11 new suggestion boxes installed at agreed locations as per demands from the community (implementation – mid-term) • Groups formed to encourage male participation in the giving feedback, due to their influence over women's decisions. |

In most of the cases above, adaptations of the BFM to context are likely to have positively influenced the amount of feedback generated. Some adaptations also had a substantial impacts on inclusion (discussed later in this chapter) and how feedback could be analysed and responded to (discussed in Chapter 5 and 6). In addition to context assessment, the pilot status of the BFMs – with implementation support from World Vision and SIMLab (as discussed in Section 3.2.10) – may have supported relevant adaptations.

There were particular limitations to the way that Approach 1 BFMs (CUAMM and HPA) could be adapted to the context:

- In HPA, the format for providing feedback through the suggestion box was adapted due to the high illiteracy rate among direct beneficiaries. However, the use of “thumbs up/thumbs down” pictorial formats meant feedback was of very limited detail, resulting in challenges in responding. In spite of adaptations, the beneficiary survey indicated that beneficiaries tended to provide feedback informally directly to project staff. Similar challenges were faced in AMREF (Approach 2) with the use of coloured papers, but non-literate beneficiaries were also able to give feedback via FGDs.
- SMS was not able to be adapted for illiterate groups given its nature; toll-free voice and messaging was dependant on the mobile network provider.³³

³³ Toll-free voice and SMS services were possible in Somaliland via negotiation with the main network provider, although this took many months and as a result was only introduced towards the end of the pilot.

Across the pilots, a majority of beneficiaries were satisfied with the process of giving feedback [indicator 10]. However, the country level end-point reviews still identified improvements to the design and implementation of the BFM, indicating a need for flexibility for ongoing adaptation [indicator 18].

3.2 Sensitising communities to BFMs [Indicators 2, 3, and 5; KLOE 1, 2, and 3]

Key finding: Sensitising beneficiaries to the process and purpose of giving feedback was necessary to make beneficiaries aware of the mechanisms and build their confidence to actually give feedback; face-to-face mechanisms supported ongoing awareness raising.

All pilot organisations undertook activities to sensitise beneficiaries to the purpose and process of giving feedback as part of the pilot design (Box 3).

Box 3: Examples of sensitisation activities undertaken

CUAMM: Introductory meetings and FGDs at village level; sensitisation meetings for beneficiaries organised by community meetings on monthly or bimonthly basis in seven out of 18 villages; t-shirts distributed in FGDs.

HPA: One-day training on BFM project with staff members from the three clinics; clips aired on Radio Hargeisa; video clips shown in MCHs; pictures added to noticeboards to explain BFM to beneficiaries; billboards in the wider community.

AMREF: Sensitisation and awareness raising sessions by CFO and community mobiliser.

ADRA: District stakeholder consultation and sensitisation of the BFM; community stakeholder consultation and sensitisation.

Rahnuma: Pamphlet about BFM designed for beneficiaries. This included information on methods and ways of giving feedback under the BFM, and information flow.

CINI: Change Agents and Lead Change Agents helped in raising awareness on the importance of feedback through home visits or in group meetings.

MAMTA: Information Education and Communication (IEC) and awareness generation activities such as wall paintings, magic shows at village level; orientation of Outreach Workers (ORWs) and group leaders (beneficiaries) on BFM; group meetings on BFM; thematic meetings with mother-in laws and husbands.

Noticeboards were to be rolled out in each pilot but their effectiveness was limited due to low literacy. In Ethiopia noticeboards were not installed at all for this reason.

3.2.1 Understanding of feedback purpose and process

The need for sensitisation was confirmed by the baseline review, which found very low levels of awareness of the maternal and child health projects and the purpose and process of the BFM in some of the pilots (AMREF, CUAMM and ADRA), given that it was in the early stages of implementation or had not started at all. Further sensitisation was recommended at the time of the

baseline. In others (CINI and MAMTA), awareness was higher as sensitisation activities were further advanced.

The end-point review indicates that improvements were achieved in beneficiaries' awareness of the existence of the BFM. The beneficiary survey³⁴ revealed that in four pilots, at least 80 per cent of target beneficiaries were aware of the BFM. In CUAMM and HPA a large number of respondents were aware that they could give feedback, but a significant number misunderstood the process or purpose of giving feedback. For HPA in particular, awareness of informal feedback channels was much higher than those channels formally piloted. For ADRA, a beneficiary survey was not conducted, but the end-point review noted a general perception among beneficiaries that many people were involved in feedback process, formally and informally; the amount of feedback received in relation to the populations of the target wards also suggests a high degree of awareness.

However, beneficiaries' qualitative understanding of the purpose and process of feedback varied across the pilots (Box 4).

Box 4: Beneficiary awareness of purpose and process of giving feedback

CUAMM: A low understanding of the BFM among the community at large was found at the end-point, as at baseline. Insufficient sensitisation at the community level was identified to be a contributory factor. Reasons include an underestimation of the level of sensitisation required, and resources needed for this, at the project design stage (including a lack of personnel on the ground to support the CFO); and community leaders' own fears about the BFM being used as an accountability tool against them.

HPA: Beneficiaries' understanding of the BFM increased between baseline and end-point. Sensitisation activities including community outreach work by maternal and child health centres, as well as by word of mouth, were found to have contributed.

ADRA: At baseline, awareness was very low as ADRA had not previously worked in the areas, so substantial increases were observed at end-point. Women's groups were found to have some knowledge of the process, but were not aware of the purpose; key informants, ToTs (community volunteers) and male groups understood both the process and purpose.

AMREF: The increase in awareness was especially evident for AMREF at end-point. The beneficiary FGDs and beneficiary survey findings indicate that all informants had a good understanding of the purpose and process of the BFM (including methods of providing feedback through women FGDs, public forum, and suggestion box), whereas at baseline they knew only of the public forum.

Rahnuma: Awareness level of feedback mechanisms had increased in both male and female students, and community members from baseline to end-point. However, female community members of one of the schools in the pilot³⁵ were completely unaware of the BFM at end-point.

³⁴ In more than one pilot it was observed that project staff over-estimated beneficiaries' awareness of the BFM. This suggests that internal monitoring does not necessarily provide a full picture of awareness to inform sensitisation activities.

³⁵ The Global School is a pilot school. Rahnuma reported that the FGD conducted at end-point was their first visit there- do we know why?.

CINI: Although it took some time for some segments of the community to understand the process and benefits, at end-point the awareness level of the community was reported to be high, particularly in areas where suggestion boxes were installed.

MAMTA: The purpose of the BFM was not fully understood by the community. The majority of beneficiaries knew of the mechanisms and used the BFM to address their personal health issues, whereas the purpose of the BFM in addressing the quality of services as a whole was less understood.

3.2.2 Existing relationships/trust with the community

Where partner organisations had an existing presence in the community, and relationships of trust between the partner and the community existed, fewer challenges were faced. In Rahnuma, at end-point the CFO shared that *“initially it was hard to engage students but as our presence in the community is for a number of years, that’s why students trusted us”*.

MAMTA has been working in the area for many years and the organisation has all the capabilities, resources and structure to work amongst the community. The OCAT found that field-level staff were confident in communication skills and were very comfortable within the community. They have a good rapport and good level of trust with females.

In CINI, the length of time the organisation has been established in the area and the high level of trust they had with the community before the BFM was implemented had a positive effect. In contrast, although CUAMM had been working in the project area for a long time, this was mainly in larger health facilities rather than at community level.

For both MAMTA and CINI, organisational structures involving networks of volunteers at community level appear to have further strengthened engagement through regular face-to-face contact with representatives of the organisation.

3.2.3 Sensitisation for Approach 1 and 2 pilots

Particular challenges were faced by the two Approach 1 pilots in raising awareness and understanding about the BFM among communities. A potential reason is the lack of face-to-face interaction with project staff as part of the BFM in this approach. For these mechanisms, sensitisation was therefore a separate and distinct activity to collecting feedback. In contrast, for pilots following Approaches 2 and 3 where community meetings and FGDs were used, there were more opportunities to reinforce sensitisation messages concurrently with feedback collection and thereby build trust between the community and organisation.

HPA (Approach 1) made substantial efforts at community sensitisation through multiple channels. Despite this, the country level end-point review recommends that more needs to be done to reach everyone who uses MCH services. The need for more awareness raising was a key point raised throughout KIs with BFM users, FGDs with MCH users and those who took part in the validation workshop.

In CUAMM/Tanzania (Approach 1), beneficiary understanding of the purpose and process of the BFM was still very low at the time of the end-point review:

“People have low understanding of the BFM and that is why very little feedback has been given.”
– FGD with community leaders, CUAMM/Tanzania, end-point

For CUAMM, there was a lot of apprehension about the BFM from the outset of the project. Community leaders were fearful about the project’s intention and were perceived by staff to have obstructed sensitisation activities such as community meetings; ongoing sensitisation was also obstructed by vandalism of noticeboards. It is also possible that fears were fuelled, rather than calmed, by the referral of feedback concerning malpractice and behaviour to the government and actions taken.

ADRA’s (Approach 2) experience provides a counterpoint to this. Strong scepticism about the BFM was observed at baseline, with participants expressing fears about giving feedback, consultation fatigue and very low expectations about receiving any response to feedback. However, by the end-point, it was observed that those who closely engaged with the maternal and child health project were more comfortable to give feedback (and give more constructive feedback) without fear of victimisation. Regular contact with ADRA field staff was identified as a primary reason behind this shift.

3.2.4 Fears of victimisation and misconceptions

In CUAMM, pre-existing apprehensions and challenges in sensitising beneficiaries meant that persistent fears and misconceptions among beneficiaries about being victimised for giving feedback were a barrier:

“we were truly in the dark until you explained to us today the process of who opens the suggestion boxes ... a large percentage of us have fear that the person who opens the suggestion box is from Ufyambe village, and if he opens and sees the feedback concerns him, then we are in big trouble.”
– FGD with pregnant and breastfeeding women, CUAMM/Tanzania, end-point

Fear of victimisation was also an issue in ADRA/Zimbabwe, where there was a general perception among women that they might be victimised and feedback, particularly negative, might be used against them. This was partly informed by previous experiences of mechanisms such as suggestion boxes being used for ‘reporting’ on individuals, or becoming hijacked for other purposes (political, reporting crime) which brought difficulties to the community. In AMREF/Ethiopia, despite good understanding of the purpose and process, participants of the validation workshop stressed that some people feared giving feedback in front of health workers and support staff in the public forum due to fear of revenge.

3.3 Beneficiaries’ awareness of entitlements and confidence to give feedback [Indicators 2, 5, and 8; KLOE 1 and 3]

Key finding: Providing beneficiaries with information about their entitlements increased awareness, but did not necessarily overcome deeper barriers to giving feedback such as the perception of aid as a ‘gift’, or fears about withdrawal of services following critical feedback during the timeframe of the pilot.

3.3.1 Information provision and awareness of entitlements

The Common Theory of Change assumes that in addition to awareness of the purpose and process of BFMs, beneficiaries also need to understand their entitlements under the project in order to have

the confidence to give feedback and follow-up on these. Awareness of entitlements was an expected pre-condition of giving feedback, but also an outcome in its own right, particularly for those projects focussed on social accountability. So regardless of the BFM, partner organisations may also have engaged in provision of information with the aim at raising awareness of entitlements.

There are indications that information provision associated with the BFMs succeeded in raising beneficiaries' awareness about entitlements to services. Increases in beneficiaries' understandings of their entitlements were observed in most of the pilots, and by the end-point review, knowledge about what services were provided and for whom, was relatively high across the pilots. For those projects that were not directly engaged in service delivery (CUAMM, AMREF, CINI and MAMTA), awareness of entitlements referred to government services.³⁶

Despite the high level of understanding, some misconceptions persisted. For example, with HPA, in spite of substantial efforts at community sensitisation, the question of who was entitled to services was not fully understood by all. For ADRA, while beneficiaries understood the project provisions well, the concept that there were 'entitlements' was not fully understood, and both community and local stakeholders articulated project provisions as gifts rather than entitlements:

"... This waiting mothers shelter is a big gift for us women, we have been favoured. Who can do this for you for free just like that? We have been here for a very long time, no one ever did this for this community ..."

– FGD with women of childbearing age, 15-24 years, ADRA/Zimbabwe, end-point

3.3.2 Confidence to give feedback

Beneficiaries' confidence to give feedback clearly increased in all but two of the pilots. In many contexts, the notion of giving feedback – particularly to those in authority perceived as higher status - was not commonplace. There are examples of beneficiaries becoming empowered to give feedback directly to such providers. In relation to the CINI BFM, one honorary health worker interviewed at end-point felt that *"the community is now closer to Government services"* as a result of the platforms established to collect beneficiary feedback.

In relation to CUAMM's BFM, a respondent from the local health department stated at end-point that:

"unlike before, beneficiaries who are HIV positive are now starting to complain about being charged for Septrin [which they should get freely as their right] at the Makombe health facility"

Less clear changes in confidence were observed for ADRA and CUAMM, where those that were closely engaged with the project showed increased confidence, but a climate of fear around the concept of reporting in the wider community was still observed at the time of the end-point review. These pilots are both operating in areas with pre-existing fears and misunderstandings, and the organisations are somewhat geographically remote from the beneficiaries they are serving.

Perceptions of project activities as a gift, rather than entitlement, meant that beneficiaries in the ADRA project area did not feel empowered to give certain kinds of feedback:

³⁶ Although in some contexts, beneficiaries were aware of their entitlements from the government, while not being aware of the partner organisation themselves, or their role in influencing services.

“... women in Zhomba believed that feedback is only given when they have to be complaining about something. They indicated that so far, they have nothing to complain about as they are satisfied with what is there, however, they went on to stress that they were not empowered to complain about things that are provided for free as a gift from well-wishers.”

– ADRA/Zimbabwe country level end-point report

This perception of services as a ‘gift’ (also noted among some HPA beneficiaries at baseline), appears to have roots in cultural norms around gift-giving as well as a fear that complaints may damage relations with the donor. Fears also persisted about being victimised for raising such issues among CUAMM’s target beneficiary group at the end-point. We should note that the time period of the pilot was short; building the confidence and earning the trust of the community may require a longer time-frame. This should be factored into plans for future BFM where context analysis reveals significant fears around giving feedback.

3.3.3 Connection between entitlements and giving feedback

The assumed connection between entitlements and giving feedback is not straightforward. In some of the pilots, beneficiaries did use the BFM to follow up in relation to their entitlements, as demonstrated by the CUAMM example in Section 4.3.2.

However, in other pilots, the perception of services as ‘gifts’ rather than entitlements may have contributed to a reluctance to give (certain kinds of) feedback:

“... we already did not have any form of reliable transport for patients, for example, so even though the E-ranger is not really the ideal vehicle, you cannot overemphasise on their lack of suitability because, it’s a gift to the community, a stop gap ...”

– Health worker, Simchembu, ADRA/Zimbabwe, end-point

“... well, it is easy for us to give feedback if it is a positive thing you want to talk about especially if we are asking for support on something else ... otherwise you may be accused of having said something that offended the donors and caused them to leave with their support ...”

– Women’s FGD participant, ADRA/Zimbabwe, end-point

The assumption underlying the ‘gift’ is if you are not grateful for it, the donor/agency may decide to withdraw or not pursue further giving.³⁷ This is distinct from fears of individual victimisation.

However, in some cases, even though beneficiaries were aware of entitlements, the function of the BFM was not always perceived in relation to entitlements from the project/government, but as a means of addressing other concerns. In MAMTA, for example, many beneficiaries used the BFM to directly enquire about health issues to outreach workers. In CUAMM, gender-based violence (GBV) was a significant issue raised via the BFM outside the scope of entitlements under the project. The BFM therefore opened up a channel through which beneficiaries could raise their own concerns. In the case of GBV, this was something that would not be raised through normal channels, and the anonymity of the suggestion box enabled people to air the issue.³⁸

³⁷ This perception as also evident for government stakeholders during the validation workshop.

³⁸ This feedback was not always women reporting GBV directly; many were made by proxy or related to neighbours.

3.4 Active use of BFM s [Indicator 6; KLOE 5]

Key finding: All BFM s were actively used but a smaller proportion of beneficiaries gave feedback in approach 1 pilots; feedback volumes varied considerably according to project

All pilot BFM s were successful in generating feedback, though the absolute volumes varied considerably between the different pilots (Box 5).

In reviewing the monitoring data from the BFM s reported by pilot organisations, different methods of counting feedback have been employed for some mechanisms. For suggestion boxes, SMS and voice calls, feedback is counted per slip, message, or call, which is usually submitted by a single individual (although in MAMTA groups reported collectively submitting a single piece of feedback in suggestion boxes). For group meetings, public forums, one-to-one meetings, feedback may either be counted per issue discussed – or alternatively – in terms of the number of people discussing the issue, in other words the total number of attendees. For ADRA, for example, total participants attending meetings at which feedback was given were recorded. For CINI, a happy/not happy format was also used alongside FGDs, meaning that each meeting yielded feedback equal to the number of participants. Neither method is more valid than the other, but we should be aware that total amount of feedback reported may represent a mixture of counting methods.

In addition, the counting of beneficiaries in attendance may not indicate demand for the BFM in public forums, community meetings, or FGDs organised for other purposes, where there are other reasons to attend.

Box 5: Quantity of feedback received

CUAMM: Between October 2014 and November 2015, a total of **428** pieces of feedback were received through the suggestion box, SMS and voice call. The six months of project implementation (June 2015 to November 2015) saw a two-fold increase in the number received. Feedback was received via suggestion box (81%), followed by SMS (7%) and voice call/returned missed call (10%); a very small amount was via multiple methods.

HPA: Between March 2014 and October 2015, a total of **2,469** pieces of feedback were received through the suggestion box, phone call, SMS and community meetings. The amount of feedback increased over the course of the pilot, levelling off around June 2015. Until July 2015, the suggestion box was the most popular mechanism; the phone line grew in popularity towards the end of the pilot after the toll-free line was introduced in June 2015.

ADRA: Between May 2014 to October 2015, a total of **2,066** individual pieces of feedback were received via the survey and suggestion boxes; a further **1,962 people participated** in community meetings and FGDs soliciting feedback on the project as part of the BFM. In addition, participation of 1,648 people in feedback and consultation exercises outside the BFM itself was recorded in the feedback database.

AMREF: Between October 2014 and December 2015, a total of **5,052** pieces of feedback were received through women FGDs, suggestion boxes, public forum and key informant interviews. The majority of feedback was gathered through women FGDs (93.45%). The amount of feedback recorded from women's FGDs increased during the course of the pilot, with relatively low numbers up to May 2015, and substantially larger amounts subsequently. This is attributable to the recruitment, training and deployment of voluntary community feedback facilitators which enabled more FGDs to be undertaken over a wider area. On the other hand, public forums and KIs yielded small quantities of feedback throughout the project.

Rahnuma: Between March 2015 and November 2015 a total of 263 pieces of feedback were received from students and families through suggestion boxes and FGDs.

CINI: Between January 2015 and November 2015, a total of **35,291** pieces of feedback were received (31,487 in group meetings and 3,804 through the suggestion box). The amount of feedback given in groups has been fairly steady during the pilot. Less feedback was received through the suggestion box in May 2015 due to elections.

MAMTA: Between the inception of the pilot and October 2015, around 700 pieces of feedback were captured.

The beneficiary survey at the end-point provides an indication of the proportion of target beneficiaries using the BFM.³⁹ The survey revealed a high use of the BFM, in relation to the target populations, in one pilot:

³⁹ Sampling for the beneficiary survey varied across the pilots; estimates of use have been triangulated by comparing actual volumes of feedback received as a proportion of the target populations.

