BENEFICIARY FEEDBACK MECHANISMS CASE STUDY
Somaliland

HPA Somaliland Community Feedback Officer

Health Poverty Action (HPA) worked to strengthen service provision at 11 Maternal Child Health facilities (MCH), in Maroodi Jex Region, Somaliland. The GPAF project targeted enhancing access and the quality of services for internally displaced women.

During the second year of implementation, the Beneficiary Feedback Mechanism Pilot was introduced in 3 of the target health facilities. The HPA pilot set out to test a low-resource new technology model of beneficiary feedback, where SMS provides a confidential and real time information channel encouraging unsolicited feedback from beneficiaries and the wider community.

Between 2014 and 2016, the UK Department for International Development (DFID) supported 7 NGOs to pilot Beneficiary Feedback Mechanisms (BFMs) as part of their maternal and child health projects[1]. 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?

To help answer these questions, three approaches to collecting feedback were tested:

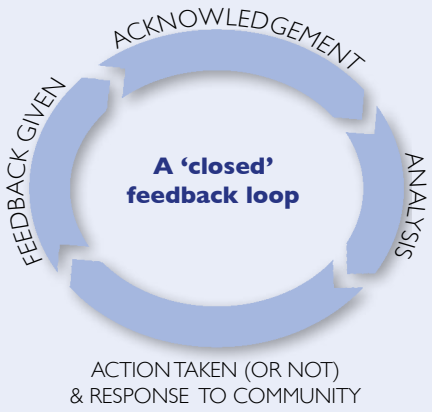
1. Mobile phone technology for feedback through SMS and voice calls
2. Structured questions to seek feedback from the community about specific aspects of the project at regular intervals
3. Community designed feedback systems where communities decided what issues they would like to provide feedback about and how they would like to provide feedback

To enable comparison across contexts, each pilot focused on collecting and responding to feedback through one of these approaches. All pilots included suggestion boxes for collecting confidential feedback, a dedicated staff member (Community Feedback Officer) and the introduction of notice boards for information provision.

Designing a Beneficiary Feedback Mechanism

The pilots defined effective feedback mechanisms as follows:

"A feedback mechanism is seen as effective if, at minimum, it supports the collection, acknowledgement, analysis and response to the feedback received, thus forming a closed feedback loop. Where the feedback loop is left open, the mechanism is not fully effective[2]".



The BFM pilots all followed the same four phase process, led by a dedicated Community Feedback Officer, as outlined below:

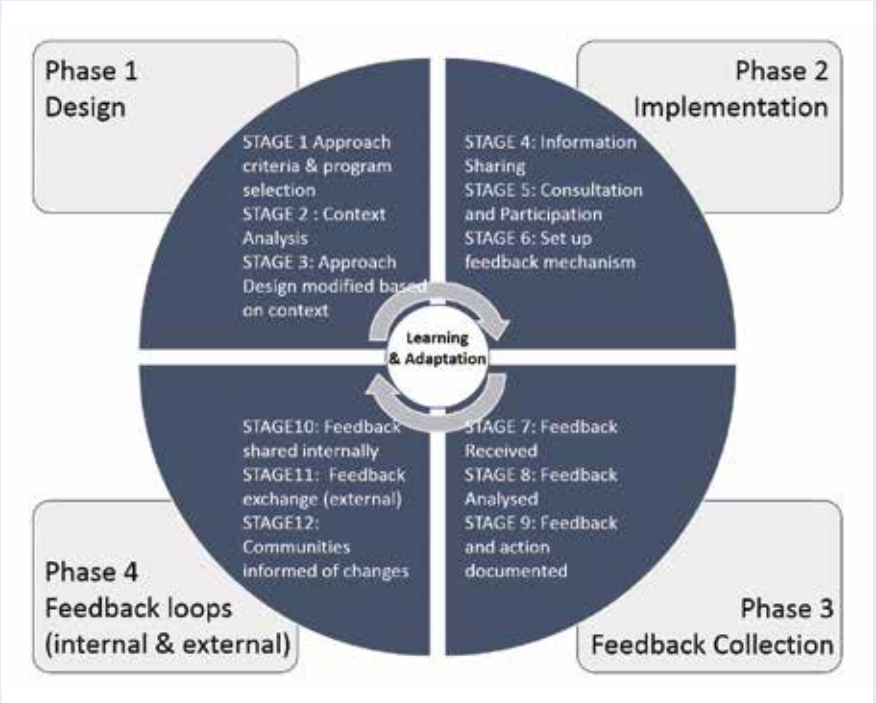
Phase 1: Design – based on a thorough context analysis of the organisation and community. This included talking to communities about how they would prefer to provide feedback and an analysis of any existing mechanisms

