amref health africa

INTRAC

World Vision
Every child free from fear

BENEFICIARY FEEDBACK MECHANISMS CASE STUDY
Ethiopia

A village meeting led by a voluteer

AMREF Health Africa implemented a GPAF project in the South Omo and Segen Area People zones of southern Ethiopia. The project aimed to improve maternal and child health through strengthening the district health system, and specifically by training community and mid-level health workers and raising community awareness. Within the project's target areas, Konso District was selected to pilot beneficiary feedback mechanisms. The beneficiary feedback mechanisms pilot was designed to foster a greater sense of voice and empowerment among project beneficiaries.

AMREF Health Africa used structured questions to seek feedback from the community at regular intervals (Approach 2), allowing beneficiaries to give detailed feedback in person (through public [health] forums, suggestion boxes, focus group discussions among women; and key informant interviews with stakeholders), allowing the partner to track changes in responses over time. This approach is based on the theory that seeking feedback on pre-determined aspects of the project provides essential information on how beneficiaries perceive the relevance, appropriateness and quality of activities being implemented. Acting on feedback received (closing the loop) motivates beneficiaries to continue providing feedback and results in improved quality of programming over time.

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:

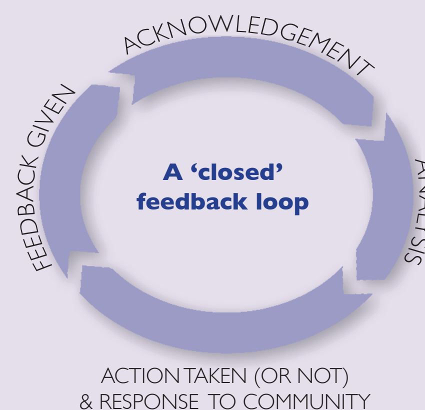
1. Mobile phone technology for feedback through SMS and voice calls
2. Structured questions to seek feedback from the community about specific aspects of the project at regular intervals
3. Community designed feedback systems where communities decided what issues they would like to provide feedback about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

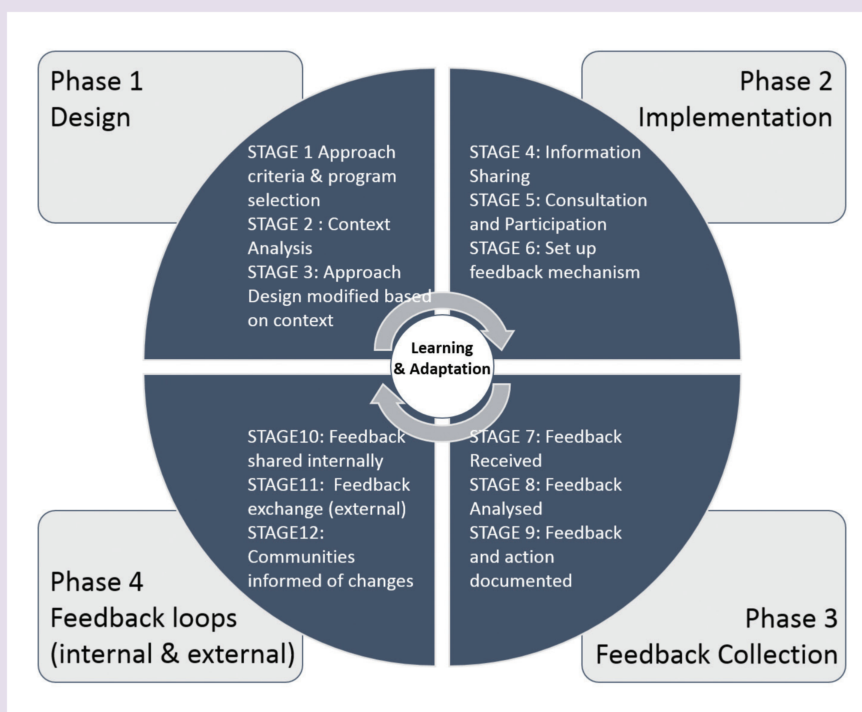
Phase 1: Design – based on a thorough context analysis of the organisation and community. This included talking to communities about how they would prefer to provide feedback and an analysis of any existing mechanisms