- In CINI, 80% of beneficiaries reported giving feedback at least once. This translated into a large volume of feedback, primarily because the use of pictorial formats within group meetings meant all participants would provide some form of feedback

Moderately high use was reported in four pilots in the surveys:

- In Rahnuma, 70% of direct beneficiaries, and 30% of indirect beneficiaries reported giving feedback, although triangulation with actual feedback received suggests this may overstate use.
- In MAMTA, 60% of direct beneficiaries reported giving feedback, with a large number giving feedback more than once.
- For ADRA, where a beneficiary survey was not possible, comparing the volume of feedback and participation in meetings with the target population, suggests a moderate to high participation in the BFM.
- In AMREF, the beneficiary survey did not cover non-users; however, comparing volumes of feedback with the target population suggest moderate participation in the BFM.

Lower use of the BFM was observed in two pilots:

- For HPA, 10% of survey respondents reported giving any kind of feedback; however, the majority of this was informal.
- For CUAMM, 14% reported giving feedback; however, triangulation with volumes of feedback received suggest this may overstate use.

The use of BFMs, as might be expected, shows a clear correlation with awareness of the BFM. An exception is CUAMM, where misunderstandings about the purpose of feedback (and fear of reprisal in particular) may have dissuaded people from using it.

3.5 Inclusion of target groups in the BFM, including the most marginalised [Indicators 17 and 19; KLOE 5]

Key finding: Multiple feedback mechanisms aided inclusion by ensuring channels that meet beneficiaries different needs are available; literacy was the most significant barrier to inclusion identified in these contexts.

Overall, the Monitoring and Review process indicates that the extent to which BFMs included the most vulnerable and marginalised were largely in line with the maternal and child health projects themselves. In each of the pilots, literacy, age, and gender determined the needs and preferences of beneficiaries' vis-à-vis feedback mechanisms. Overall, no major inclusion issues were identified, with the exception of CUAMM, where the requirement for literacy, combined with cost of using a mobile phone, may have excluded non-literate beneficiaries without the means to pay for voice calls from accessing the BFM.

In each of the pilot BFMs, different groups of beneficiaries had different requirements and preferences about mechanisms, according to age, gender, and literacy levels. The nature of feedback provided also affected beneficiaries' decisions of which mechanism to use, particularly where the issue was confidential or sensitive.

3.5.1 Poverty and illiteracy

Low levels of literacy among direct beneficiaries appear to have affected the use of some feedback mechanisms. As outlined in Chapter 1, this factor, and cultures of oral rather than written communication, seem to have influenced beneficiaries to favour mechanisms where feedback is given verbally (though this is less relevant for adolescents and their use of the suggestion box).

Low levels of literacy seem to have particularly affected the use of SMS in the Approach 1 pilots and the suggestion box across the three approaches (CUAMM; HPA; AMREF; and MAMTA). In CUAMM, poorer women in the community did not give feedback due to a lack of phone ownership and illiteracy. The Project Manager felt the project was “*designed to get feedback from the more wealthy or middle class of the village*”.

When adaptations were made to facilitate the participation of those who were illiterate (in HPA through the use of a tick-box ‘thumbs-up/thumbs-down’ and AMREF through the use of coloured papers), it resulted in data perceived to be less actionable (see Chapter 8). In MAMTA and HPA, examples were observed where beneficiaries found ways to access the BFM by asking others to help them fill in suggestion box slips, although it was recognised that this had drawbacks in terms of confidentiality.

3.5.2 Gender

The pilot BFMs were successful in engaging women, who were the primary target group for maternal and child health interventions. This was expected, but is notable, given contexts where women traditionally do not get involved in public life in the way that giving feedback on an NGO or government service entails.

Men were not direct beneficiaries of most of the projects and, as expected, their engagement in the BFMs was substantially lower than that of women. The perception in many contexts that MCH is purely a women’s issue, lack of engagement in the project itself and in some cases lack of access to the BFM appear to have restricted men’s participation in the BFM (Box 6).

Whilst pregnancy and childbirth are often perceived as women’s realms in developing countries, there is growing evidence that women’s access to MCH services and clinical outcomes for mother and child health in developing countries can be improved via male involvement.⁴⁰ In many contexts, men are decision-makers and gatekeepers to women’s health-care seeking. They can affect pregnancy and childbirth through responding to complications, seeking medical help, paying for transport, and allocating household resources.⁴¹ Involvement in giving feedback through the BFM supported men in communities to become more involved in the project and maternal and child health interventions:

Box 6: Male participation in the BFM and MCH

HPA: Men’s uptake of the BFM was lower than women’s as they tended not to be users of the maternal and child health centres. Many of the maternal and child health services are thought to

⁴⁰ See: <http://jech.bmj.com/content/early/2015/02/19/jech-2014-204784.full>

⁴¹ Lewis, S., Lee, A. and Simkhada, P. (2015) ‘[The role of husbands in maternal health and safe childbirth in rural Nepal: a qualitative study.](#)’ *BMC Pregnancy and Childbirth.* 15:162

be less relevant to men as they relate to the upbringing of a child, which is generally perceived to be the role of women.

Rahnuma: Very little feedback was received from men through the suggestion box. Their physical access was limited as the boxes were installed inside schools and health clinics.

MAMTA: Although at baseline it was observed that participation of male members would have been an added advantage to the project as they are decision-makers in families, the end-point review found that most men did not give feedback as they were not directly involved in the project (despite being aware of the process of providing feedback). In both Rahnuma and MAMTA, men were not targeted in the project design or the approach.

CINI's (India) experience provides a counterpoint. Male participation in the BFM increased from baseline to end-point due to the formation of a male club to involve men in the project. At end-point, men were aware of the mechanism; provided valuable feedback; and made suggestions on improving services. This demonstrates successful adaptation to facilitate male participation.

In both ADRA and HPA, although women's participation in the BFM was higher overall, men were overrepresented in community meetings (where agendas covered wider topics than MCH). In both cases women were less able or willing to give feedback. Certain adaptations were made in ADRA including introducing women-only FGDs, a mobile feedback box, and a quick feedback form, which enabled more women to provide feedback. The role that men/husbands play as decision-makers in reproductive health was leveraged by CINI, where male clubs were established during the course of the pilot and by ADRA, via men were involvement through the construction of the Waiting Mothers' Shelter (Box 7).

Box 7: Beneficiary Feedback Mechanism supports male engagement in MCH in Zimbabwe

For ADRA, participation in construction of a waiting mother's shelter provided opportunities for men in the community to become more involved in the MCH interventions. A male beneficiary gave an account of how his involvement as a man in the construction of the waiting mothers' shelter, and giving feedback, has brought about some outcomes he is proud of and that he is benefiting from:

"I started getting involved in 2014 when we were asked to come and work in the clinic to build that house where pregnant women stay while waiting to give birth. At that time, not everyone understood why we had to be doing this work, but we did it anyway ..."

"... During the course of the year, my wife got pregnant and I learnt some things about being supportive to her, actually, in this community men are not so involved in women's issues but that mind-set is changing ..."

"My wife came to the waiting mothers' shelter and stayed there for 14 days and she gave birth without any problems a day ago. While she was here, I visited her often sometime twice a day ..."

"I am benefiting from outcomes that I believe were shaped by my contribution too. I mean, I put my labour into that waiting mothers' shelter and gave my opinions and views."

The validation workshop confirmed that the BFM supported ADRA to engage men about the benefits of the waiting mother's shelter and gain their support in terms of contributing labour to the project. This engagement was crucial to the eventual use of the shelter since decisions regarding where a mother gives birth will often be made by her husband.

Such buy-in may have been achieved via other means in the absence of a BFM, but this case indicates that the BFM brought project staff closer to the community than they might otherwise have been, supporting the project outcomes.

3.5.3 Disability

Although the findings revealed little around the issue of disability, there are indications that some mechanisms may not allow access for those living with disabilities to participate in the BFM.

There is limited information on inclusion of disabled people in the BFM as people with disabilities were not specifically targeted in the projects, and feedback databases were not disaggregated by disability. Survey samples at end-point were also too small to disaggregate by disability in a meaningful way.

However, in CUAMM, disability was mentioned by community leaders as one reason, among many others, for non-use of the BFM. However, the consultant also gave the following example of a woman living with disabilities whose situation was uncovered through the BFM by neighbours:

'Under these circumstances they [women of child bearing age who are marginalised from accessing MCH services, and even invisible to CHWs in the community, due to very high levels of vulnerability] are excluded from the BFM because they do not even have access to MCH services. A good

example is that of a poor woman who is crippled and neglected by her husband who [is] said to only care about alcohol ... She is a mother to four children (the oldest is nine years old) and none of them have accessed any MCH services. Her case and that of another woman whose conditions are similar were uncovered this year through the BFM by her neighbours’.

– CUAMM end-point country-level report

In ADRA, the findings indicate that the BFM design did not make explicit provisions for those living with disabilities to participate. The M&E Manager and CFO reported that those living with disabilities may not have been able to travel to the centres where community meetings are conducted.

Similarly for HPA, the MCH Project Manager mentioned during a KII that she had not come across anyone with disabilities using the BFM.

3.5.4 Young people⁴²

Only Rahnuma and ADRA specifically targeted youth as direct beneficiaries; in other pilots youth were indirect beneficiaries. The experiences of Rahnuma and MAMTA highlighted different needs of young people regarding feedback mechanisms. Suggestion boxes were popular for young people in both contexts, due to their preference for giving feedback confidentially, and because they are more likely to be literate, compared with their parents. Notice boards were also found to be useful in communicating responses back to young people in schools, in contrast to other contexts.

With the exception of Rahnuma, where suggestion boxes were located within schools, youth were not well engaged in giving feedback. This was often because maternal and child health issues were not thought to be relevant to the age group (cited in ADRA’s case), but also because timing of some BFMs (e.g. focus groups) clashed with school hours.

3.5.5 Adaptation of mechanisms increasing accessibility to target populations

Across the three approaches, pilots that adapted feedback mechanisms during implementation received increased quantities and quality of feedback from groups potentially excluded from the original design, for reasons outlined in Section 4.1.

⁴² Note that the category of “young people” was often interpreted, according to local contexts, as excluding anyone who is married and/or is pregnant or has children, regardless of age. Thus a pregnant 15 year old may be regarded as a women of child-bearing age.

Box 8: Inclusion and BFM adaptation

HPA: The introduction of a toll-free line during the last quarter of the pilot resulted in voice messaging becoming the most popular mechanism: “*the fact it was free ensured that I would give feedback regularly.*” – KIII, HPA/Somaliland, end-point

AMREF: Recruiting, training and deploying volunteer feedback facilitators to collect feedback during women’s FGDs contributed to an increase in feedback collected through KIs during the latter part of the pilot (albeit in relatively small quantities) as the CFO had more time to collect feedback from key informants. As discussed in Box 5, the amount of feedback recorded from women’s FGDs also increased during the course of the pilot, as the use of voluntary community feedback facilitators enabled more FGDs to be undertaken over a wider area.

Rahnuma: Female project staff were engaged in the BFM to gather feedback from female beneficiaries when it was found they were not comfortable providing feedback to a male CFO during the pre-determined questionnaire FGD.

CINI: The design of user-friendly pictorial feedback formats was a contributing factor to success of the BFM. Beneficiaries found these to be an easy way of providing feedback on services.

3.6 Use and non-use of different feedback channels [Indicator 17; KLOE 1 - 4]

Key finding: *In these contexts, beneficiaries preferred channels that: involved face-to-face interaction, were low/no cost, had no literacy requirement, provided an immediate response and were familiar to them; lack of confidentiality and fear of victimisation were reasons for non-use .*

3.6.1 Feedback channels used

Table 7 gives an indication of the proportion of feedback received via different channels. As noted in Section 4.4, the method of counting pieces of feedback (by person engaged, or by issue) varied across the pilots, so the proportions are only indicative. Nevertheless, it gives some sense of the demand for each of the channels.

Table 7: Indicative proportion of feedback received via different mechanisms during the pilot

| | Approach 1 | | Approach 2 | | | Approach 3 | |
|-----------------------|------------|-----|------------|-------|---------|------------|---------------------|
| | CUAMM | HPA | ADRA | AMREF | Rahnuma | CINI | MAMTA ⁴³ |
| Suggestion box | 81% | 63% | 6% | 4% | 59% | 11% | 6% |

⁴³ For consistency with other projects using FGDs as a feedback mechanism, data for MAMTA are taken from the beneficiary survey. MAMTA recorded FGD feedbacks by issues raised, rather than # people raising it.

| | | | | | | | |
|---|----|-----|-----|-----|-----|-----|-----|
| Voice call | 9% | 28% | * | * | * | * | * |
| SMS | 7% | 7% | * | * | * | * | * |
| Community meeting/ public forum | * | 3% | 14% | 2% | * | * | * |
| FGDs (open and pre-determined questions) | * | * | 64% | 93% | 41% | 89% | 76% |
| Other, e.g. directly to CFO/staff | 3% | * | 15% | 1% | * | * | 18% |

Focus group discussions (whether open or via the use of pre-determined questionnaires as in Approach 2) and suggestion boxes were the most popular feedback channels across all projects and approaches. Where both of these methods were provided (Approaches 2 and 3), it seems that FGDs generated the most feedback,⁴⁴ with the exception of Rahnuma, where suggestion boxes were placed in schools and used by adolescents (targeted beneficiaries) (see below).

3.6.2 Poverty, literacy, and traditional gender roles

The fact that all of the pilots were in poor communities is likely to have had a strong bearing on the preferred choice of mechanism. As stated in Section 4.5.1, low levels of literacy and cultures of oral rather than written communication, seem to have influenced beneficiaries to favour mechanisms where feedback is given verbally. As noted earlier, both AMREF and HPA altered the suggestion box formats to make them accessible for less literate audiences using coloured papers and pictorial formats.

The fact that all of the pilots were in poor communities appears also to have severely limited the use of mobile SMS as a feedback channel. For HPA, where ownership of mobiles phones was more widespread (77% reported owning a phone in the beneficiary survey) but literacy was low (over 50% could not read at all, or could not get the meaning of most words), use of SMS remained low. However, the introduction and publicising of a toll-free phone line led to a substantial increase in the volume of voice calls, to the extent that more feedback was received by voice call than via the suggestion box during the last months of the pilot. Low levels of SMS usage are also likely to be related to the traditional oral culture identified during the baseline and contextual analysis.

Additionally, poverty limited access to SMS and voice-call BFs in CUAMM. The CFO in CUAMM noted that when asked why they did not give feedback, some beneficiaries would say “*I have no phone*” or “*I can’t write*”. Mobile ownership was also gendered, with husbands often in possession of a household phone.

⁴⁴ The comparison is somewhat problematic, as feedback counting methods varied from project to project.

Community meetings and public forums were a feature of some of the BFM (ADRA, AMREF, CINI, MAMTA); as noted above the fact that the agendas are often controlled by men, while MCH is perceived as a women's business. In contexts, it was observed that there was limited the scope for discussing MCH issues and the BFM in community meetings.

3.6.3 Immediacy of response

Immediacy of response is an important factor in determining beneficiaries' preferred feedback mechanisms, for example group meetings in ADRA and MAMTA, and the toll-free line in HPA. In contrast, one reason for low uptake of the suggestion box in ADRA was its anticipated turnaround time. The finding that immediacy of response is highly valued is also supported by a suggestion by project beneficiaries that ADRA could have further increased feedback channels through the use of social media, especially WhatsApp groups, due to the potential for the quick spread of information.⁴⁵

"... nowadays, you will find that most ToTs, WHC, and some community leaders have access to mobile smartphones and communicate on WhatsApp, since ADRA gives their response to feedback to the community leaders and ToTs, they could have done groups and you would know that many people are reached by feedback in a short space of time rather than for us to wait to hear after at a community meeting...here at the clinic, the health workers use that with the DNO and some VHWS ..."

– Ward Health Committee Member, ADRA/Zimbabwe, end-point

3.6.4 Familiarity and visibility

Face-to-face feedback channels (community meetings and FGDs) and suggestion boxes share a proximity to the target beneficiaries in some projects, in that they involve visible infrastructure or activities at the community level. Despite their disadvantages such as literacy requirements and the lag in receiving a response, the use of suggestion boxes was relatively high.

The convenience of accessing mechanisms (in terms of time cost) does not seem to have been a major inhibiting factor, but as noted earlier, distance may influence awareness. In CINI, the project staff in their KII shared that the awareness level of community on BFM was high, particularly in the area where drop boxes were installed. They perceived that around 80% of mothers were aware of the BFM in areas where drop boxes were installed, as compared to around 60% of mothers who were aware of all means of providing feedback in areas where drop boxes were not installed.

3.6.5 Confidentiality and anonymity⁴⁶

Confidentiality requirements were evident for some groups and in some contexts, but not others. As noted earlier, for Rahnuma and MAMTA, adolescents appeared to prefer confidential mechanisms, as they did not want to discuss reproductive health issues publicly or in front of their families. In CUAMM, being able to provide feedback or discussing things confidentially was important for beneficiaries, and revealed a drawback of mobile-based mechanisms in a context where personal mobile phone ownership was low:

⁴⁵ It should be noted, however, that under the operational conditions given by the Ministry of Health, ADRA cannot respond or receive feedback via the phone.

⁴⁶ We use confidentiality to mean that the identity of a feedback giver may be known by those administering the BFM, but not by other beneficiaries or stakeholders. Anonymity means the identity of a feedback giver is not known by anyone except the feedback giver themselves.

“if you try to borrow a mobile phone from either a friend or your husband they will ask who are you talking to? Then they tell you speak while they listen to everything you are saying a situation which undermines confidentiality”. – Female FGD participant, Ufyambe village, Tanzania

Conversely, in MAMTA, women expressed a preference for giving feedback as part of a (female only) group; and there are indications that seeing others give feedback encouraged more vulnerable beneficiaries to engage.

Where fears of reprisal were greater, beneficiaries were more concerned that the feedback mechanisms should be anonymous, to the extent that even supposedly anonymous feedback mechanisms still invoked fears. Some CUAMM beneficiaries were concerned that they might be identified via their telephone numbers when giving feedback via SMS or voice calls⁴⁷. In ADRA, concerns were raised about the location of suggestion boxes in front of clinics, in case they were identified by clinic staff. In spite of concerns, ADRA received substantially more feedback via non-confidential mechanisms than it did via the suggestion box.⁴⁸

3.6.6 Previous negative experiences of specific mechanisms

Finally, specific fears and negative experiences of mechanisms in the past impacted on their use in some contexts. In the Gokwe North district of Zimbabwe, where ADRA piloted beneficiary feedback, suggestion boxes had previously been introduced by another international NGO that had subsequently withdrawn from the area. However, the box had been used to report crimes and also disseminate political information, causing trouble for the community and making government stakeholders wary. ADRA had to carefully negotiate the implementation of suggestion boxes in this area with government stakeholders, while beneficiaries' use of the boxes was low compared with other mechanisms. Context analysis that reviews existing and previous mechanisms, and community and stakeholder perceptions towards them, may pick up such issues during the design phase.

3.7 Contribution to empowerment outcomes [Indicators 5 and 10; KLOE 1]

Key finding: BFM's have contributed to empowering beneficiaries to claim their entitlements; they are also valued intrinsically as platforms through which beneficiaries can exercise voice.

As noted in Section 4.3.2, across the pilots, we observed increasing confidence to give feedback in most pilots. This had both instrumental value (in generating feedback) and an intrinsic value for beneficiaries as a platform through which they could exercise voice and generated a sense that they are being listened to.

Participants at the validation workshop for HPA's end-point review, for example, reported that one of the reasons that they liked the feedback process was that it gave them a sense of voice. During a KII in the end-point review, one beneficiary said that she liked the BFM because *“our opinions and voices were being taken into consideration.”*

⁴⁷ This may be a misunderstanding about technology, or reflect the close-knit nature of the community

⁴⁸ One hypothesis might be the suggestion box users in a very sensitive context may be discouraged from submitting routine suggestions as they fear they might be seen outing feedback in the box, and risk being associated with other (perhaps critical) feedback that was already in the box.