Phase 2: Implementation – setting the system up and raising awareness among staff, communities and local government stakeholders about it

Phase 3: Feedback collection – receiving, documenting, referring and tracking action in response to feedback

Phase 4: Feedback loops fully functioning – with trends shared internally and externally (for example to fund managers) and changes made in response shared with feedback provider(s)

While implementing these four phases, some commons lessons emerged, as well as experiences unique to each.



[1] The projects were funded through DFID's Global Poverty Action Fund
[2] CDA Collaborative Learning Projects, cdacollaborative.org

HEALTH POVERTY ACTION'S EXPERIENCE IN MAROODI JEX REGION

Raising community awareness

Information sharing is a critical component of an effective beneficiary feedback mechanism. Beneficiaries and the wider community need to have access to appropriate and targeted information in formats that are accessible to them. There is a direct correlation between the provision of information and the volume and quality of feedback received. HPA used a number of channels to provide information on the GPAF project and to raise awareness of the purpose and how to use the Beneficiary Feedback Mechanism. Initially information was shared through posters, billboards and notice boards, as well as through community meetings. However, the high levels of illiteracy among targeted beneficiaries meant that the written formats had limited effectiveness. HPA worked to mitigate this challenge by introducing other means of information provision, including using their regular radio programmes to sensitize people on the available feedback channels, as well as creating a video demonstrating how to provide feedback. This video was played at the health centre waiting rooms to capture attention of targeted beneficiaries.

Collecting and responding to feedback

In addition to SMS, the pilot established multiple channels for providing feedback intended to minimise barriers and increase accessibility for beneficiaries and the wider community. These included: a missed call option as part of the SMS system, suggestion boxes at each MCH, and monthly community meetings.

The SMS and voice call system was managed through Frontline SMS/Cloud. When an SMS is received, it is logged by the Frontline Cloud system and sends an automatic acknowledgement to the sender. The feedback received is stored on the system, enabling analysis and tracking of responses (closing the loop). Frontline Cloud can also record 'missed calls', enabling HPA to call individuals back to ask for their feedback. This option was particularly important due to the high levels of illiteracy and low income of the target beneficiaries.

Suggestion boxes located at each maternal and child health clinic were opened approximately every two weeks. This allowed for confidential feedback to be provided in writing. In practice, confidentiality was compromised as beneficiaries asked health staff to write the feedback on their behalf. To help ensure people were free to share their real opinions, HPA provided pictorial tick box forms designed to help those with low literacy levels use the suggestion boxes to share feedback. The feedback collected from suggestion boxes was entered manually into a database (separate from the Frontline Cloud system).