In at least two pilots (HPA and MAMTA), it was observed that beneficiaries also valued and felt empowered by hearing the suggestions of others, even if they had not given feedback themselves.

In MAMTA, the local consultant noted a number of personal stories of change, demonstrating how the activities under the BFM had initiated empowerment of previously marginalised individuals on a very personal level (Box 9).

Box 9: Nisha's story (MAMTA/India)

Nisha is a 35-year-old woman living with her family and three daughters and a son. She has studied up to 10th standard (age 15-16). She was a reserved person and was not confident enough to come out of the house and talk to the people in her community. She did not take part in any community events. Since she was a very quiet person, she was not taken seriously in her family and was never involved in any decision-making.

She observed that an Outreach Worker (ORW), Uma, comes to their community and conducts women's group meetings and discussions. She also heard some women discussing about the benefits of the meetings and decided to join the group. Nisha asked ORW to talk to her family to let her join the group and after several meetings ORW was able to convince Nisha's family to let her be a part of the group.

Nisha attended all the meetings regularly and started giving feedback about antenatal/postnatal care and accessing job cards for MANREGA [livelihood programme]. She became a group leader of two groups and gained the confidence to gather women and conduct the meetings. She tells the women in her group about the services they can use and facilitates information sharing; for example, she convinced all the women in her group to use iodine salt in their food. She has also convinced all the members of her groups to have institutional rather than home deliveries, with a 100% success rate to date.

Nisha is now confident and informed and talks to her husband and mother-in-law about health and family issues. She is now involved in family discussions, has decided not to have any more children, and her decision is supported by her family. She sends her two older daughters to school regularly.

Through leadership of the groups, she has also helped other women to gain confidence, voice their opinions and use services to which they are entitled.

Source: MAMTA, country-level story of change, end-point

This intrinsic value of feedback was more fragile in contexts where a climate of fear persisted around the concept of feedback. In CUAMM, for example, a respondent during the end-point review noted that:

"Suggestion boxes are there, and we have raised health related issues, but they are not actioned, what then is the use of the boxes?"

– CUAMM/Tanzania, end-point review

This is an indication that some of the beneficiaries feel that concerns are not being responded to. These examples raise the question of whether the BFM can remain intrinsically valued in the longer-term. Under the right conditions, it may be a starting point for deeper and long-term empowerment

of marginalised communities to articulate their needs and hold others to account. However, if feedback is not seen to be acted upon or the mechanisms are not sustained, it is plausible that beneficiaries may eventually feel disempowered by the mechanism.

Empowerment also supported accountability outcomes that were not anticipated as a result of the pilot. In some contexts, with increased confidence to give feedback as a result of the BFM, beneficiaries were empowered to claim their entitlements from service providers directly:

“unlike before, beneficiaries who are HIV positive are now starting to complain about being charged for Septrin [which they should get freely as their right] at the Makombe health facility”

– Respondent from local health department, Tanzania

“[The] community is now closer to the government services because of the project intervention.”

– Honorary health worker, MAMTA, India

3.8 Comparing the three approaches and assumptions in the theory of change [KLOE 2]

Key finding: Approaches 2 and 3 appeared more successful in generating feedback than approach 3, as the feedback channels were more accessible to the target beneficiaries.

3.8.1 Impacts of different approaches to collecting feedback

As discussed in Chapter 3, comparison of the three approaches is made problematic by the small number of pilots, and large number of potentially confounding factors. Therefore our conclusions are necessarily tentative. We summarise below (table 8), where there is the clearest evidence of differences between the three approaches in relation to collecting feedback and inclusion.

Table 8: Collecting feedback and inclusion: comparing the three approaches

| | Approach 1: unsolicited, low-resource (e.g. SMS, voice call) | Approach 2: solicited, pre-determined indicators (e.g. survey, FGDs) | Approach 3: solicited, participatory (e.g. FGDs) |
|---|--|--|---|
| | CUAMM Trustees, HPA | ADRA, AMREF, Rahnuma | CINI, MAMTA |
| Design, context analysis and adaption of BFM | More challenging to adapt mobile-based mechanisms to the context. Suggestion box formats developed to overcome literacy barriers | Less adaptation required for the intended mechanisms. Suggestion box formats developed to overcome literacy barriers | |
| Sensitising communities to BFM | Unsolicited and lack of visibility of the mechanisms led to lower awareness/use of BFM in spite efforts of to sensitise beneficiaries | Mechanism more familiar to beneficiaries and visible at the community level. Face-to-face interaction allows clarification of purpose and process of the BFM | As approach 2; CINI and MAMTA also made use of their networks of volunteers to sensitise beneficiaries to the BFM |
| Information provision and awareness of entitlements | Information provision largely separate from the feedback process. | Face-to-face interaction allowed organisations to clarify entitlements at the same time as receiving feedback | |
| Active use of BFM | Lower use of BFM as a proportion of target population than Approach 2 | Higher use of BFM than approach; CINI showed highest use of BFM | |
| Inclusion of target groups | Cost and literacy barriers; women less likely to own a mobile phone than men. | Few inclusion issues identified; adolescents preferred the suggestion box due to confidentiality | |
| Use and non-use of different feedback channels | Most feedback was received via the suggestion box rather than mobile; although HPA’s toll-free voice line was popular in the latter part of the pilot. | Suggestion boxes were used less in these contexts, as face-to-face channels were available. The exception is Rahnuma where adolescents preferred to use the suggestion box within the school for confidentiality reasons | |
| Contribution to empowerment | Evidence of contributions to empowerment across the three approaches. | | |

Approach 1 pilots faced greater challenges in fully adapting the mechanisms to the context, even though in the case of HPA, significant changes were made with the use of pictorial formats and toll-free phone line. Ultimately, these did not lead to as high engagement of beneficiaries in the BFM as observed in the other approaches. One reason is that the mechanisms employed under this approach reduced the opportunities for ongoing sensitisation of the community to the BFM. In other approaches, project staff had more regular contact with beneficiaries and this appears to have translated into greater use and more clarity about the purpose of the BFM. With a majority of feedback coming via suggestion boxes under Approach 1, closure of feedback loops was more difficult as noticeboards were found to be infrequently used.

Approaches 2 and 3 prioritised face-to-face mechanisms which were found to have advantages in these contexts, both in terms of sensitisation and in terms of how well they aligned with beneficiaries' preferences for giving feedback. Closure of feedback loops was more straightforward in FGD and meeting contexts.

Fewer challenges were observed in Approach 3 pilots in terms of sensitisation and access to the mechanisms, though this may reflect the organisational contexts rather than the specifics of the approach. The participatory design process used in Approach 3 appeared to generate relevant and appropriate mechanisms for the contexts.

While CINI and MAMTA, the Approach 3 pilots, appeared to stand apart from other projects in terms of generating feedback and also the degree to which BFMs supported empowerment outcomes, this may be for reasons other than the approach itself. First, both are in India, with a different social context and also, it could be argued, a country where local civil society has been at the forefront of participatory approaches to development. Second, these two projects were the most focussed on social accountability, with a blurring of boundary between the BFM and the project itself. Third, both organisations relied on a substantial network of volunteers to deliver their projects and the activities under the BFM. All of these factors plausibly contribute to the differences observed.

3.8.2 Findings relevant to the theory of change

While the monitoring and review process was not designed as an evaluation against the theory of change, the information gathered is relevant to the linkages described in the theory of change.

In terms of collecting feedback, the assumptions and linkages in the theory of change broadly held true, in that:

- A detailed and appropriate situational analysis was required to underpin the design of the mechanism (1.1)
- The involvement of beneficiaries in the design phase as associated with mechanisms requiring fewer adaptations during the implementation phase, suggesting this mechanisms were more appropriate from the outset⁴⁹ (1.2)
- As well as an appropriate feedback mechanism (1.3), sensitisation of beneficiaries to the purpose and process of giving feedback (1.5)
- Attitudes of those gathering and responding to feedback (1.9)

⁴⁹ Beneficiaries themselves expressed interest in technology-based feedback mechanisms during the context analysis, but preferred more traditional mechanisms in practice.

- There was an iterative process of beneficiaries providing feedback and receiving responses (and observing responses to others' feedback) that ultimately led to them providing informed and relevant feedback.

The confidence of beneficiaries to give feedback appeared less contingent on being informed about and fully understanding their entitlements (1.4 and 1.7) than the theory of change implies.

Confidence appeared to be more influenced by whether they *trusted the organisation* collecting feedback. Trust was easier to establish for organisations with an existing presence in communities, and where the organisation was closer to the community both geographically and having staff as a visible face. It was difficult to establish in politically sensitive contexts and where beneficiaries fear reprisal or withdrawal of services if negative feedback is given. Ultimately it took time, and visible results, to build trust in these contexts. It was also important that beneficiaries had realistic expectations of what organisations could provide or changes they could achieve, which is where information provision supported trust building.

Some assumptions in theory of change did not appear to strongly influence the success of feedback generation and inclusion:

- Information provision about entitlements (1.4). Information provision did not in and of itself give people the confidence to claim entitlements; beneficiaries also gave feedback in the absence of clear knowledge of entitlements.
- Support to those gathering and analysing feedback (1.6). OCAT reveal most organisations felt they had capacity to collect feedback and it was not a strong theme in end-point interviews.

4. Key findings: project-level feedback loops

This chapter presents key findings focussing on the theme of analysing and responding to feedback at point of service (decisions made at, for example clinic, school or community level), and project level (decisions made within the projects in each of the seven pilots). It is relevant to the first third and fourth phases of implementation⁵⁰: feedback collection and feedback loops, and is also relevant to “Step 2” of the Theory of Change, which is the initiation of feedback loops, at project, partner organisation and higher levels in response to feedback.

The chapter explores the different feedback loops in turn, and higher levels (fund holder, fund manager and donor), looking at the volume and type of feedback dealt with at each level. Next we examine feedback loops that are closed *externally* (i.e. by referral to government service providers or other agencies). It then discusses how information is flowing *between* the feedback loops at different levels, and how feedback is being used by each of the pilot organisations in their respective contexts.

4.1 Point of service feedback loops [Indicators 7 and 12; KLOE 4, 6 and 7]

Key findings: Most feedback loops were closed at the point of service. Some mechanisms yielded a significant amount of feedback deemed out of scope or not actionable by projects.

Across the pilots, a substantial volume of feedback loops are closed at the point of service.⁵¹ By point of service, we mean that they can be resolved by project implementers/intermediaries (such as health workers) in the field, and do not require decisions from the project staff. There are three ways in which feedback loops were closed at the point of service:

- Issues raised can be **resolved** through responses decided at point of service level, by project implementers, the CFO or intermediaries. Feedback may also be referred externally at the point of service.
- The feedback may be deemed **out of scope**, and are either referred elsewhere (e.g. to government stakeholders or other NGOs) or the response to beneficiaries is simply that the feedback is not within the scope and therefore cannot be actioned.
- Feedback may be deemed **non-actionable**, mainly because of a lack of detail about the exact issue raised, and acknowledged and recorded, but no action taken.

Each of these are discussed in turn below and illustrated in Table 9. Feedback and associated responses at point-of-service were not systematically coded across the pilots, so it is not possible to quantify the proportion of feedback falling into each of these categories.

Table 9: Examples of feedback loops closed at point of service

| Feedback resolved at project level | Out of scope feedback | Feedback not deemed to be actionable |
|------------------------------------|-----------------------|--------------------------------------|
|------------------------------------|-----------------------|--------------------------------------|

⁵⁰ “Four Phase Feedback Model”, in BFM Inception Report, 18 June 2014.

⁵¹ For Approach 1, point of service and programme levels are difficult to distinguish as both suggestion box and SMS/voice call feedback was initially handled by programme staff such as the CFO, rather than by staff in each clinic or village.

| | | |
|--|---|--|
| <ul style="list-style-type: none"> • Garbage collection issue (CINI) • How to access antenatal and postnatal care services (MAMTA) • Information provision, regarding for example, use of iodised salt, folic acid and iron (MAMTA) | <ul style="list-style-type: none"> • Feedback requesting food/nutrition (ADRA) • Lack of mosquito nets (AMREF) • Feedback referred directly from suggestion box by health-workers (ADRA) • Gender-based violence and child protection | <ul style="list-style-type: none"> • Coloured 'traffic light' papers used in AMREF suggestion boxes • Tick-box 'thumbs up/thumbs down' suggestion form used by HPA for non-literate users • Some SMS feedback (unless called back for more information) |
|--|---|--|

4.1.1 Issues resolved at point of service

A major reason why some feedback loops were closed at point of service was simply that the issues raised were within the mandate of project field staff and intermediaries to resolve immediately. This was particularly the case for MAMTA, where around 50% of queries were resolved by the Outreach Worker (ORW) locally, and CINI where a significant volume of feedback concerned personal health queries or requests for information about how to access services.

Closure of feedback loops at point of service was more prominent for the two pilots implementing Approach 3 (CINI and MAMTA). The use of face-to-face feedback mechanisms administered by project field staff and volunteers (rather than dedicated BFM staff) may have provided greater opportunities for project implementers to respond directly to beneficiaries. Another reason may also be linked with the context and programming styles of these particular organisations, where the distinction between the 'project' interventions in terms of awareness raising and information provision, and the beneficiary feedback mechanism, was less clear-cut.

4.1.2 Issues that are deemed 'out of scope'

Some feedback was deemed to be out of scope of the project by staff reviewing feedback at the frontline, and feedback loops were closed at the point of service (responding to the beneficiaries to inform them that feedback was not within the scope of the project). Such feedback was often interpreted by field-level staff in terms of a lack of awareness among beneficiaries regarding their entitlements under the project, and a response clarifying the scope of the project was given. In such cases, the needs articulated by beneficiaries remain unaddressed, although repeated feedback about the same issue may lead staff to refer the issue to project level or to external stakeholders (discussed in Section 5.2).

ADRA, in particular, experienced such a consistently high volume of feedback unrelated to the project that they developed two notices: "Scope of the Programme" and "Frequently Asked Questions". These were placed on noticeboards and distributed to field staff in an attempt to reduce the numbers of feedback they received which were not deemed to be actionable.

The country-level end-point report found that:

"According to the CFO, it appears that from the onset, when ADRA opened up feedback lines, the community thought whatever they requested was going to be acted upon according to their request and therefore, they were disappointed whenever they heard that ADRA was not going to be able to

meet their requests that are outside the programme provisions. According to one community leader, the community is now aware of the possible response that they will get from the CFO, i.e. if it's not on the noticeboard on the programme brief, it will not be possible to address under the current programme."

– ADRA/Zimbabwe country-level end-point report

Feedback deemed 'out of scope' appeared to be more common in Approach 2, where feedback was collected against pre-defined questions. This is perhaps surprising, as the questions used for Approach 2 were expected to have improved the relevance of feedback. Out-of-scope feedback appeared were also observed – albeit to a lesser degree – in Approach 1, where unsolicited feedback was expected to yield more irrelevant feedback. One possible explanation is that the structuring of feedback in Approach 2 influenced project staff more than it did the beneficiaries – meaning they worked with a narrower definition of what was 'in scope' than those working in Approach 1. Again, specific organisational contexts may also play a role. ADRA, for example, was implementing three very specific interventions under the GPAF project, with limited engagement in other MCH issues in those communities, and had less established systems in place to enable referral. In other projects such as CUAMM, as well as CINI and MAMTA, referral systems were more developed. Feedback also stimulated organisations to engage with external stakeholders: HPA, for example, engaged with the World Food Programme after receiving feedback about ration packs distributed at MCH clinics.

The closure of 'out-of-scope' feedback at point of service raises the question of whether such feedback might be considered 'within scope' at higher level feedback loops, where the perceived possibilities for changes might be greater. This in turn raises critical questions about what are the criteria that determine whether a feedback is "within scope" and who evaluates feedback against these criteria? How these are answered clearly depends on organisational and project contexts, but there may be potential opportunities for greater responsiveness if careful consideration is given in the design of a BFM, to how 'out-of-scope' feedback will be dealt with. We return to these questions of information flow in the conclusions.

4.1.3 Non-actionable feedback

Finally, a proportion of feedback were considered non-actionable. This predominantly occurred where the pictorial and tick-box response forms used alongside suggestion boxes (to make them accessible for non-literate beneficiaries) resulted in feedback lacking the necessary detail to define an appropriate response (AMREF and HPA). In the case of HPA, SMS messages often contained limited detail to action feedback; however, the CFO would follow-up with the feedback giver to clarify the feedback.

A critical question is whether feedback could have been used at other levels to inform decision-making – this is explored further in Chapter 6.

Other types of feedback in this non-actionable category include:

- In MAMTA, local boys put love notes in the suggestion box meant for adolescent girls, who they correctly perceived to be using the suggestion box.
- In CUAMM, 108 separate pieces of feedback were submitted to the suggestion box in May 2015 (accounting for nearly one third of suggestion box feedback over the entire pilot) that

mentioned one person's name, a female, without saying anything else. The reason for this is unknown.

4.2 Project level feedback loops [Indicators 7, 13, 14, and 15; KLOE 4, 6, and 7)

Key findings: Beneficiary feedback is supporting projects to respond to the needs of their target groups, adapt their interventions, and support accountability.

Feedback deemed relevant to the project and actionable, but requiring responses that could not be decided at point of service, was referred to project level. By project level, we mean within the mandate of the UK-Aid Direct funded project (rather than the UK Aid direct fund as a whole, or the implementing organisations as a whole). The data indicate that the majority of feedback was dealt with at this level.

“the Programme Manager... stating during a KII that ‘90% of issues raised’ required a decision at her level.”

– HPA/Somaliland end-point country-level report

In all of the pilots, the information coming from the BFM was reported to be valued by the MCH project managers [Indicator 15]. The time dedicated to responding to feedback, plans to scale up beyond the pilot, and efforts to push for more substantive changes from senior decision-makers were all cited as evidence that feedback was valued by the project managers. For example:

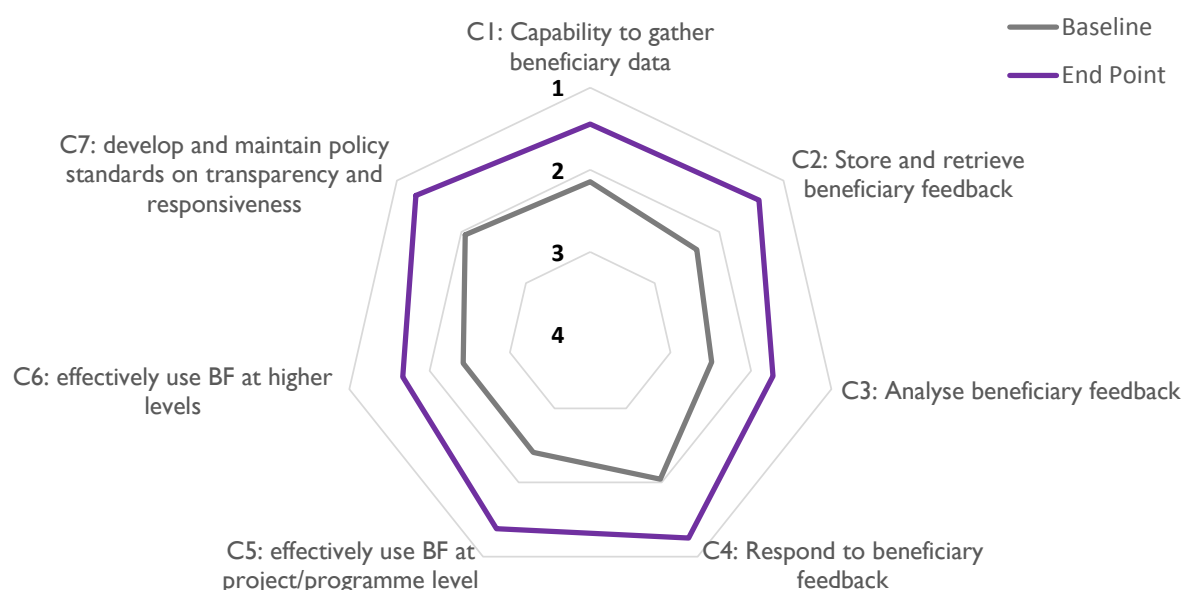
“the entire team of BFM project (i.e. ORWs, Program Manager and CFO) sit together to analyse feedback received on a weekly basis, we take actions and do follow-ups until it gets resolved”.

– Project Manager, MAMTA/India, end-point

4.2.1 Capacity to analyse feedback

An organisational capacity assessment tool (OCAT) was used in FGDs with project staff at baseline and end-point to assess the self-identified capacity of the organisations, with respect to seven capability categories related to the BFM. Improvements from baseline to end-point were reported in across almost all capabilities and pilot organisations, but less progress was observed in relation to analysing beneficiary feedback (Figure 2). At the end-point, on average across the organisations, staff scored this capacity at 1.7 (on a scale of 1–4, where 1 is the highest capacity), while other capacities were in the range 1.3 to 1.4.

Figure 2: Organisational capacity assessment, changes from baseline to end point



Note: Capacities were rated on a scale of 1 – 4, 1 representing the highest capacity. Scores are averaged across the seven pilots. Scores for each pilot are given in Annex 6

Organisations primarily analysed and used feedback case-by-case, referring issues on for action, leading to functional feedback loops at project level. However, in relation to organisations' ability to analyse and use of feedback at higher levels, two weaknesses were identified in qualitative data (Table 10). First, there were challenges with the input and organisation of beneficiary feedback data. Most organisations maintained basic databases in Excel that were updated by the CFO. In one case, multiple spreadsheets were used, while in two cases the BFM was integrated into the organisations' management information system.

Second, most but not all organisations recorded the action taken based on feedback in their databases, but few were able to categorise the content of feedback in way that could be meaningfully aggregated. Even in CUAMM, where the most detailed coding system was employed, there was a large "other" category that accounted for more than one in five pieces of feedback.

Table 10: Methods for storing and analysing feedback

| Organisation | How is BFM stored? | Responses recorded in database? | Feedback content codes used? |
|--------------|---|---------------------------------|------------------------------|
| ADRA | Mater database (Excel) | Yes | No |
| AMREF | Mater database (Excel) | Yes | No |
| CINI | MIS database (integrated with M&E system); ward-level follow-up registers | Yes | Two: Happy / not happy |

| | | | |
|-------------|--|---|--|
| CUAMM | Master database; Frontline Cloud also used | Yes (though responses by govt. not tracked) | 25 different ad-hoc issue codes used, some specific (“GBV”) others very general (“Suffering”, “other”) |
| HPA | Multiple excel spreadsheets, Frontline Cloud not much used | No | - |
| costs MAMTA | Master register | Yes | Eight themes linking to relevant project areas |
| Rahnuma | Master database (soft copy) | Yes | - |

However, apparent weaknesses in data management do not seem to have translated into challenges with responding to feedback at project level. This was rated strongly using the OCAT, and it was also observed that feedback loops were closed in most pilots, regardless of their approach to organising and coding data. The likely reason is that feedback is simply handled on a case-by-case basis, and responded to individually rather than analysed *en masse*. It may be the costs, in terms of human time and capacity required to record feedbacks in a very structured way, outweighed the benefits at project level.

4.2.2 Use of feedback

At project level, responses to feedback have taken the form of real-time adaptations to the projects, in terms of identifying needs and improving existing activities. Feedback has also played a role in holding organisations to account for their performance.

Identifying needs and improving existing activities: There are indications that beneficiary feedback is providing more detailed assessments of needs *prior to implementation* and informing relevant adaptations required to activities *after implementation*, improving the relevance and effectiveness of the design of interventions. This includes detailed considerations about how the interventions should be tailored to the specific contexts and information about beneficiaries’ needs that have not been already identified (see Box 10).

Box 10: Examples of feedback in helping to identify needs and improve existing activities

Feedback increased beds available for MCH clinics in Somaliland

In HPA, the end-point review noted that the BFM often produced requests for increased supplies. The feedback database, which spanned July 2014 to October 2015, shows that requests for beds were made multiple times. Once the issue was brought up through the BFM it was fed upwards to the Project Manager and then the Country Director who was the main decision-maker as it was a budgetary issue. It was felt by project staff that the additional beds contribute to the overall aim of the project in improving neonatal, maternal and child health

through encouraging those in the community to give birth with the help of skilled attendants. If this service was not available, many would be forced to give birth at home as hospital costs are too expensive for many.

Feedback lead to additional nutrients for in Pakistan

In April 2015, as the BFM was starting to collect feedback, it was clearly noticed that the most feedback was about the nutrient packs [given to adolescent boys and girls]. Rahnuma discussed this feedback internally and referred it up to management level. Rahnuma's management decided to take this issue to the donor level as it required budget amendments. Additional resources were required from the fund manager; the fund manager in turn identified some unutilised resources, saved from the overall project budget. This change required DFID approval, which was given within two weeks. Additional nutrients (Milo and Cornflex) were added in the pack to fulfil the demand of beneficiaries.

Feedback informed more flexible terms of use for 'e-Ranger' ambulance, and a new sub-office, in Zimbabwe

In ADRA, feedback was sought via pre-determined questions about the provision of 'e-Rangers' (adapted motorbike ambulances) under the organisation's MCH project. Originally intended to be for the exclusive use of pregnant women, after feedback from the community, the terms of use of the e-Ranger were relaxed to allow for it to be used for other emergencies if there were no presenting maternal issues at the time.

"... If they hear our views and concerns on the services here, they will try to change things where they could for the benefit of the community. For example, we have seen so far that when we complained about the conditions of use of the e-Ranger, they changed them because it makes sense to open it up for other emergencies ..."

– Community leader, ADRA/Zimbabwe, end-point

In another example from ADRA, unsolicited feedback was received from stakeholders and the community for ADRA to be located within the district in which they are operating. In response, ADRA obtained a small sub-office within Chitekete, the main growth point in the project area, to facilitate close contact with community. ADRA is exploring whether this can be transformed into a full field office.⁵²

Accountability for performance: Feedback has also supported accountability of MCH services. For those implementing service delivery type interventions, accountability was of the pilot organisations themselves. Where pilot organisations were mainly working to influence government, the BFM has played the role of a social accountability tool, enabling beneficiaries to hold government service providers to account.

Box 11: Examples of how feedback has enabled beneficiaries to hold project and government staff to account

⁵² During the pilot, field officers were based at ADRA's office in Gokwe South, a considerable distance from the target beneficiaries for the GPAF programme in Gokwe North.

Holding project staff to account for misconduct in Pakistan and Zimbabwe

In Pakistan, Rahnuma fired one of their Lady Health Visitors (LHV), following a complaint registered through BFM. In August 2015, a complaint was received from a community focal person via a suggestion box installed at a health clinic. He complained that the LHV was overcharging for medicines provided during a mobile camp. Rahnuma investigated this issue under their accountability policy, and found evidence of misconduct, resulting in the firing of this LHV in November 2015.

In Zimbabwe, ADRA received complaints from beneficiaries regarding the negative attitude and conduct of project staff, particularly in terms of arriving late for meetings. According to the M&E Manager during the mid-term review, this issue was brought to everyone's attention and staff were encouraged to uphold recommended values. Beneficiaries reported that such behaviour stopped subsequently and they had witnessed attitudinal changes among the staff that they had complained about. This was believed by ADRA management to have had a positive effect on the project.

Holding government staff to account for misconduct in Tanzania

CUAMM received feedback regarding the misappropriation of a range of hospital supplies including medical equipment, beds, blankets bed-sheets and other items from the Maternal Waiting Home of the Kiponzelo Health Centre. After querying government staff on the circumstances surrounding the embezzlement, the officer in charge was ordered to return all the items within an agreed time frame.

4.3 Closure of feedback loops at project level [Indicator 13; KLOE 4, 6, and 7]

Key finding: Closure of feedback loops was easier with face-to-face and mobile-based mechanisms, and more challenging for anonymous mechanisms and in geographically dispersed contexts. Noticeboards were of limited value in closing the loop, except in schools.

The evidence suggests that there were functional feedback loops at project level in all of the pilots, i.e. between users of the services delivered by the partner organisation (beneficiaries) and partner staff directly involved in the delivery of those services (e.g. CFO, project managers, M&E officers). Across the pilots, a substantial majority of beneficiaries were satisfied with both the feedback process and the way in which responses were communicated to them (even if they were not always happy with the content of the response).

The most widely used method for communicating responses were all face-to-face: via FGDs, community meetings and outreach workers. Noticeboards were also used to communicate responses, but these were frequently ignored, and in some contexts actively disliked. An exception was Rahnuma, where adolescents were familiar with using the school noticeboard. However, the feedback loops at health centre level were less effective as the community was less aware of the noticeboards installed.

Many projects realised the advantages of communicating actions taken to the wider group, to demonstrate the results of giving feedback and encourage others to do so. This was also necessary to avoid dealing with the same queries time and time again. Towards the end of the pilot, ADRA

developed a Frequently Asked Questions sheet (in English and local languages) that was placed on noticeboards and distributed to field staff and outreach workers.

Closing the feedback loop was more challenging for organisations working with populations dispersed over large and remote areas such as ADRA and CUAMM. ADRA utilised their network of outreach workers (known as ToTs) who communicated by phone, and in some cases communicated directly by phone with beneficiaries to communicate actions taken. For CUAMM, according to the CFO, closing the feedback loop was much easier for those giving feedback through SMS and voice call as it was easy to acknowledge receipt and then indicate action taken directly to the person providing feedback. However, closing the feedback gap for beneficiaries who used the suggestion box was more cumbersome because acknowledgement of the receipt of feedback and informing them on action taken could only be done through information panel boards at the village office or health facility. Findings from the FGDs, however, show that very often beneficiaries did not read information panels. It was also found in CUAMM that in most villages some people had removed or vandalised information placed on noticeboards, which raises some questions as to their appropriateness to that context.

4.4 External feedback loops [KLOE 6 and 7]

Key finding: Beneficiaries frequently gave feedback beyond the scope of the projects which required working relations with government service providers and explicit referral protocols to respond effectively.

Both at point of service and project level, a significant amount of feedback was referred externally to government service providers. This was explicit in the design of the BFM pilot.

External referrals at point of service appeared more common for MAMTA and CINI, both advocacy-based projects encouraging direct interactions between community groups formed under the project and government service providers. In other pilots, whether working together with government services or delivering services directly, relations with government service providers tended to be mediated by project-level staff. It seems plausible that the programming style of these organisations and the Indian context in terms of local government structures had some influence over this.

For MAMTA, while most of the feedback was responded to by outreach workers providing information to beneficiaries, almost all of the remaining feedback was referred to government bodies such as ASHA, ANMs, CHC and Gram Pradhan. Much of the feedback was responded to by local authorities (e.g. regularisation of JSY⁵³ benefits to mothers, issuing more job cards in project villages, repairing of hand pumps for drinking water). Some feedback was discussed in government platforms at the local level; however, responses were often delayed due to slow the decision-making process in the government system. Feedback was also used as evidence for MAMTA to initiate evidence-based advocacy with local authorities. The project witnessed some impacts at the local level such as more women accessing getting JSY benefits, and increased immunisation in project villages.

ADRA experienced challenges in coordinating with external stakeholders on the BFM, as the project was focussed on direct service delivery, and the feedback method of suggestion boxes was viewed as a complaints mechanism given previous associations with boxes (Box 12). Considerable efforts were

⁵³ Janani Surakhya Yojana (JSY) is a maternity scheme of the Government of India to promote institutional delivery by providing nominal monetary incentives to the mothers.

required to establish referral channels, and compromises in transparency of processes were required (the initial screening of feedback in suggestion boxes was actually undertaken by government health staff).

Box 12: Overcoming challenges in establishing stakeholder relationships in Zimbabwe

The M&R process in Zimbabwe noted a considerable degree of scepticism about the BFM from government stakeholders at the outset of the pilot. District stakeholder consultation and sensitisation for the BFM took place during July to August 2014. Health Ministry stakeholders at district level (MoHCC) did not immediately understand the purpose of the BFM and viewed it as a separate project from ADRA's MCH project, which had begun in November 2013. The timing differences brought scepticism and suspicions that ADRA was trying to police and monitor the Ministry activities. There were also some negative experiences in the locality, with a suggestion box scheme run by a previous international NGO being used for political purposes. Overcoming these doubts were critical to implementing BFM in this politically sensitive context.

ADRA continued to engage the MoHCC and explained the BFM and its purpose. This lengthened the timelines. Eventually, the partners agreed for the BFM to go ahead with specific conditions:

- There would be joint opening of the feedback boxes for transparency and accountability purposes. The partners set up a committee responsible for opening the feedback boxes. The committee was comprised of the CFO, a community representative and health worker.
- ADRA would only record issues raised about their project and not anything outside their scope of operations. If ADRA became aware of issues directly relating to health, they were to report it to the MoHCC at district level and not forward any of that detail to the UK or elsewhere.

The drawback of this arrangement was that the responsibility for closing the feedback loop for issues outside ADRA's mandate lay with government stakeholders, for feedback via the suggestion box, and ADRA had no means of following this up. However, other mechanisms such as the FGDs were unaffected.

The CUAMM end-point review revealed strong coordination with the local government departments. Feedback was used to resolve numerous instances of staff malpractice and inappropriate behaviour towards beneficiaries (Box 13).

Box 13: Feedback supports local government services to improve behaviour of nurses towards beneficiaries in Tanzania

For CUAMM, the BFM was used to highlight complaints about staff conduct, and practices. Explaining the malpractices, one respondent said:

"... nurses commonly slap and pinch the expecting mother during the labour process, which we don't like but thought are allowed to do ... and every time you take the baby for treatment the doctor prescribes drugs which, and even if it is 3 or 4 days after receiving supplies of drugs from the district, the doctor tell you that they are out of stock go and buy them."

These issues were brought to the attention of district health officials by CUAMM, and prompt actions were observed. With regard to the action on the feedback given, one participant noted some progress, but issues remained:

“we are happy with the changes in the behaviour of the nurses we have seen. So far though the bad language has changed, the nurses are still irresponsible because if the clinical officer is absent, they still come to work late and one notes long queues of patients waiting to be attended.”

One challenge observed in CUAMM, was in closing the feedback loop after actions were taken. As noted in Section 4.2.1, noticeboards were vandalised, and the end-point review noted that beneficiaries were frequently unaware of actions taken, unless observed directly. Beneficiaries were also highly fearful of being victimised by staff if they were known to have made a complaint. This illustrates the challenge in managing external relationships, even when there are good relations at institutional level.

Finally, stakeholders also included non-government entities. HPA received feedback related to the World Food Programme (WFP), which was utilising the clinics to distribute food rations.

Where working relationships were particularly close with those agencies, such as CUAMM, the partner was closely involved in tracking the government response. However in most of the pilots, the response of government agencies was not formally tracked, although informal monitoring appears to have taken place.⁵⁴

4.5 Contribution to improvements in programme quality [Indicators 8 and 18; KLOE 4, 7 and 10]

Key finding: BFM enabled real-time adaptation of projects to the needs of their target group, and supported accountability. In some contexts, they also provided a direct contribution to project outcomes through awareness raising.

There is evidence that feedback loops are resulting in changes to projects, both prior to implementing activities, and through adapting activities that are already underway. These changes appear to fall into three broad categories.

The first are improvements in the way that projects adapt to their contexts and beneficiaries' needs. This kind of “adaptive programming” was more relevant in pilot organisations implementing direct service delivery. Requests of a similar nature in advocacy-based projects or those engaging with government service providers are directed to the relevant provider, and are therefore manifested as a social accountability outcome.

⁵⁴ In the case of ADRA, the process agreed with the local government for opening the suggestion box meant that ADRA staff were not made aware of the content of feedback that were not within their remit, and therefore could not follow up on what actions relevant stakeholders had taken.

The second are improvements in the accountability of projects and/or stakeholders to beneficiaries. This was evidenced in both projects engaged in direct service delivery, and those working with government service providers or taking an advocacy approach.

Third, in some instances, the BFM is also making direct contributions to project outcomes. This seems to be related to the increase in the face-to-face contact between project staff and beneficiaries, and the increases in awareness of the MCH project that was associated with that. The outreach and awareness raising function is more evident for Approach 3 pilots, but is evident across all the pilots, with the possible exception of CUAMM. For ADRA, the example of male involvement in MCH supporting women's access to services (Chapter 4) illustrates this. For MAMTA and CINI also, there was a blurring between activities seeking and responding to feedback, and those raising awareness of MCH issues and entitlements more generally.

The subsequent effect of these changes on MCH outcomes was not within the scope of the Monitoring and Review, but the changes observed plausibly improve the relevance and effectiveness of the maternal and child health projects implemented.

4.6 Value for money [Indicators 21, 22, and 23; KLOE 8]

Key finding: Pilot BFM's involved relatively significant resource investments, regardless of the feedback approach; efficiencies were observed where feedback mechanisms integrated with project activities.

We discuss value for money at project level, because that is where most costs and benefits are observed to have occurred.

4.6.1 Costs to implementing organisations

Overall, data collected by World Vision indicate that the financial cost of implementing BFM's at country level in each pilot to be around 25,000 GBP on average. These costs were covered by the budget allocated for the pilot.⁵⁵ Staffing costs, the employment of a full-time Community Feedback Officer, are clearly a significant driver of this. It was observed that most projects spent a considerable amount of time and resources in adapting the BFM to different situations and changing circumstances. The set-up of the BFM and sensitisation of beneficiaries were therefore significant expenditures.

Some differences in the financial costs were noted between the three approaches. World Vision data show that, contrary to expectations, the Approach 1 pilots had the highest financial costs – this is largely explained by contextual differences such as remoteness and fewer field staff on the ground (CUAMM), higher operating costs (HPA), but the greater investment in sensitisation required by the approach is also a cost driver. Approach 2 pilots were the lowest cost, reflecting integration with existing activities, while Approach 3 were just above average.

Staff time is a significant cost, but critical to the functioning of the BFM's. Approach 1 was expected to minimise this through the use of technology. However, the experience of HPA was that SMS and voice messages needed to be followed up by the CFO to clarify the feedback before action could be taken, thus resulting in a more manual process than originally envisaged. Approach 3 pilots benefited

⁵⁵ The support provided by World Vision, Frontline SMS and INTRAC consultants in-country is likely to have contributed to the results observed, and was funded on top of these in-country costs.

from integration with project activities, and particularly the networks of volunteers that facilitated many of the meetings, at which BFM activities were also conducted.

The role of the CFO was central to the pilots, as they were designed. However, there are indications that projects are exploring models for sustaining BFMs without a full-time CFO. These will be interesting to follow up.

4.6.2 Costs to beneficiaries

The financial cost of accessing the BFMs for beneficiaries was low to zero. However, financial costs were noted as barriers where they occurred (for example SMS and phone airtime costs). Additional evidence that beneficiaries in these contexts were highly sensitive to monetary costs include the observed take-up of HPA's toll free phone line, once it was introduced.

The time-cost of providing feedback, although significant, did not appear to be a concern for beneficiaries when the mechanism was perceived to be operating well. This was the case, even where a considerable amount of time was involved in attending meetings. In a few instances concerns about time being wasted were raised. For ADRA, staff arriving late at meetings was an issue raised via feedback. For Rahnuma, the end-point review revealed a very small number of beneficiaries dissatisfied with the BFM due to time wastage in FGDs. The consultant reports that the reason was that they didn't feel the discussions were relevant, as they were from middle-income groups.