Billboard explaining how to give feedback

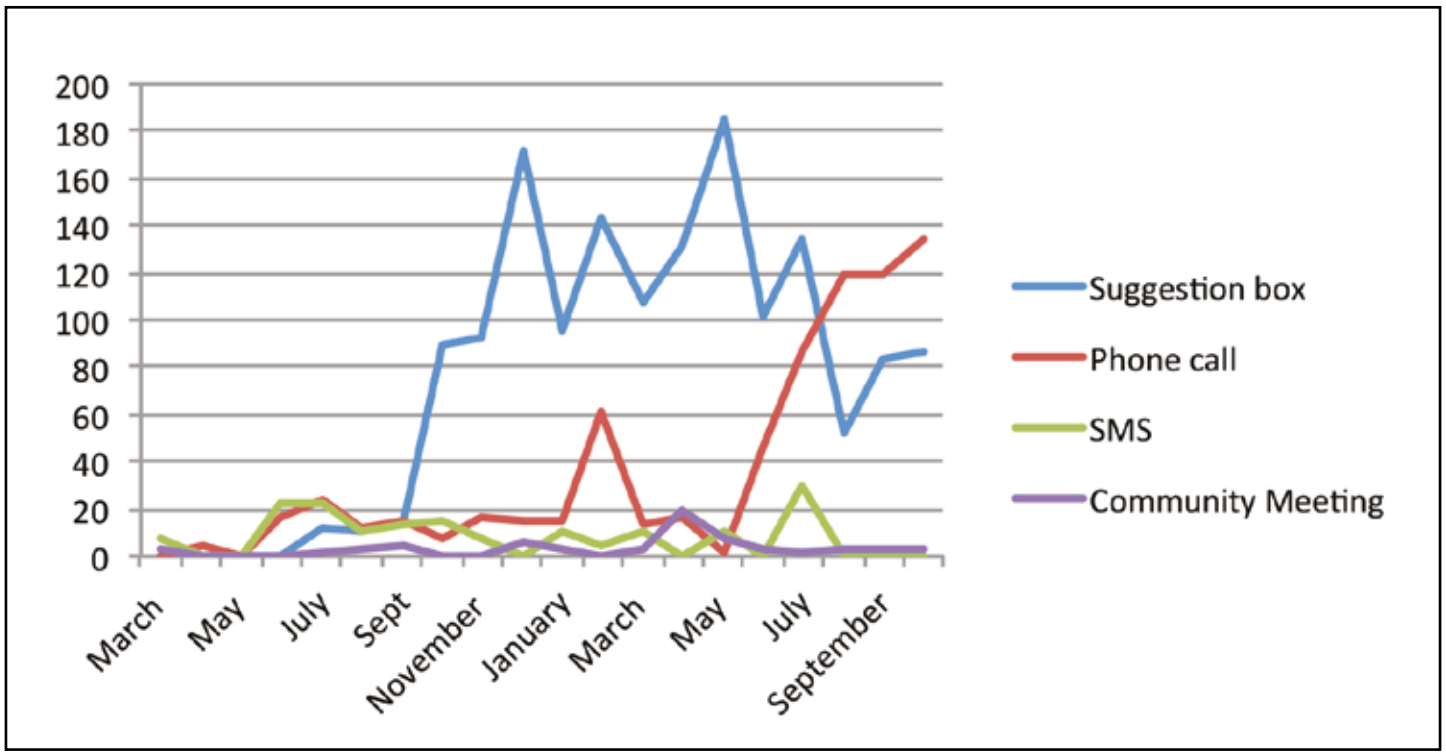
Monthly community meetings at the MCH were led by HPA's Community Feedback Officer. The meetings provided a forum to give feedback face to face, as well as to discuss the feedback received through other channels, and the responses given. Any feedback that could not be responded to in the meeting was documented, and responses provided through notice boards or at the next meeting.

Alongside these channels, feedback was also provided informally through staff at the MCH and directly to the Community Feedback Officer. The endline survey found that people who said they gave feedback, tended to do so in person to a member of the MCH rather than using one of the formal mechanisms. This finding is consistent with the cultural norms for the area.

All of the feedback received is processed by the Community Feedback Officer, either using Frontline Cloud or manually entering it into a database. The collated feedback is then shared at weekly project meetings of HPA staff. The department staff then makes an 'action plan' and responses to the feedback are passed back to the community by the Community Feedback Officer. Where possible, this is done directly (eg. through SMS or voice call), and otherwise responses to feedback are given through the notice boards and at community meetings.

Feedback loops are therefore effectively closed at programme level, with the CFO being critical to this functioning well. Moreover, this has meant that in some cases, the loop can be closed almost instantly when the CFO already knows the response, such as where it relates to standard agency policy, or to a request that has been received already.