4.6.1 Value for money

The evidence reviewed so far in this report suggests that the pilot BFMs have supported empowerment, project quality and accountability outcomes (although the contribution of the BFM cannot be rigorously established) to varying extents. Beneficiaries appear to value the BFMs as a platform for voice and which incur few costs. Senior decision-makers in most of the pilots also report that BFMs have been useful to projects, and plans for sustaining and scaling BFMs beyond the pilot (discussed in Section 6.4) indicate the value to organisations, although there are some indications of plans to do so with more limited human resources. Whether the BFMs represent value for money for the donor would require an assessment of whether project quality and accountability have impacted on outcomes of the projects themselves, which is beyond the scope of this review.

4.7 Comparing the three approaches and assumptions of the Theory of Change

Key finding: Differences between the approaches to collecting feedback did not appear to translate into any systematic differences in responding to feedback

As noted in chapter 2, the three approaches varied the mechanisms by which feedback was sought and the types of feedback (unsolicited, solicited, and participatory). The only major difference observed between the three tested approaches was that approach 1, by the design of the mechanisms, was more centralised and there was less opportunity for staff to close feedback loops informally. Conversely, approaches 2 and 3, many project staff and volunteers were involved in collecting feedback face-to-face and often queries were resolved directly at point of service.

Although we expected approach 1, being unsolicited, to yield less relevant information, in practice context and sensitisation affected this more than the approaches, and beneficiaries across the

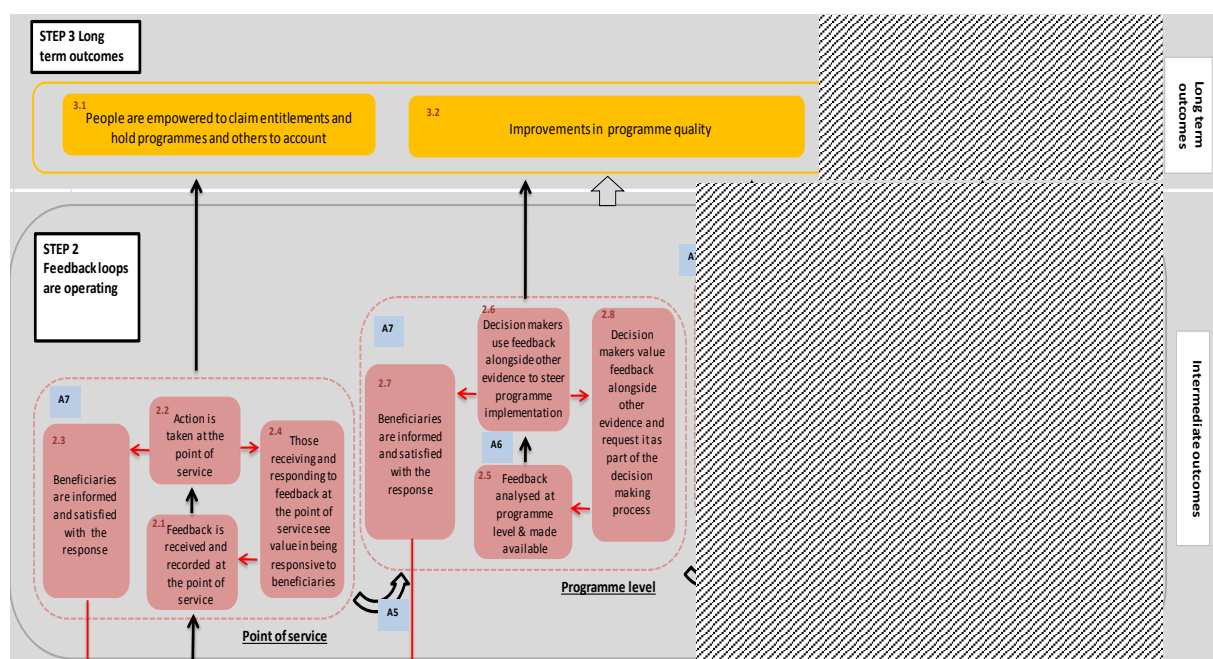
projects provided feedback on issues that were of concern to them, even if they were outside the scope of the projects.

At project level, the assumptions and linkages in the theory of change broadly held true, in that:

- Provision of feedback by beneficiaries set in motion feedback loops at point of service, where actions were taken and beneficiaries were informed and satisfied with responses.
- Where relevant, feedback was referred to project level as similar feedback loops operated, and responses were communicated back to beneficiaries via staff/mechanisms at point of service.
- At outcome level, beneficiaries were observed holding projects and others to account and changes were made as a result of feedback that had plausible improvements in project quality.

One clear omission from the CTOC was any reference to how projects might interact with external agencies (e.g. government authorities) to respond to feedback from beneficiaries. More explicit consideration of referral mechanism's and processes to support and monitor the handling of feedback by external agencies would improve future theories of change regarding beneficiary feedback.

Figure 3: Common Theory of Change, project level feedback loops



5. Key findings: upper feedback loops

This chapter explores how feedback has informed decision-making above the project level; i.e. at the level of the partner organisations as a whole, fund holders (if different from the partner organisation), fund manager and donor.

5.1 Decisions at higher levels on individual pieces of feedback [Indicator 16; KLOE 4 and 7]

Key findings: Very little feedback was referred to stakeholders higher up the aid delivery chain because partners had the mandate to respond to feedback at project level

Most feedback did not require decisions about the issues raised to be made above project level. However, a minority of individual issues were referred upwards for decisions. Higher level feedback loops include those responsible for pilot organisations' projects as a whole (either in-country, or thematically such as MCH), the fund holder (if different from the pilot organisation), the fund manager and donor.

Our data suggest that only a handful of feedback required intervention by the UK Aid Direct fund manager, and only one by DFID itself (to approve the roll-over of budget in Rahnuma). Table 11 shows the highest level at which a decision was made regarding specific responses to feedback.

Table 11: Highest level reached by feedback in upper feedback loops

| ↑ | Level | Project/Issue | Action taken |
|---|--|--|---|
| | DFID level | Rahnuma: additional nutrients to be added to nutrient packs | DFID approved use of unspent funds |
| | UK Aid Direct fund manager level | CUAMM: construction of Waiting Mothers' Shelters | Budget approved |
| | | AMREF: construction of Waiting Mothers' Shelters ⁵⁶ | Budget reallocation approved |
| | | AMREF: extending 'community conversations' | Budget approved |
| | Fund holder level (where applicable)⁵⁷ | ADRA: procurement of additional bicycles so that volunteers would not need to share (as planned - earlier purchase was of fewer, higher quality bicycles on advice of govt.) | Joint decision taken to retain the same number of bicycles. |
| | Regional level | HPA: procurement of ultrasound machine | Regional Director approved medical need and use of budget |
| | Country level | HPA: increased number of beds | Country Director approved budget |
| | | HPA: request for increased rations from WFP | HPA passed request on to the World Food Programme (WFP), who did not make changes |
| | Local level stakeholders | CUAMM: high incidence of gender-based violence reported via BFM | Coordination with police |
| | Project-level | | |

⁵⁶ This issue was raised by a government stakeholder during a KII with the CFO, which was part of the BFM for AMREF.

⁵⁷ MAMTA, Rahnuma and CUAMM were funded directly in-country. All others went through UK-based fund holders.

Where feedback did enter the upper feedback loops, it appears to have been for procedural reasons of budgetary sign-off, rather than because of any significant changes to the project's strategy or approach (for example, changes that would have required an amendment to their logframe). That is not to say that changes were necessarily small in nature; for example, HPA's investment in an ultrasound machine represents not only significant capital expenditure, but also ongoing costs in training staff and maintaining the equipment. This response was escalated to HPA's Regional Director, who approved the use of funds outside the project (Box 14).

Box 14: Feedback informs procurement of ultrasound facilities in Somaliland MCH clinics (HPA)

One change which has come out of HPA's BFM is the provision of an ultrasound machine for use by the maternal and child health clinics. According to the Programme Manager, the amount of requests for an ultrasound machine was 'overwhelming'. Feedback from July to October in 2015, revealed that the issue of the ultrasound was mentioned over 40 times, through community meetings, and voice messaging. The alternative of going to diagnostic centres is untenable for many families, as average monthly household incomes in the areas which the MCH operate in is very low, making diagnostic centres in town too expensive.

As a result, this feedback was referred upwards to the Project Manager, then the Country Director then the Regional Director who eventually agreed that there was a need for an ultrasound machine for use at the maternal and child health clinic level. As such, the Project Manager felt it was the most difficult issue she has had to escalate upwards to first the Country Director then the Regional Director. She explained that part of the reason for the Regional Director agreeing to make this change to the project was that he himself came from a medical background and so the arguments related to medical care were the most convincing.

Follow-up with HPA staff at fund holder level reveals the decision-making process:

"[the ultrasound machines] were purchased with other project funds with existing budget for medical equipment. However, budget for training [staff how to use the equipment], has had to be put in project proposals and we anticipate it being carried out early in 2016. The decision to procure ultrasound machines for the HCs was largely due to the feedback and the fact that the BFM pilot health centres serve larger populations. Therefore equipping them to provide additional MCH services, should have a greater impact."

Given the low levels of income in the neighbourhoods which the maternal and child health centres operate in, this allows people who would not normally be able to afford such care to have better antenatal care, in keeping with the aims of the project on neonatal, maternal and child health.

We found no evidence that potential responses to feedback were impeded by the fund manager or donor. Most requests for budget changes escalated to the fund manager were within the 15% budget flexibility threshold, so were dealt with responsively without recourse to the donor. Partner staff contacted during the Monitoring and Review report interactions with the fund manager to have been positive and swiftly dealt with.

Only one response (Rahnuma – for additional funding for nutrient packs) required DFID approval, which took more time because of the financial protocols surrounding use of roll-over funds, but was ultimately granted.

We also observed one case (a request for one bicycle per community volunteer receiving training from ADRA) where the fund holder, in coordination with implementing partner, decided to pursue an alternative response (training fewer volunteers, so each had their own bicycles) after having considered the issue together. However, the end-point review suggests that this feedback loop was not effectively closed:

“... well we always hear the ADRA staff saying we have sent the information to the headquarters, and sometimes this goes on for a long time and we know that that’s where things die unaddressed ...”

– Project volunteer (ToT), ADRA/Zimbabwe, end-point

The above illustrates the risk that feedback or responses may ‘leak’ between the different levels of feedback loops, and if the expected response is not observed, the assumption may be that feedback has been ignored, when in fact a decision has been made. This was also highlighted in the HPA case above, where not all beneficiaries were aware that the ultrasound machines had, in fact, been purchased, since the machines were not yet in active use.

The fact that the BFM was implemented after the inception stage of the maternal and child health projects themselves may have influenced the number of decisions escalated to upper feedback loops. Pilot organisations only began receiving feedback once the major elements of the projects had already been agreed and a logframe signed off with the fund manager. Thus, the design of the pilot may have limited the perceived room for manoeuvre in terms of planning new activities in responded to feedback.

5.1.1 Use of feedback at higher levels

To date, we have not observed significant evidence of organisations using feedback (and responses) to systematically learn about what is working, in what context, and why. One reason for this may be that the length of the pilot was too short to capture such changes (spanning only one programme cycle), but also that the scale of the pilot was limited and organisations may have been focussing on scaling up before focussing on using feedback to learn. One exception may be the review of Maternal Death Surveillance Reporting within AMREF, triggered by beneficiary feedback from the pilot BFM in Ethiopia (Box 15).

Box 15: Feedback ensures implementation of Maternal Death Surveillance Reporting in Ethiopia

Many mothers died with preventable pregnancy related causes in Ethiopia. An approach called Maternal Death Surveillance Reporting (MDSR) was initiated by stakeholders to monitor the cause of each maternal death. The project incorporated this initiative as part of its activities to improve maternal and child health services in Konso District.

The project trained Health Extension Workers (HEWs), staff from health centres and the District Health Office on MDSR. The training focussed on establishing mechanisms of surveillance and reporting of causes of maternal deaths when they occur. The expected outcome was that a system rooted in the community and stretching to all levels of the health system would be established. It was intended that a committee would be established at village/Kebele level in which the HEWs are to be members. Similarly, a committee would also be established at the district level and the health centre level. A reporting format including lines of enquiry was prepared and dispatched to HEWs and health centres. However, the initiative has not been implemented in the District in the last two years.

Two years after the implementation of the project, AMREF embarked on the implementation of the pilot BFM project to assess beneficiary views on services. One of the services was MDSR. As per the predetermined questions for key informants, the CFO asked the HEWS whether the MDSR was being implemented in their village/Kebele. The response of all the HEWs was that although they were trained on MDSR they hadn't started implementing the initiative. Neither the Kebele level nor the District level MDSR committees were established. The feedback was reported to the project manager (by the CFO). Then, the project manager contacted staff from AMREF UK. Conventional monitoring would have overlooked and perhaps would have found the problem after the project had already been completed, with little or no chance of taking action to put things back on the right course. Subsequent discussions between AMREF UK and the project manager led to the decision to review the MDSR status in the District. The response was communicated to the CFO and relayed to the HEWs by the CFO.

While AMREF was planning to act upon the feedback to reinvigorate the MDSR initiative, a national report for 2015 revealed that about 13,000 mothers passed away due to maternal-related deaths. This triggered other major stakeholders like the World Health Organisation (WHO) to initiate a review of the MDSR system.

Following this, the project organised a district-level MDSR review to reinstate its implementation. It was understood that the weakness of the MDSR committees was system induced. The structure of the MDSR committee was that, at health centre level, the committee was headed by the centre head, and the midwife was deputy chairperson. The MDSR was treated as a separate initiative, marginal to other structures. It was, therefore, overlooked.

AMREF also organised two rounds of Integrated Refresher Training for HEWs and health staff, making MDSR part of the content. Minute capturing books were also purchased and distributed to health posts and health centres for use by the committees. The feedback generated by the BFM led to the correction of activities that would have had little chance of being corrected under conventional systems. This lesson would, therefore, continue to inform AMREF health Africa programming in the future.

On the other hand, there are potential learning points coming from feedback that indicated where more formalised or systematic learning could be developed, for example, the impact of male involvement in MCH, observed in ADRA (see Box 7). Of course, tacit learning may well be taking place within staff cadres involved.

5.2 Integration with existing M&E systems [Indicator 1; KLOE 3]

Key finding: Beneficiary feedback enabled organisations to respond to issues in real-time, complementing existing M&E approaches.

While alignment of BFM with the project activities was clear across the pilots, the extent to which organisations integrated the BFM into their existing systems varied. The main point of integration expected was with the organisations' existing M&E systems. In four cases (CINI, MAMTA, Rahnuma and CUAMM), greater degrees of integration were observed, while in three (ADRA, HPA and AMREF) the BFM was run in parallel with the existing M&E system.

Country Directors for both HPA and ADRA reported that this was due to the pilot status of the BFM, and indicated integration would follow if the BFM was scaled up. The decision to integrate BFM into existing M&E may also have been informed by the existing approaches of the organisation (both CINI and MAMTA placed emphasis on participatory programming) or pre-existing BFMs (Rahnuma and MAMTA). While there are indications that advantages of an integrated approach include staff buy-in and wider staff involvement, there are no indications that the degree of integration had significant impacts on how feedback was actually used [Indicator 1]. It is possible that as projects increase in scale, integration will be necessary to handle higher quantities of feedback.

A perceived advantage of BFM – over and above organisations' routine monitoring data – was the ability to address issues rapidly as they arise (in 'real-time') rather than waiting for monthly or quarterly reports. In three of the pilots, organisations felt this was a particular advantage of the BFM (Box 16).

Box 16: Perspectives on real-time feedback

CUAMM: A respondent from the DMOs office in a KII said he felt that the BFM added value to the existing system of monitoring because feedback was ongoing and not limited to the existing monthly or quarterly systems. Feedback was given on issues as they happened (i.e. shortage of drugs, human resource issues behaviour/malpractices) and action to respond to the issues was taken promptly for issues that were urgent, while those that were not urgent were addressed through the existing M&E systems.

ADRA: According to the M&E Coordinator, the constant feedback that the community provided was very useful because they did not have to wait for the standard routine M&E activities such as the mid-term review and end-of-project evaluation to learn that some things could have been improved.

HPA: During a KII, the Country Director described how the data received during the BFM could be used to make changes immediately, whereas the normal M&E process only resulted in changes at a few points in time such as end-of-project evaluations. He said that for the amount of money spent, the quality of the data was very good and useful. The CFO also reported that usual

M&E systems would be more systematic and generally at less regular intervals; however, this pilot created a system which allowed for much quicker changes to be made as feedback was brought up throughout the duration of the pilot.

What is less clear is the extent to which the issues raised in beneficiary feedback would have been picked up during routine M&E activities. In some cases, there are instances where it is clear that the BFM had identified additional issues. In AMREF, for example, a problem with the timing and format of radio information messages was picked up during women's FGDs organised as part of the BFM:

"The problem that the radio spot messages were not serving the beneficiaries has eluded conventional monitoring techniques for two years."

– AMREF/Ethiopia, end-point country-level report

Box 16: Feedback improves effectiveness of health messages in Ethiopia

One of the methods that AMREF used to provide health information to women in Ethiopia was a regular radio-spot on a local government radio station. The transmission was in Konso language, twice weekly at 5-6pm on a Saturday and 2-3am on a Tuesday.

During the third year, the BFM pilot project was embarked upon in the District. Focus group discussions with women were held monthly in each of the 15 villages/Kebeles taking part in the BFM pilot. The women were asked to provide feedback on each service, their entitlements from the project, including the radio spot messages. The feedback collected in all the 15 villages/Kebeles over the months invariably and consistently showed that the radio spot messages were not actually reaching the women. The reasons for the radio spot messages not reaching the women were lack of access to radio for the women and inconvenience of transmission/air time.

The CFO reported the feedback to the project manager. The project manager, having noted the recurrence of the feedback, decided to attend one of the FGD sessions at Naleya Segen village/Kebele. He asked the women to suggest an alternative way to access the messages. The women suggested two options. The first was to dispatch health staff to transmit the messages on public meeting days. The other was to record the messages in audio and video on CD/DVD and memory chips to be passed around.

The feedback was reported to AMREF UK who supported finding alternative means to get the messages to the women. The transmission of the spot messages in Konso language were abandoned, but airtime already paid for could not be recovered. Fortunately, there was a related parallel activity to produce information and communication materials with which the case could be aligned. Discussions were held with the Zone Finance and Economic Development Department - Population Affairs Desk, which was stakeholder to the IEC/BCC activity to modify the initiative to include recording of audio and video messages, as this is what the women suggested during the FGDs. Consensus was reached and standard MCH health messages were translated into Konso language and converted into suitable formats including duplication on CD/DVD to be dispatched to health centres and health posts. The lesson was disseminated across AMREF Health Africa Programmes and the organization now wants to apply it to other projects being implemented in contexts like Konso.

In other cases, issues may have been picked up later by routine monitoring activities; without a counterfactual it is difficult to say to what degree that would have occurred.

Nevertheless, there are indications that the BFM has brought more systematic approaches to the ways in which organisations *respond* to requests and feedback from beneficiaries, that may lead organisations to prioritise and expedite responses. The expectation that feedback will be responded to and that response communicated back to beneficiaries clearly provides a mandate for taking action, and the specific referral pathways established have supported organisations to address issues quickly. In CUAMM, for instance, officials in the DMOs office reflected on this change:

“...unlike before when it used to take some time to resolve issues that were raised by feedback from beneficiaries, now the DMO acts on issues immediately as soon as they are raised. Depending on the seriousness of the feedback, the DMO for instance calls the team members and assigns a specific person to follow up the particular issue”.

– DMO Office officials, CUAMM, end-point

The implication is that BFM can provide more real-time data than traditional monitoring activities. However, it is worth noting that beneficiary feedback is used in participatory monitoring and evaluation (PM&E) approaches used by some organisations; whether or not a BFM provides benefits over and above PM&E approaches has not been explored in this pilot.

5.3 Feedback informing donor reporting and strategic planning [Indicators 4, 7, and 16; KLOE 7]

Key finding: beneficiary feedback informed organisations’ reporting to the fund manager and strategic planning. However, low capacity of organisations to analyse and code feedback, may have limited its usefulness to stakeholders at higher levels in the aid delivery chain.

The fund manager reported that beneficiary feedback was recorded in reporting formats for the UK Aid Direct-funded projects, as a result of engagement with the BFM pilot. Thus, beneficiary feedback informed the reporting of all partner organisations to the fund manager. CINI was the only pilot organisation to have included an indicator in their project logframe that used information gathered via the BFM, and the fund manager believes they were better informed of the BFM in this case (Box 17).

Box 17: Using indicators derived from beneficiary feedback in project logframes

At the outset of the pilot, inclusion of indicators *derived from* beneficiary feedback in project logframes was discussed with organisations. However, the timing of the BFM pilot vis-à-vis the projects meant that project logframes were already being finalised, and the BFM pilot of covered only a proportion of project areas, so most organisations chose not to use the BFM to inform reporting against the logframe.

Only CINI included an indicator derived from beneficiary feedback in their log-frame (covering all CINI project areas, not only those included in the BFM pilot):

Output: *“Enhanced capacity of key stakeholders and service providers enables quality service delivery”*

Indicator: *“Number of community feedback report cards showing improved quantity and quality of services provided by the Government health providers (focussing on JSY and ANC/ PNC check-ups)”*

The indicator was based on beneficiary feedback collected via pictorial score cards completed at meetings and focus group discussions. In this case, the type of information is no different from that which might be derived via a survey of beneficiaries or participatory monitoring. However it is available on a far more regular basis, and if the volume of feedback collected is high, may allow monitoring at a more granular level (e.g. individual clinics).

In some cases, there is evidence that beneficiary feedback has informed pilot organisations' strategic planning and relationships with external stakeholders above project level. MAMTA reported that feedback supported the development of a 2020 vision document, as well as advocacy with the government. Rahunma also reported that the BFM influenced strategic planning. However, it is not clear what material changes have resulted from inclusion of feedback in reporting to the fund manager and informed strategy planning during the course of the pilot.

Through the Organisational Capacity Assessment Tool (OCAT) (full results are given in Annex 6), staff identified that “*effective use of feedback at higher levels*” remained an area of weakness. Although most organisations perceived improvements from baseline, these were smaller than for other capacities. One organisation even reported a reduction in capacity to use feedback at higher levels, from baseline to end-point, perhaps indicating a reality check on their expectations.

As noted earlier in this report, there is little evidence that coding of data to enable meaningful analysis and aggregation of feedback took place. There is therefore a plausible link between the capability to analyse feedback and whether organisations can make use of feedback at higher levels, as senior managers and those in upper feedback loops do not have sight of individual feedback, unless the issue requires substantial changes to the project.

Linked to this, there is a risk that pieces of feedback that are not actionable at project level, but nevertheless contain information useful for more strategic levels, are not being analysed and fed into reporting/decision-making. As noted in Section 4.1, ‘traffic light’, ‘happy/sad faces’ or ‘thumbs up/thumbs down’ formats, do not contain sufficient detail to respond at project level; however they may be actionable at higher levels as performance management data.

There is little evidence that pieces of feedback have been used in this way during the pilot. This may be because the value of aggregating feedback is limited for this pilot given the small scale of the BFM pilots in comparison to the projects overall. It may also be because The emphasis on responding to feedback and ‘closure’ of the feedback loop in the design of the pilot may also have led to reduced focus on exploring opportunities to use aggregated feedback data. It may also be due to the additional skills and resources required to systematically code and store (an advantage of technology-based feedback mechanisms) and integrate the content of feedback with M&E systems. The use of feedback at an aggregated level v.s. case-by-case closure of loops was not explicitly tested in the Theory of Change or the three approaches to beneficiary feedback, and may be worthy of further research.

5.4 Evidence of change at higher levels

Key findings: there are early indications that the pilot has stimulated organisations to explore options for sustaining and scaling the use of beneficiary feedback within their programmes.

Overall, it is too early to say with any degree of certainty whether the BFM have potential to be scaled-up or institutionalised, as at the time of the end-point review, the pilot BFMs had been functional for less than two years.

For most of the pilot organisations, the experience of implementing BFMs has been largely positive and supportive of their programming. There are some early indications that the pilot organisations are making plans for sustaining the BFMs beyond the pilot, and scaling up BFM within their own programmes (Box 18).

Box 18: Plans for sustaining and scaling BFMs

HPA: On the back of the Somaliland pilot, HPA included BFM in new proposals and has been awarded three new contracts for projects with a BFM component.

ADRA: KIs with project staff including the Country Director reveal that ADRA Zimbabwe intends to integrate the BFM into other programmes in the future while taking considerations of the lessons learned through the programming.

Rahnuma: Based on the pilot, Rahnuma is starting to integrate beneficiary feedback into its monitoring systems and has made a commitment to beneficiary feedback in its next five-year strategy.

MAMTA: For the pilot project sites, the mid-term review revealed that MAMTA rolled out a BFM in a new district, within the project budget (using existing staff and learning from the pilot to make it more efficient); they also had plans to scale up BFM as “community monitoring mechanisms” beyond the project itself. The end-point review notes that community members are eager to sustain it with the help of the group leaders and feel they have the capacity to undertake the mechanism and run it successfully in the community. MAMTA have also been approached by the government of a neighbouring province to roll out BFM, and have included it in their 2020 strategy document.

CINI: CINI has initiated a series of ‘community watch groups’ involving community members and change agents, to sustain the BFM component in the absence of funding via the pilot. This represents a shift to an approach linked more with social accountability models.

It is interesting to note that the two Approach 3 projects are approaching the question of scaling up by finding less resource-intensive ways of implementing BFMs, while other organisations are tending to look at resourcing BFMs via further funding proposals.

In terms of BFMs becoming more institutionalised at policy and donor levels, as noted in Chapter 6, we did not find functional loops at strategic/policy or donor levels at the end-point review and to our knowledge, beneficiary feedback arising from this pilot is not being used at these levels to shape policy or donor decision-making. While there may be changes in appetite for BFMs occurring at these levels, and the pilot itself has spurred interest in BFMs in the wider community, it would be difficult to attribute that to the operational BFMs themselves.

5.5 Comparing the three approaches and assumptions in the Theory of Change

Key findings: Limited use of feedback was made at higher levels, with no clear differences observed between the three approaches

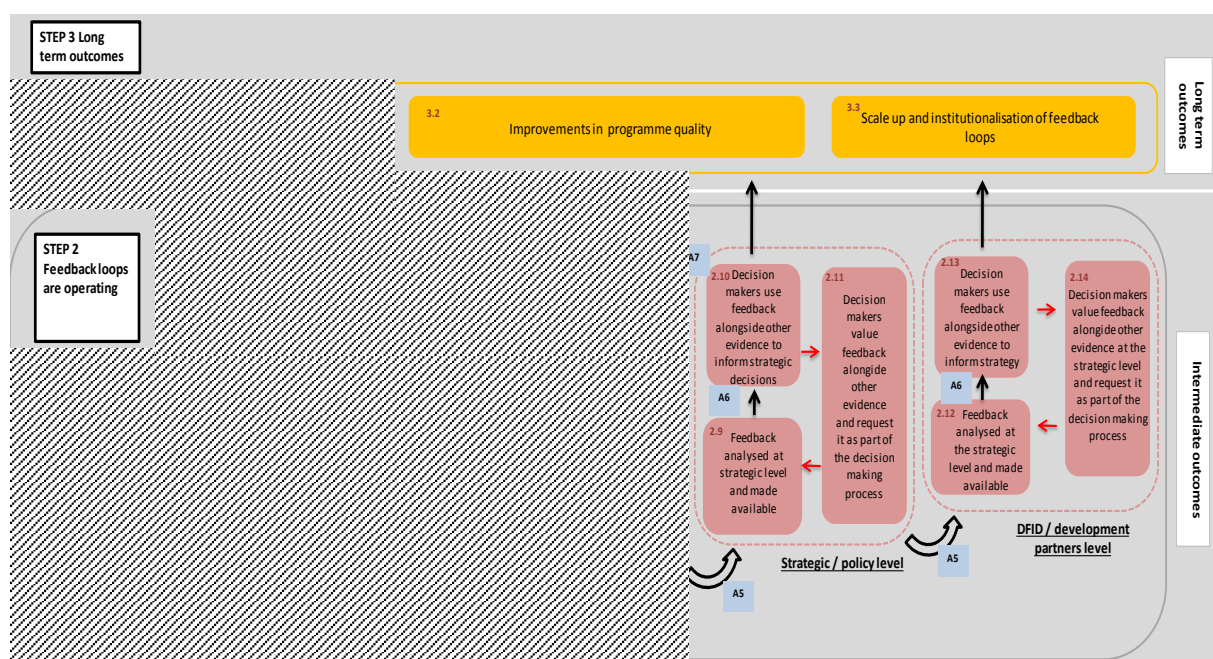
No clear systematic differences between the three approaches were observed in the flow of feedback to higher levels. Although approach 3 pilots appeared more advanced in their integration and institutionalisation of feedback, this may reflect the organisations rather than the approach.

The experience in these pilots revealed that, handled on a case-by-case basis, the closure of feedback loops at project and project level resulted in very little feedback flowing to strategic/policy level or higher, and therefore feedback loops at strategic and donor levels were not activated.

Opportunities to aggregate and summarise feedback for monitoring purposes were not fully utilised in the pilots, perhaps because the value of aggregation for small-scale pilots was limited. However, some learnings that arose from feedback seem to have spread wider than the projects themselves.

The common theory of change did not explicitly identify mechanisms by which feedback would be flow from project level to strategic level. We suggest that systematic coding and aggregation of feedback, may be necessary for feedback loops operate at higher levels, but it may not be sufficient. Future research is needed to assess the demand for, and value of, beneficiary feedback to strategic decision-makers and donors themselves.

Figure 4: Common Theory of Change, project level feedback loops



6. Conclusions

Seven pilot beneficiary feedback mechanisms were reviewed, with the objectives to: assess whether BFM approaches were being implemented as planned; assess the information flow between beneficiaries, projects and donor; review the performance, effectiveness and efficiency of the mechanisms, and provide learning for stakeholders in order to improve decision-making and programming.

This review finds that the seven pilot organisations were successful in establishing functioning beneficiary feedback mechanisms, albeit with differing strengths and weaknesses. Context – both organisational and country/community – appears to be a major factor in the variations observed. The extent to which we can draw out definitive comparisons between the three different approaches to collecting beneficiary feedback is therefore limited, and adaptations to context in the pilots themselves also muddies the distinction between the three approaches.

- **Adaptation of the BFM and sensitisation of the community are critical to collection of feedback and inclusion**

The observed level of engagement of beneficiaries with the pilot BFMs was contingent on adaptation of the BFM design to the context and target group, and investment in community sensitisation. Adaptation supported the functioning of BFMs overall, but also aided inclusion of sub-groups. Beneficiaries in these contexts were not confident to give feedback to begin with, and sensitisation to the purpose and process of the BFM was important to generate awareness and overcome fears and misunderstandings. Ongoing adaptation and sensitisation during the implementation phase was found to be necessary.

The design of the pilot, by specifying three broad approaches, placed certain restrictions on the scope for adaptation (particularly for Approach 1). However, implementation support from World Vision and SIMLab may have provided additional prompts or capacity to adapt. Although there is no formal counterfactual, the experience indicates that implementing a BFM “off the shelf” would be less likely to engage beneficiaries, particularly the most marginalised, compared with one that has been contextualised thoroughly.

- **Context determines beneficiaries’ preferred feedback mechanisms**

The mechanisms that were preferred by beneficiaries appear heavily dependent on context (in this case MCH services in contexts of high poverty). The apparent preference for more ‘traditional’ mechanisms such as FGDs and suggestion boxes reflects contexts where face-to-face oral interactions are the predominant methods of communication. In these contexts, factors that prompted the active use of a feedback channel included:

- Proximity to the community, in that feedback occurs locally and visibly (face-to-face and suggestion boxes)
- No requirement for literacy (face-to-face and voice calls)
- Immediacy of getting a response (face-to-face and voice calls)
- No cost (face-to-face, suggestion boxes and toll-free voice calls)

SMS, which was used little in the context of this pilot, did not align with any of these factors (which was recognised by the implementing partner, SIMLab, from the outset with the addition of voice calls as a mechanism).

It is also possible that as feedback was often not provided directly (face-to-face) to the person/institution responsible for the intervention, it was easier for beneficiaries to speak honestly and openly.

- **Assumptions in the Theory of Change were valid for collection of feedback**

The experience of the pilots suggests that the assumptions in the common Theory of Change (CTOC), with regard to collecting feedback, were broadly credible. The only exception is that information provision and awareness of entitlements will necessarily lead to more relevant feedback. While perceiving services as entitlements (as opposed to gifts) appears to be an important condition in facilitating active use of BFM, it does not guarantee relevance. In practice, a BFM opens up a channel for the target beneficiaries to express their needs and issues. The extent to which organisations can ‘control’ what feedback is given is limited. In any case it is not necessarily desirable, since critical issues such as gender-based violence were highlighted and addressed through unsolicited feedback.

- **BFMs support real-time adaptation and accountability at project level**

The review finds that feedback loops were operating at point of service, and project level, and that information was flowing between those levels relatively freely. The findings suggest that feedback was used to respond to issues and concerns of beneficiaries in real-time. Feedback generated organisational responses that addressed the needs of the target groups, adapted implementation to context and enabled accountability. The BFM was perceived to bring advantages of real-time information (compared with the pilot organisations’ routine M&E), and in some cases highlighted issues that had not been picked up during routine M&E.

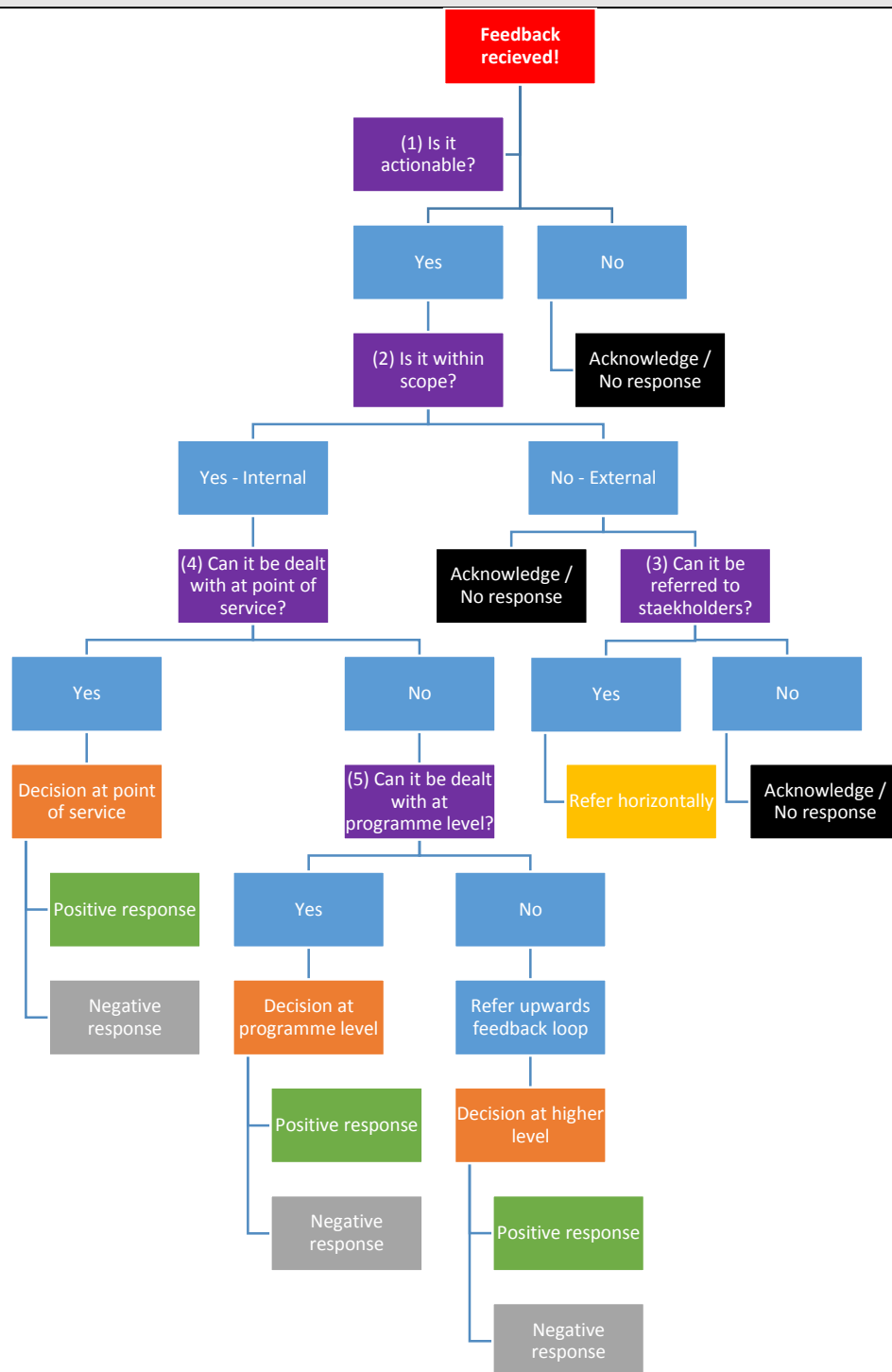
- **Closure of feedback loops at project level restricts use at more strategic levels**

Very little feedback reached strategic/policy or donor levels, and those that did were primarily for reasons of budget mandate. No particular blockages were found between project level and the upper feedback loops. On one hand, this is good, as it means organisations felt that they had the mandate to respond to feedback without intervention from Headquarters or donors. On the other hand, there is the possibility that staff may filter out feedback on issues that are beyond the project mandate, reducing the scope for feedback to inform more significant changes in approach.

There are a number of key decision-points that determine how feedback is filtered and feedback loops closed at different levels. Box 19 presents a decision tree⁵⁸ that illustrates these questions and the different outcomes that might occur. Note that this represents a generalised picture, and may differ in each organisational context.

⁵⁸ Created by the INTRAC at the end-point review stage of the M&R process.

Box 19: A feedback decision tree



This decision tree prompts a number of questions about information flow:

- Who makes the decisions and what is their capacity? In some cases, particularly Approach 1 where the feedback mechanisms (suggestion box, SMS, voice calls) were managed centrally, decisions were made by the CFO. In other pilots, these decisions were made by field staff or

volunteers, and in two cases (AMREF and ADRA), government health workers were involved in the initial screening of feedback.

- When is feedback recorded into the feedback database/register? In some cases, it was right from the start, but in others, only feedback that was actionable and within scope was recorded. In others, feedback dealt with at the point of service was not necessarily recorded at all.
- On what basis is it decided what is in scope and out of scope? If feedback is deemed out of scope, then this closes the feedback loop. However, if the loop for such feedbacks was not automatically closed, there is the potential that what is thought out of scope at the point of service, may be relevant to decision-making at other levels. This question was not fully answered by the pilot, but the indications are that these decisions were largely taken by field staff based on their judgement, rather than against a specific set of criteria.
- How are referral mechanisms established, and are they monitored by the organisation seeking feedback? In ADRA's case, as noted above, referral from the suggestion box occurred at the point that the box was opened. For CUAMM, the organisation clearly had a very good working relationship with local stakeholders and was able to track progress on dealing with feedback.
- **Use of feedback at higher levels may require different approaches to handling feedback information**

Although some pilot organisations reported integration of BFM into their M&E systems, and use in strategic planning, the pilot placed less emphasis on using feedback at an aggregated level. The theory of change and the design of the BFM approaches focussed on successfully generating feedback and closing the loop, rather than on a more 'extractive' use of feedback as an M&E tool. The capacity to code (i.e. classify the content of) and analyse feedback remained relatively under-developed⁵⁹, and decision-making on the basis of aggregated feedback was not observed. This focus may also have influenced the extent to which feedback was able to inform decisions at higher levels. The literature and methodologies developed around participatory monitoring and evaluation, may be very relevant to developing alternative models for using feedback at higher levels.