Once the BFM was established, HPA received an average of 150 pieces of feedback per month, which included suggestions, complaints and (in the majority) thanks or praise for MCH staff. The level of usage of the BFM increased over the pilot's implementation as people grew in confidence.



Changes as a result of beneficiary feedback

The beneficiary feedback received during the pilot was focused at project level. Some common themes were: requests for medical equipment, requests for increased food rations, requests for community awareness raising on specific issues, complaints of staff absenteeism, and (in the majority), appreciation for services at the MCH. It is important to note that the quality of feedback changed over time, as people became more familiar with the concept and use of the BFM.

Information generated through the feedback mechanisms led to many positive changes at the MCH. Examples include: increased budget for utility bills to allow the MCH to run more effectively, additional beds for those giving birth to promote institutional safe delivery, and provision of an ultrasound machine to allow staff to detect high risk pregnancies early and refer women for specialist help. These changes all contribute to strengthening the maternal, neonatal and child services provided through the GPAF project.

Generally, people were happy with the responses they received to feedback, even in cases where the response was that HPA could not make the change they had requested (e.g. increase in food rations from the World Food Programme). Seeing changes made as a result of feedback encouraged people to continue to provide feedback, as well as receiving responses to the feedback raised.

The integration of the BFM component into the GPAF project was received positively by beneficiaries. Importantly, it gave them a sense of voice and the perception that the MCH staff and HPA were listening to what they have to say, evidenced by changes being made as a result of feedback.

> *"people feel that someone is listening to their opinion and their opinions or advice can be acted on"*
> KII participant.

At baseline, there was little understanding of feedback; this had significantly changed by the endline with respondents being confident to share suggestions or concerns. Furthermore, the access to feedback channels supported a greater sense of ownership of the MCH and the GPAF project – people felt that their feedback was improving services for the wider community, not just themselves.

Beneficiary feedback provided significant added value for HPA in identifying project level changes that could be implemented immediately to improve project outputs. Standard monitoring and evaluation processes being at fixed times in the project cycle, do not lend themselves to creating opportunities for course correction. The establishment of the feedback system also led to increased cooperation between departments and improved internal communication. Senior staff understood and valued the role feedback can play in improving services.

The cost of implementation was low. However, the lack of a more sophisticated system for collating and analysing data meant the Community Feedback Officer had to invest a lot of time in manually updating the feedback register. The project could have been more effective if a feedback database had been in place, able to bring together feedback by phone and other methods, and with more resources invested in staff to manage it.

Daughter helping mother write feedback

LEARNING FROM HPA'S EXPERIENCE

Despite the short duration of the pilot, significant learning was generated on the process of integrating beneficiary feedback systems as well as the benefits of receiving and responding to feedback in strengthening programme quality. The main lessons from HPA's experience are highlighted below.

Continuous adaptation to context enhances effectiveness and value for money

Throughout implementation, HPA was flexible and demonstrated a willingness to adapt the design of the feedback system to better respond to the context. There are several examples of changes made in order to improve accessibility and use of the beneficiary feedback mechanism. The introduction of additional methods of information provision was fundamental to increasing understanding and uptake of the options for feedback. While the endline survey noted that these methods only reached a small percentage of beneficiaries (e.g. video within health facilities could only be seen by those already accessing health services), the adaptation of information provision to non-written forms helped mitigate barriers to participation for potential users in a largely illiterate population.

Similarly, HPA identified the need to adapt the feedback channels available. Opportunity to provide feedback through suggestion boxes was expanded to non-literate people or those with low literacy through the creation of a pictorial check box form. That this was experienced as effective is demonstrated by consistently high volume of feedback received through this channel (see table on p.4).

> *"Initially for the Beneficiary Feedback Mechanism, the route of communicating was SMS. We didn't receive the expected responses from the community and that's because [...]the majority ...are illiterate. [...] Somali people are an oral society, even their educated people, when they want to talk to you they will never send you SMS. They like to call you and then talk and talk and talk".* HPA staff member.