- **There are different considerations for BFM in service delivery interventions and social accountability approaches**

A significant contextual factor at the organisational level was whether feedback was being sought on an intervention the partner organisation was implementing directly, or whether on feedback related to government interventions or services. In the former, the scope for response was determined largely by the organisation and project (and the degree to which the project was perceived to be flexible). In the latter, however, the BFM becomes more of a social accountability tool. For organisations where the maternal and child health project was primarily using social accountability approaches (CINI and MAMTA), the BFM directly supported project objectives, and there was a blurring of the boundary between the BFM and the project itself. The relationship with government

⁵⁹ FrontLine Cloud, an online solution developed by SIMLab, offered significant capacity in this regard, but was under-utilised due to the limited take up of the SMS mechanism.

services therefore played a much stronger role in how feedback could be resolved. There are potentially different design requirements for a BFM in relation to these programme modalities.

- **Indications of positive effect of BFM on expected outcomes**

In many of the pilots there is evidence that beneficiaries have been empowered to hold decision-makers to account (outcome 3.1, CTOC). Wider empowerment effects were also observed, with beneficiaries valuing BFMs as a platform for voice.

There are indications that beneficiary feedback generated responses that improved programme quality (outcome 3.2, CTOC). These have included incremental adaptations to make projects more relevant and effective in engaging with the contexts in which the projects are operating and the needs of the target beneficiary groups. Changes required reallocation of budget lines to different activities, and in some cases, bringing additional resources into the projects.

There is also some evidence of improvements in accountability, both in terms of how aid is used (i.e. between beneficiaries and implementing partners), and in terms of social accountability, (i.e. enabling beneficiaries to hold government service providers to account). These were primarily in the areas of staff discipline and use of facilities and resources.

It is too early to say whether BFMs are becoming institutionalised or scaled (outcome 3.3, CTOC). However, there is little evidence so far that feedback loops are informing decision-making higher up the aid-delivery chain.

- **The three approaches showed different advantages with respect to feedback generation, but no clear distinction in how feedback is responded to**

Approaches 2 and 3 appear to have generated more and higher quality feedback, primarily because they made greater use of oral and face-to-face feedback, overcoming the barriers of illiteracy that were present in most contexts. For similar reasons, inclusion in the BFM was easier via oral feedback, although multiple channels were shown to be important.

However, the apparent advantages of Approaches 2 and 3 in terms of generating feedback do not appear to have translated into greater ability to analyse and respond to feedback. The Approach 1 pilots appeared equally capable of using feedback in decision-making and responding appropriately (although relying on noticeboards to inform beneficiaries of responses was not effective in community/village contexts).⁶⁰ Similarly, little distinction can be made between pilots in terms of outcomes. Approach 3 pilots appear stronger on empowerment outcomes; this may be plausibly due to how the approach interacts with organisational and contextual factors and may not hold true for all contexts.

7. Recommendations

The Monitoring and Review process explored the experiences of seven organisations piloting Beneficiary Feedback Mechanisms (BFMs) as part of maternal and child health projects, funded by the

⁶⁰ The exception is the use of noticeboards in schools, which was effective for Rahnuma.

UK Department for International Development. The process yielded learning relevant to different audiences, that informs a number of recommendations.

7.1 For the seven partner organisations

The in-country validation and learning events, as well as the country-level reports, have provided rich learning specific to each context. Issues and actions identified through these mechanisms should be prioritised. More general issues include the following.

- The most pressing issue; the existing BFM's are to be sustained:
 - For service delivery based projects, consider whether additional resources can be found to sustain the existing approach (in particular the CFO's salary), and if not, whether there are ways to manage the existing mechanism with lower resources, for example by integrating further with project activities.
 - For projects engaging with government service providers, consider: to what extent beneficiaries are empowered and have the capacity to collect and manage a feedback process themselves, or engage with a government-led feedback mechanism, and what support might they require on an ongoing basis.
- If existing BFM's are to be retained:
 - Set a point to review the feedback indicators (Approaches 2 and 3) and specific feedback channels – in consultation with beneficiaries – to ensure the BFM remains relevant to communities and their contexts.
 - Consider whether analysis and storage of feedback can be made more systematic and robust, particularly with regard to coding and aggregating feedback and tracking responses.
 - Some organisations may improve inclusion by further adapting mechanisms, e.g. increasing the number of suggestion box points, thus reducing the distance for beneficiaries to travel to use them, or introduction of pictorial suggestion box formats
 - Review whether noticeboards add value as mechanism for communicating responses back to communities.
- In some contexts, further exploration of how the BFM might be used to engage males in MCH, removing barriers to women accessing MCH services.
- Further consideration should be given to what issues are deemed 'within scope' of the programme and how 'non-actionable' feedback may be utilised.
- Explore whether changes to programmes as a result of the BFM have led to observable difference in project outcomes.

- A strong desire – and in some cases concrete plans – to scale BFM was observed among most of the pilot organisations. Organisations should evaluate their own experiences with the pilot BFM – but also the alternatives – and conduct design and contextualisation research to ensure that models chosen to scale are the most appropriate.

7.2 For organisations considering implementing BFM in the future

- Appropriate feedback mechanisms are highly dependent on context; a thorough context analysis should be undertaken to inform the design. This should include target beneficiaries preferences to give feedback (including different sub-groups), power analysis, barriers and enablers to give feedback, whether there are existing BFMs or previous experience of feedback mechanisms
- When choosing feedback channels in marginalised contexts, particular consideration should be given to literacy, cost and how visible and familiar a particular feedback channel will be to beneficiaries when implementing BFMs in very marginalised contexts.
- Implement more than one mechanism to support inclusion of groups with different needs. Mechanisms involving face-to-face contact with staff may be supplemented by confidential mechanisms to ensure inclusion of different groups and more sensitive issues.
- Sensitisation of target beneficiaries is a critical part of implementing a beneficiary feedback mechanism, particularly in marginalised contexts. Sensitisation should include both the process and purpose of the BFM.
- Alongside sensitisation of the target communities, engagement of ‘external’ stakeholders is necessary to overcome misunderstandings about the purpose of BFM and establish concrete referral channels for feedback that is beyond the scope of the organisation.
- Inform and engage those who may be held to account via a BFM (whether organisations own staff, front line staff of government service providers, or community leaders) to reduce the risk that these groups perceive the BFM in solely negative terms and seek to undermine it.
- Ensure that the scope for the organisation to respond to feedback is communicated to all staff, and particularly those who are the ‘first contact’ for beneficiary feedback. This includes the flexibility for changes within a programme cycle, and the ways in which the organisation might respond in the longer-term.
- Monitor feedback mechanisms and be prepared to adapt them during implementation. The need to adapt to context means that piloting in new areas/programmes at a small scale and then scaling up may be an efficient approach.
- Give careful consideration to the processes and capacity for analysing feedback, if feedback is intended to inform higher-level decision-making.
- Consider what an exit strategy for the BFM might look as part of the design process, and whether certain options may be more or less sustainable over the longer-term.

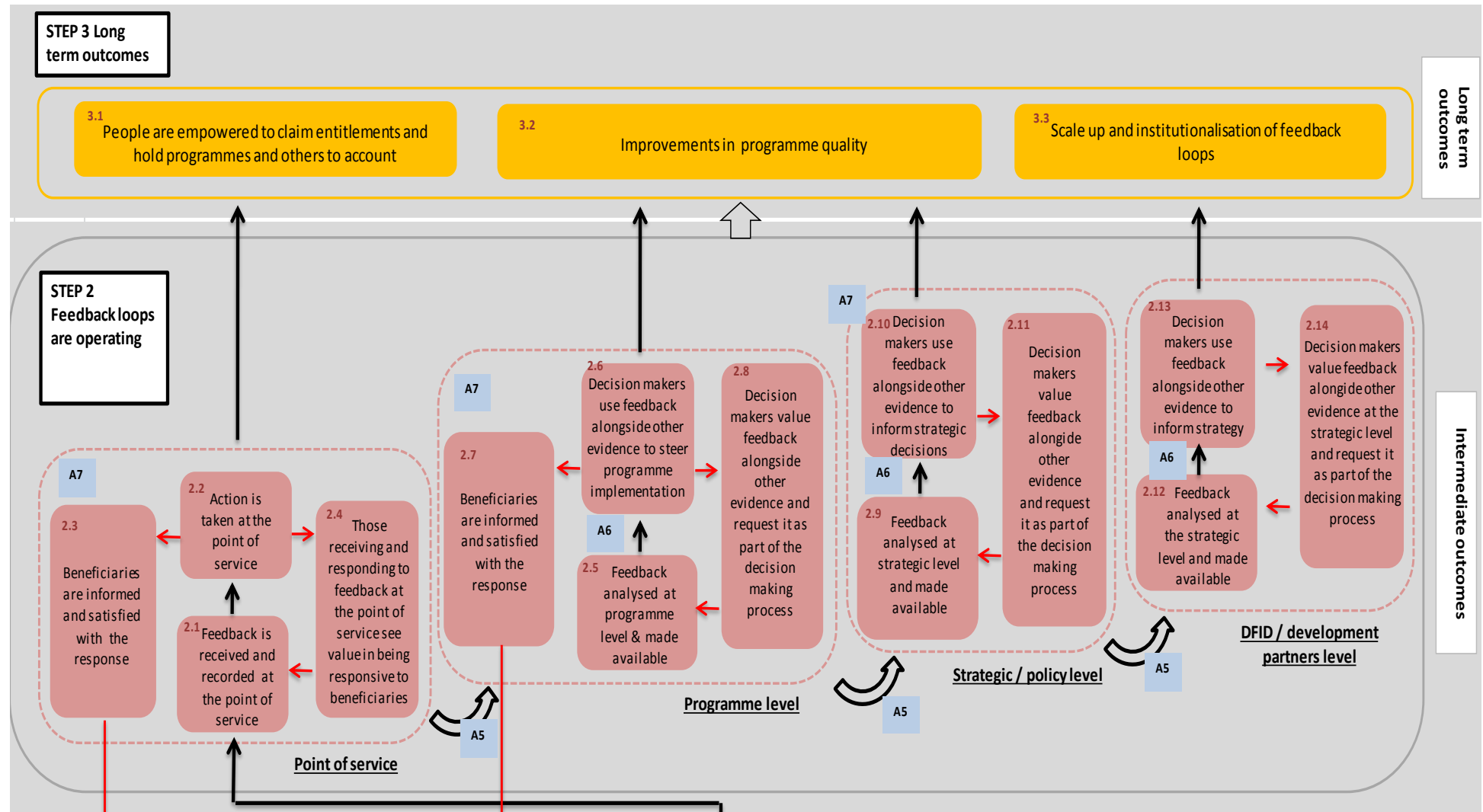
- In the absence of the above, to question the value of information that is likely to be yielded from the BFM.

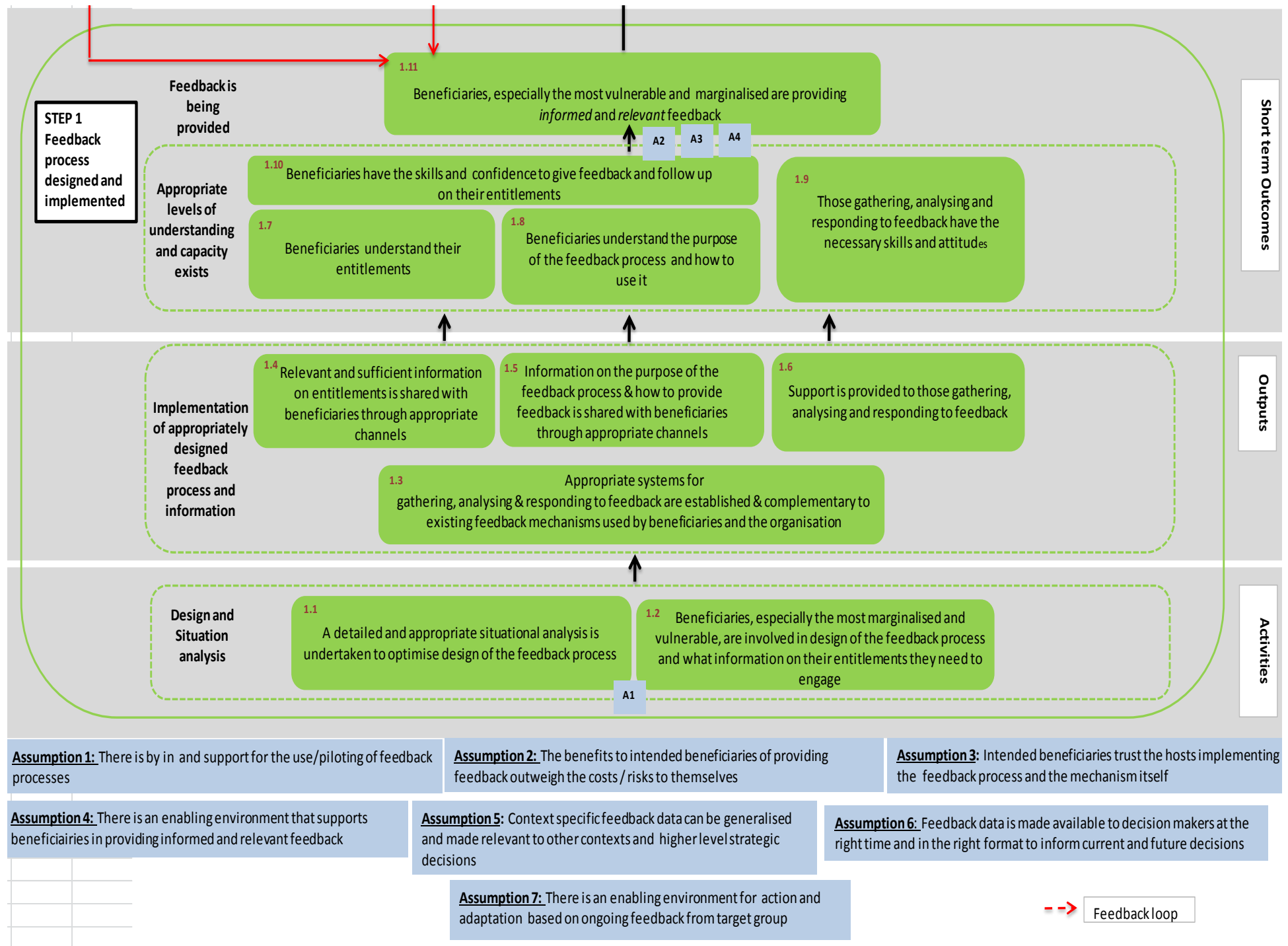
7.3 For donors and policy-level stakeholders

- Consider BFMs as a complement to monitoring and evaluation in designing programmes
- Implementing organisations should be resourced (both time and money), but also held accountable, for a thorough context analysis to inform the design of BFMs.
- Implementing organisations should be resourced (both time and money), but also held accountable, for adequate sensitisation of the community to a BFM, to ensure use and inclusion.
- Ensure that there is flexibility in both budgets and planned activities, so that partner organisations are able to respond to feedback and adapt their programmes accordingly. Ensure implementing organisations understand scope for project changes
- BFMs may face fewer challenges, and potentially have greater scope for impact, if integrated into project delivery and M&E from the outset.
- Ensure that stakeholders at different levels in the aid delivery chain have a clear and realistic understanding and buy-in about how feedback is intended to be used by different levels.
- If BFMs are intended to inform decisions at more strategic levels, consider what kinds of information are expected (for example aggregated feedback), how information is expected to flow, and how to articulate demand for feedback within a complex and multi-layered aid delivery chain (e.g. via a designated point-person). If feedback is intended to inform, for example, log-frame reporting,
- Support implementing organisations to develop sustainable exit strategies for BFMs at the start of the process to avoid disillusionment or dissatisfaction in communities about the practice of giving feedback once the programme ends.

Annex I: Common Theory of Change

Source: World Vision (2014, June) 'Design, Implementation and Monitoring of Beneficiary Feedback Mechanisms: GPAF Pilot Project PO 6076: Inception Report, Period: April 2013-May 2014.'





Annex 2: Theory of Change for the three approaches⁶¹

Approach 1: Mobile technology based 24hr access to a two-way feedback system through SMS and voice (via missed call)

Approach 1 provides an accessible feedback mechanism that supports existing beneficiary feedback mechanisms (BFM) using low-cost, accessible mobile technology. This approach tests the hypothesis that where the technology exists and is accessible, mobile can be an effective, efficient and equitable mechanism for obtaining feedback. The approach further tests whether mobile can build fast, two way communication to complement traditional engagement tools.

Approach 1 Theory of Change

| RIEC theory of Change Step | RIEC key part of Theory of Change | Detailed aspect of Approach 1 within each step | Approach 1 – Theory of Change |
|--|---|---|--|
| Step 1: Feedback Process is designed and implemented | Design and situational analysis | <ul style="list-style-type: none"> Design will take into consideration the following based on the results of the context analysis which will assess (not exclusively): Knowledge and culture of mobile phone use, literacy, mobile network coverage in target area, levels of mobile phone ownership among target population | Certain elements must be in place from the beginning for a mobile feedback system to be effective and the System must be communicated well to ensure use and adaptation where necessary |
| | Appropriate levels of understanding and capacity exist | | |
| | Implementation of appropriately designed feedback process and information | <ul style="list-style-type: none"> Feedback mechanisms will be rolled out according to context specific design and integrated into existing feedback and M&E systems where possible Number and system through which to give feedback will be publicized to target communities Anyone can provide feedback and at any time Feedback is quick and easy Mechanism is confidential | Feedback is obtained from anyone in the target area enabling unintended impact to be identified and an understanding of the impact on non-beneficiaries. As feedback is confidential this will increase the range of people who feel able to respond. Also, as feedback is in real-time, it will be high quality as it's based on the timeframe of the responder rather than the agency. |
| | Feedback is being provided | <ul style="list-style-type: none"> Feedback is unstructured and unsolicited A Service Level Agreement will be established between partner and beneficiaries to guide response times and what partners will feedback on. This will be part of wider feedback policy of organization and be communicated through the | Unstructured and unsolicited feedback provides feedback free from bias of guided questions |

⁶¹ World Vision (2014, June) 'Design, Implementation and Monitoring of Beneficiary Feedback Mechanisms: GPAF Pilot Project PO 6076: Inception Report, Period: April 2013-May 2014.'

| | | | |
|---|--|--|---|
| | | information provision channels e.g. noticeboards | |
| Step 2: Feedback loops are operating | Feedback is received and recorded | <ul style="list-style-type: none"> Feedback is documented in the feedback database through call/SMS logs using the Frontline SMS system Feedback is easy to analyse as recorded from SMS/Voice Feedback is free from bias as relates to a number not a person | Analysis of feedback using the qualitative data analysis framework will be relatively straightforward to record and analyse as input directly to database from SMS. Analysis will be free from bias or power dynamics as only a number will be used to identify the source of feedback. |
| | Action is taken and beneficiaries are informed and satisfied with the response | <ul style="list-style-type: none"> Two-way feedback mechanism can be established if requested by responder Summary of feedback and action will be posted on information boards | If a response is required, using SMS is the quickest and easiest tool and ensures individuals can hold the partner to account for responding. |
| Step 3: Long Term Outcomes | Feedback Improves Programme Quality | Project and partner teams will use feedback to make appropriate changes to projects to make them more responsive to the needs of beneficiaries. | Through real-time, unstructured and unsolicited feedback that is analysed and used by the project, programme quality will be improved. |

Approach 2: Participatory Research Model Using Pre-Determined Questions

The theory of change for Approach 2 is that through engaging participatory research at regular intervals, beneficiaries have an opportunity to give feedback on key project elements predetermined by the partner organisation, resulting in a sense of empowerment and greater voice in the project for beneficiaries.

Through regular, semi-structured questions the feedback loops can be operationalised and beneficiaries can see the adaptation of the project stemming from their feedback as actions and response can be shared at regular intervals in conjunction with soliciting further feedback, this constant iterative feedback loop will motivate beneficiaries and the partner to offer and respond to feedback with greater intensity over the life of the project as both parties observe the mutual benefit of the feedback.

Approach 2 Theory of Change

| RIEC theory of Change Step | RIEC key part of Theory of Change | Detailed aspect of Approach 2 within each step | Approach 2 – Theory of Change |
|--|---|---|--|
| Step 1: Feedback Process is designed and implemented | Design and Situational Analysis | <ul style="list-style-type: none"> Context analysis and community consultation determines appropriate methods of feedback and integrated with existing Monitoring and Feedback systems | Methods in which beneficiaries desire to feedback will be taken into consideration in the design of the mechanism(s) to ensure participation and appropriateness |
| | Implementation of appropriately designed feedback process and information Feedback is being provided | <ul style="list-style-type: none"> Feedback is structured and solicited. Structured and set questions ensure quality feedback through asking for feedback on relevant programme aspects Beneficiaries are participate through the giving of feedback and participate in community validation of results Targeted beneficiaries will provide feedback at regular intervals throughout life of project Through targeting beneficiaries an inclusive group will provide feedback including the vulnerable Through structured and solicited feedback, high quality and relevant feedback can be obtained that represents the diversity of the project participants. | The feedback will be structured and therefore relevant to the project as partner organisations themselves determine the scope of feedback based on particular information gaps or areas of programming they wish to improve. It will also be easier to process in this form. High participation including vulnerable beneficiaries due to targeting and soliciting, ensuring feedback is representative across project participants. Structured questions guide the feedback process and render it easy for people to engage |

| | | | |
|--|---|--|--|
| Step 2: Feedback loops are operating | <p>Feedback is received and recorded</p> <p>Beneficiaries are informed and satisfied with the response</p> <p>Action is taken as a result of feedback</p> | <ul style="list-style-type: none"> • Community validation exercises allow beneficiaries to comment on summary of feedback and proposed actions before it is addressed at project level • Feedback is easy to analyse as set questions ensures responses are streamlined • Due to regularity of feedback requests, this establishes a 2 way mechanism opportunity for the programme partner to explain the action taken and response to the previous feedback given thus encouraging further dialogue • Feedback will be easy to aggregate across sites | <p>Predetermined questions ensure feedback is relevant</p> <p>Beneficiaries are involved in holding partner organisations accountable for implementation and feedback loops are embedded</p> |
| Step 3: Long Term Outcomes | Feedback Improves Programme Quality | Feedback Mechanisms will complement and add value to existing M&E systems to improve appropriateness and effectiveness of the intervention | Changes made as a result of feedback will enhance project appropriateness for the target population and hence quality |

Approach 3: Beneficiary Led Feedback Approach (with Partner Support) based on Contextual Adaptation

The theory of change for Approach Three is that through high participation and ownership of the feedback loop design by beneficiaries, feedback will be enhanced in both quality and quantity and therefore be the most effective. The results of this approach will therefore test the hypothesis that the increased cost (financial and human) of Approach 3 leads to greater feedback and subsequently improved development results which go beyond the project to the partner organisations and other aspects of the community.

Beneficiaries will have been engaged in the process of deciding what they feed back on, how, when, where and to whom (through an exploration of options with the partner organisation) and will be involved in the analysis and action. The results of the detailed context analysis will also enable World Vision and the partner (who will be providing technical and facilitation support) to be able to undertake their role effectively in guiding the process to ensure an appropriate design and to overcome any existing barriers to implementation. This will be done with an appreciation of the skills and capacities of the target population.

Due to the high level of participation and shared decision making processes with beneficiaries there will be constant, iterative feedback loops that obtain feedback, analyse contextual changes and then respond and adapt to these changes. This will be based on feedback, monitoring and learning processes.

Beneficiary feedback loops by definition seek to empower beneficiaries as active participants in the development process and this approach places the greatest emphasis on beneficiaries themselves designing who, what, when, where and how feedback will be obtained and analysed.

Approach 3 Theory of Change

| RIEC theory of Change Step | RIEC key part of Theory of Change | Detailed aspect of Approach 3 within each step | Approach 3 – Theory of Change |
|---|---|---|--|
| Step 1: Feedback process is designed and implemented | Design and Situation Analysis | <ul style="list-style-type: none"> • In depth context analysis and rolling community consultations take place • The mechanism is designed with beneficiaries through a process of exploration and generation of options and joint decision making. • The process of identifying beneficiaries/groups of beneficiaries will be carried out during design as not all targeted beneficiaries will be able to engage. The pilot will work with existing organised groups where possible. | The feedback mechanism has high level of ownership of beneficiaries and due to high engagement will be contextually and culturally appropriate |
| Step 1 | Implementation of appropriately designed feedback process and information | <ul style="list-style-type: none"> • Beneficiaries determine how, when, what on and to whom they provide feedback (within an established framework) through identification of indicators that they measure themselves | As beneficiaries have a strong role in the design of the mechanism it will foster greater utilization and produce higher quality feedback. |

| | | | |
|--|---|--|--|
| | Feedback is being provided | | Process will be empowering and foster enhanced participation |
| | Appropriate levels of understanding and capacity exists | <ul style="list-style-type: none"> Capacity of targeted beneficiaries will be assessed during context analysis and through community consultations Capacity will be strengthened where possible through process-particularly for more vulnerable individuals | Feedback mechanisms will be designed with the beneficiaries and set to appropriate level |
| Step 2 Feedback loops are operating | <p>Feedback is received and recorded</p> <p>Action is taken and feedback is used in decision making</p> | <ul style="list-style-type: none"> Beneficiaries are part of the process of recoding progress against indicators set, relaying this back to Partner/others and following up on actions | Beneficiaries are not only giving feedback to partner but follow up on actions through high engagement and involvement in the entire feedback process and thus ensuring full accountability of the partner to beneficiaries. Participation of the beneficiaries and ownership in all stages of the feedback loop ensures high quality engagement |
| | Beneficiaries are informed and satisfied with the response | Project staff will update communities and targeted beneficiaries of changes made to project/organization as a result of feedback through community noticeboards and meetings, and engagement with individuals/groups who gave feedback. Beneficiaries will follow up on pending actions with Partner | Beneficiaries are not just informed of changes made as a result of feedback but are supported to be part of the change process and to hold the partner accountable where agreed actions have not been carried out |
| Step 3 Long Term outcomes | <p>People are empowered to claim entitlements and hold projects and others to account</p> <p>Improvements in Programme Quality</p> <p>Scale up and institutionalization of feedback loops (beyond project).</p> | <p>Of all the approaches this will have the strongest emphasis on empowering beneficiaries to hold projects/partners to account</p> <p>Improvements in program quality will be assessed through comparison groups</p> <p>Through greater dialogue between the communities and the implementing partner, feedback loops will be more entrenched between beneficiaries and the partner organisation, and go beyond the project</p> | A feedback mechanism that is designed and implemented by beneficiaries will ensure high quality and regular feedback. Beneficiaries will also be part of designing systems that ensure the partner is held to account to respond to the feedback, this empowers beneficiaries and ensures projects are adapted resulting in improved programme quality. Where effective, Feedback mechanisms which are largely designed by beneficiaries will go beyond one project to foster improved accountability between beneficiaries and other actors in the community. |

Annex 3: Design changes during inception⁶²

A number of changes were made during the inception phase. These are summarised below and in Table A3.1.

- **The number of BFM pilots was reduced** from nine projects in eight countries to seven projects in six countries, as a result of some projects withdrawing.
- **The pilot included a deeper context analysis:** context analyses were already envisaged for the Approach 3 model, but during the design phase it was agreed that a detailed in-country context analysis was required to inform all three approaches.
- **The inception period was extended:** from an original four month period ending in August 2013 (four months) to one year (ending May 2014) as a result of including the in-depth country context analyses to inform the three technical approaches.
- **Changes to Approach 1:** due to the low level of literacy in the targeted project areas, the approach was broadened out from just SMS to include voice calls (via a missed call system).
- **Adjustments to expectations on the reach and purpose of feedback loops:** The World Vision UK-led consortium was to feed back to DFID and the fund manager (Triple Line) on the BFM pilot and raise any issues of great concern, but were not acting as evaluators of the performance of the partner organisation.

Table A3.1: Overview of approach design evolution⁶³

| | Original Bid | Design at Inception Report Stage (August 2013) | Final Design (as per June 2014 Inception Report) |
|---------|--|--|---|
| General | Community Feedback Officer (CFO) ⁶⁴ to be recruited per project, and matrix managed by WVUK and the partner organisation. Budgeted as part-time (50%) to be shared with an existing partner or local World Vision position. | Full-time CFO to be recruited per project. Reasons included reducing pressure of the pilot on partner organisations, and ensuring feedback would be adequately responded to through a dedicated staff member who is known in targeted communities. | CFO 100% full-time position embedded in partner organisation. |

⁶² World Vision (2014, June) 'Design, Implementation and Monitoring of Beneficiary Feedback Mechanisms: GPAF Pilot Project PO 6076: Inception Report, Period: April 2013-May 2014.'

⁶³ Adapted based on Inception Report (2014, June)

⁶⁴ The roles of the CFO included working with beneficiaries to advise them on their right to receive relevant, timely and accurate information about the GPAF project; their right to give feedback; setting up feedback mechanisms; collecting and analysing data; and referring feedback to management or project staff as appropriate.

| | | | |
|------------|--|---|--|
| | Context Analysis after design with most emphasis on Approach 3 | Light touch context analysis with more emphasis on Approach 3 | Detailed in-country context analysis across all 3 approaches |
| | Different degrees of information provision across approaches | Feedback boxes and noticeboards to be standard across all three approaches | Feedback boxes and noticeboards to be standard across all three approaches |
| | | Development of standard stages in feedback cycle with some differences per approach | Further development of stages model |
| | Evidence largely from WV and other NGO lessons and experience in implementation | Best practice and existing literature informing design | Greater use of evidence and best practice to inform design |
| Approach 1 | Feedback to be sent directly to a platform to be built by SIMLab which would enable partner organisations, DFID and project partners to see feedback | Possible use of mobiles in information provision using autoreplies and push messaging | Both options withdrawn |
| | Phones to be purchased to increase uptake for those without access to a mobile (community phones) | Use of SMS Sync (non-Frontline SMS technology) to log missed calls to enable voice option | Frontline Sync and Frontline Cloud developed |
| Approach 2 | Focus on implementing tried and tested feedback mechanisms which have been effective in other contexts eg feedback boxes, noticeboards, community, interviews, surveys, log books. Mobile tech also considered | 4 different methods: FGDs with community scorecards, Beneficiary Reference Groups, Feedback Boxes and Direct feedback to CFO Set guidelines for replication as not new mechanisms so quick to roll out | |

| | | | |
|------------|--|---|---|
| | Women given option to provide feedback at health centres or village level | | Feedback mechanisms likely to be focussed around health centres and schools where beneficiaries receive services (e.g. exit surveys) |
| Approach 3 | Variety of different options for community participation, information provision and consultation to be considered based on context and beneficiary preferences, including for children's participation | Beneficiaries to determine their own indicators for measuring success and effectiveness of project. Beneficiaries to also set own rating system and format in which they will feed back to the partner organisation | Beneficiaries to decide on indicators against which they will feed back to the partner organisation on project/services. Recognition that partner support and facilitation essential |
| | Use of capacity assessment and self-assessment checklist based on WV Accountability Framework | Appreciative Inquiry approach to facilitate and explore ideas with community groups | Detailed context analysis at beginning to be built on iteratively during start up |

Annex 4: Indicators⁶⁵

| Indicator |
|---|
| (1) Establishment of feedback system and alignment with other systems and processes |
| (2) Beneficiaries' understanding of project entitlements |
| (3) Beneficiaries' understanding of feedback purpose and process |
| (4) Staff capacity to: a) gather; b) analyse; and c) respond to feedback |
| (5) Beneficiaries' confidence to give feedback and follow up on their programme entitlements |
| (6) Quantity of feedback (units of feedback received) |
| (7) Status of what happened with the information: (e.g. # and descriptions of those acted on; # acknowledged; # responded to, # filed, # ignored, etc.) |
| (8) Quality of feedback |
| (9) Number of people engaging with the feedback process |
| (10) Beneficiary satisfaction with feedback process |
| (11) Beneficiary satisfaction with feedback response |
| (12) Functioning feedback loops at point of service |
| (13) Functioning feedback loops at project level |
| (14) Project implementers value feedback |
| (15) Project managers value feedback |
| (16) Senior decision-makers using beneficiary feedback |
| (17) Reasons for use or non-use of BFM |
| (18) Range of suggested improvements to BFM |
| (19) Number of beneficiaries reached by BFM |
| (20) Quality of responses to feedback received by communities |
| (21) Money (£) spent promoting the BFM |
| (22) Money (£) spent implementing the system |
| (23) # staff days spent on the BFM (training, implementing, monitoring, learning) |
| (24) Costs (days and £) to beneficiaries |

⁶⁵ World Vision with INTRAC and Social Impact Lab (2014, June) 'DFID Beneficiary Feedback Mechanisms (BFM) GPAF Pilot Monitoring and Review Plan Version 6.'

Annex 5: Methodology – supporting tables

Beneficiary level

Table A5.1: Beneficiary level tools and sample sizes

| Tool | | ADRA | AMREF | CINI | CUAMM | HPA | MAMTA | Rahnuma | TOTAL |
|--------|------|------|---------|---------|---------|---------|---------|---------|---------|
| FGDs | Base | 8 | 10 | 9 | 9 | 11 | 9 | 16 | 56 |
| | Mid | - | 1 | 2 | 1 | - | 2 | - | 4 |
| | End | 12 | 10 | 7 | 15 | 6 | 9 | 24 | 83 |
| | | | | | | | | | |
| KIs | Base | - | - | 8 | - | - | - | 4 | 8 |
| | Mid | 2 | - | 6 | - | - | - | - | 8 |
| | End | - | - | 7 | - | 9 | - | - | 16 |
| | | | | | | | | | |
| Survey | End | - | 1 (225) | 1 (210) | 1 (150) | 1 (150) | 1 (200) | 1 (140) | 5 (925) |

Note: numbers in brackets indicate total sample sizes

Intermediary level

Table A5.2: Intermediary level tools and sample sizes

| | | ADRA | AMREF | CINI | CUAMM | HPA | MAMTA | Rahnuma | TOTAL |
|------------|------|------|-------|------|-------|-----|-------|---------|-------|
| KIs | Base | 1 | 10 | - | 3 | 4 | 8 | 2 | 26 |
| | Mid | - | 2 | - | - | - | 6 | 1 | 2 |
| | End | 4 | 9 | - | 3 | 3 | 9 | 16 | 44 |
| | | | | | | | | | |
| Group | Base | - | - | - | - | - | - | - | - |
| Discussion | Mid | - | - | 4 | - | - | - | - | 4 |
| | End | - | - | 2 | - | - | - | - | 2 |

Organisational level

Table A6.3: Organisational level tools and sample sizes

| | | ADRA | AMREF | CINI | CUAMM | HPA | MAMTA | Rahnuma | TOTAL |
|------|------|------|-------|------|-------|-----|-------|---------|-------|
| OCAT | Base | 1 | 1 | 1 | 1 | 1 | 1 | 2 | 6 |
| | Mid | - | - | - | - | - | - | - | - |
| | End | 1 | 1 | 1 | 1 | 1 | 1 | 2 | 8 |
| | | | | | | | | | |
| Klls | Base | 2 | 2 | 8 | 4 | 4 | 8 | 5 | 28 |
| | Mid | 1 | 2 | 6 | 3 | 3 | 6 | 1 | 15 |
| | End | 4 | 2 | 6 | 3 | 4 | 7 | 8 | 34 |

Annex 6: Meta-analysis of Organisational Capacity Assessment Tool (OCAT) Results

| Approach 1 | | | | | | Approach 2 | | | | Approach 3 | | | | Average | | |
|--|-------|-----|------|-----|------|------------|-------|-----|---------|------------|------|-----|-------|---------|------|-----|
| | CUAMM | | HPA | | ADRA | | AMREF | | Rahnuma | | CINI | | MAMTA | | | |
| | Base | End | Base | End | Base | End | Base | End | Base | End | Base | End | Base | End | Base | End |
| Capacity 1: Capability to gather beneficiary data | 2.0 | 1.6 | 2.0 | 1.8 | 2.5 | 1.3 | 2.5 | 1.8 | 1.5 | 1.0 | 2.8 | 1.8 | 1.8 | 1.0 | 2.1 | 1.4 |
| Capacity 2: Store and retrieve beneficiary feedback | 2.0 | 1.5 | 2.5 | 1.3 | 3.0 | 2.0 | 2.7 | 1.7 | 2.0 | 1.0 | 3.0 | 1.3 | 1.3 | 1.0 | 2.3 | 1.4 |
| Capacity 3: Analyse beneficiary feedback | 2.5 | 2.0 | 2.5 | 2.0 | 3.0 | 2.5 | 2.7 | 2.3 | 1.0 | 1.0 | 2.8 | 1.3 | 3.0 | 1.0 | 2.5 | 1.7 |
| Capacity 4: Respond to beneficiary feedback | 1.5 | 1.5 | 1.5 | 1.3 | 2.7 | 1.0 | 2.4 | 2.0 | 1.0 | 1.0 | 2.5 | 1.0 | 2.8 | 1.0 | 2.0 | 1.3 |
| Capacity 5: Effectively use BF at project/programme level | 3.5 | - | 2.8 | 2.0 | 2.3 | 1.5 | 2.0 | 1.8 | 1.5 | 1.0 | 3.0 | 1.0 | 1.8 | 1.0 | 2.4 | 1.4 |
| Capacity 6: Effectively use BF at higher levels | 2.5 | - | 3.5 | 1.3 | 2.0 | 2.5 | 2.0 | 2.0 | 1.0 | 1.0 | 2.5 | 2.3 | 2.0 | 1.0 | 2.4 | 1.7 |
| Capacity 7: Develop and maintain policy standards on transparency and responsiveness | 2.0 | - | 2.8 | 1.3 | 2.7 | 2.0 | 2.0 | 1.5 | 1.0 | 1.0 | 2.0 | 1.0 | 2.0 | 1.0 | 2.1 | 1.3 |
| Average | 2.3 | 1.7 | 2.5 | 1.5 | 2.6 | 1.8 | 2.3 | 1.9 | 1.3 | 1.0 | 2.6 | 1.4 | 2.1 | 1.0 | | |

Overall, capacities have increased from baseline to end point. Observed weaknesses are in Capacity 3 (analysing beneficiary feedback) and Capacity 6 (effectively using beneficiary feedback at higher levels). Comparing OCAT results more generally across organisations is problematic, since the scales are subject to interpretation, and each organisation identified its own “capacities” within each of the seven categories. Rahnuma, which was building on an existing BFM, rated its capacities the highest at baseline, while Rahnuma and MAMTA both rated themselves the highest at end point. Otherwise, no pattern is clear.

About the pilot

Between 2014 and 2016, the UK Department for international Development supported seven non-governmental organisations to pilot beneficiary feedback Mechanisms as part of their maternal and child health projects. The projects were funded under the department's Global Poverty Action Fund (now UK Aid Direct). World Vision UK led a consortium to support their journey and learn:

- What makes a beneficiary feedback system effective?
- Does it improve accountability to communities and the delivery of projects?
- Is it worth the investment?

Monitoring and review support was provided by INTRAC (UK) and consultants in each of the six countries. Development and implementation of mobile-based beneficiary feedback mechanisms was supported by SIMLab, and learning from the pilots was supported by CDA.