The option of requesting a call back from HPA through leaving a 'missed call' was important in encouraging users to provide feedback. This was further improved by the provision of a toll free number, allowing beneficiaries to call and give feedback free of charge.

Despite the contextual challenges posed by low literacy levels and unfamiliarity with the concept and practice of feedback, it is of particular interest to note that from beneficiaries' perspectives the main barrier to provision of feedback was cost. This too was mitigated with the provision of the toll free number (though late in the pilot), and following this voice calls took over from the suggestion box as the most popular method for providing feedback.

Use of technology

The Somaliland pilot was designed to test the use of SMS as a feedback channel. A detailed context analysis concluded that mobile technology would work in Maroodi Jex, as there were high levels of interest in using SMS to provide feedback, as well as high levels of access to (although not ownership of) mobile phones among target beneficiaries. However, in practice the strength of cultural preferences for sharing information and feedback in person or at least on the phone meant that the SMS channel was the least used. High levels of illiteracy created a further barrier in the use of SMS in limiting confidentiality; people would need to entrust someone else to provide feedback on their behalf. HPA's reaction to this situation was critical in ensuring increased use of the beneficiary feedback system: rather than try and encourage use of SMS, and try to fit the channel to the context, they pro-actively sought to use technology in a way that better fitted with the target beneficiaries. This change (voice calls and the toll free number) led to increased use of technology to provide feedback. Further, using enabling voice calls as a feedback channel enhanced the quality of feedback received. Feedback through pictorial tick box forms in suggestion boxes was largely not actionable due to the lack of detailed information; increase in (two way) feedback through voice calls has led to increased actionable feedback.

Community sensitisation and stakeholder buy in are essential

The greatest barrier to provision of feedback in this pilot has been identified as a lack of knowledge and awareness of the BFM, particularly in the wider community. While effort was made in community sensitisation, the endline review concludes that more was needed. Information provision in the form of noticeboards, bill boards and other written material had limited effectiveness in Maroodi Jex, where illiteracy is high and people value face to face communication. Indeed, although the project used community meetings, health staff and radio to raise awareness of the different channels available for providing feedback, the survey results showed most people heard about it through another person.

Health staff and key stakeholders were initially unsupportive of the beneficiary feedback mechanisms due to misconceptions of their purpose. Additional training provided by HPA led to increased understanding and buy-in, with some staff even directing beneficiaries to the formal mechanisms available when given feedback in person. Since a significant proportion of the feedback received provides affirmation and positive acknowledgement of the work of health staff (as opposed to complaints) has also increased buy in.

NEXT STEPS FOR HPA

Health Poverty Action is keen to take forward the learning from this pilot, and has already incorporated beneficiary feedback mechanisms into the design of several new projects. The experience of the World Vision consortium pilot has reaffirmed the importance of including beneficiaries throughout project planning and implementation.

"Through collecting and reviewing feedback and suggestions HPA has been able to improve the implementation of projects and provide better programming for future projects, with more participation and representation of beneficiaries. We are proud that we are now more accountable to our beneficiaries".

Community Feedback Officer meeting with a beneficiary

Supported by

This material has been funded by UK aid from the UK Government; however the views expressed do not necessarily reflect the UK Government's official policies.

The Beneficiary Feedback Mechanisms Pilot closed in April 2016. This Case Study is one of a suite of eight compiled by World Vision UK and its partners. In addition, learning from the pilot has been captured through learning documents, a short video documentary and practical guidance. These resources will be made available for other organisations to use. For more information or feedback, please contact the Evidence & Accountability Team at World Vision UK.
World Vision is also committed to enhancing its own accountability, including actively integrating beneficiary feedback into its own development and humanitarian programmes across the world.

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World Vision UK, together with the International NGO Training and Research Centre (INTRAC), CDA Collaborative Learning Projects, and The Social Impact Lab Foundation (SIMLab), were contracted by the UK Department for International Development to manage a pilot designing, monitoring and implementing different approaches to beneficiary feedback mechanisms (2013-2016).