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

AMREF HEALTH AFRICA'S EXPERIENCE IN KONSO DISTRICT

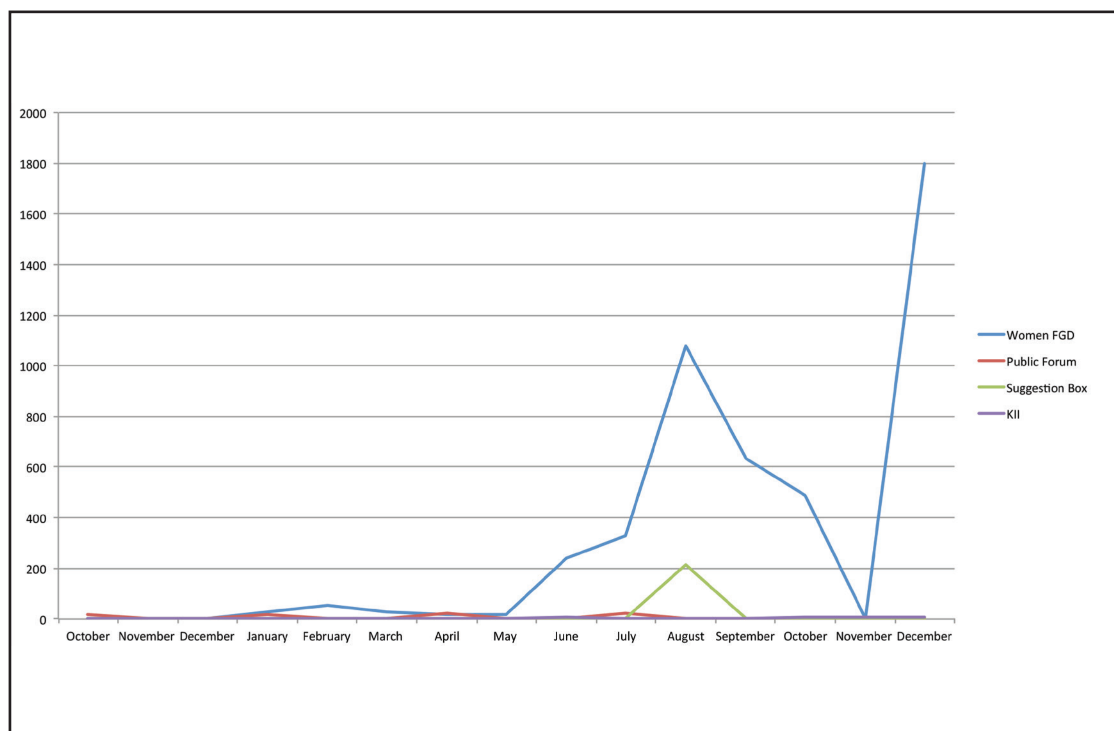
Raising community awareness

Managing information provision was challenging in Konso District where the majority of the target population are illiterate. Standard options for sharing information, such as notice boards, posters and fliers, would not work in this context. AMREF Health Africa was able to share information using existing networks. One example is the Health Development Army (HDA), which is a network of female community selected health activists. The HDA has at least 30 members in each Kebele[3], and each HDA member has five subordinate members, allowing for messages to be shared with a large number of people.

The district health authorities were the implementing partner for the GPAF project and health workers and health extension workers also supported the spread of information.

Collecting and responding to feedback

AMREF Health Africa used four channels to seek feedback from the community: Focus Group Discussions with women (targeted beneficiaries), public forum, suggestion boxes (both available to direct and indirect beneficiaries) and Key Informant Interviews (with health personnel). The pre-determined questions were focused on the appropriateness and effectiveness of GPAF supported activities at the health centres, as well as beneficiary perceptions of AMREF Health Africa. Some questions were directed to local government to assess their willingness to receive and respond to feedback on government services. The feedback collected from these channels was entered into a database by the Community Feedback Officer. The highest volume of feedback was generated through the women only focus group discussions, and the endline survey showed that beneficiaries were unaware of the Key Informant Interviews as these targeted health staff only.



NB1.High spikes in volume of feedback due to volunteer facilitators being introduced thus increasing number of focus groups.

NB2. Election period from January – June 2015 limited project activities

The focus group discussions were held monthly, facilitated by volunteers and the participants were selected representatives, including HDA and non-HDA members. While these discussions generated significant amounts of feedback, the majority were not acted on because they were out of scope of the GPAF project, for example requests for mosquito nets. The focus groups were challenging in that they were generally too large (20-40 participants), and the topography of the region made it a long process to travel and host the FGDs. However, as this was a space created to

[3] A Kebele is the smallest or basic unit of administration in the Ethiopian political system.

hear women's voices, it is encouraging to see the high levels of participation in the FGDs. The endline noted a majority of beneficiaries identified the focus groups as a preferred channel for providing feedback. This was because in contrast to the public forum, the FGDs presented a two-way feedback channel focused only on the GPAF project, they were accessible for women (held in the village at a place and time of their convenience). This option encouraged women to give feedback as the group size was relatively small and there were no health personnel present.

The public forum is a government run community meeting that is convened approximately once a quarter to receive feedback on the health centre as a whole. AMREF Health Africa identified this as an existing method to be used to gather feedback. However, the GPAF health project was one of many items on a busy agenda and so was not prioritised. Further, the GPAF partner had no control over when they were convened, which was not always regularly. The large number of attendees limited participation, as well as the location of the meeting. Women only made up 10-20% of attendees. Since health workers were present they also feared "revenge" following any negative feedback. The public forums were also not used to respond to feedback, so there is no opportunity to close the loop using this one way channel.

Suggestion boxes were set up in 6 out of the target 15 kebeles. The inclusion of suggestion boxes was common to all pilots, and adaptation was key to enabling people to feed back effectively in illiterate societies. AMREF Health Africa provided coloured paper to create a voting system: health centre users were able to provide a green slip if they were 'satisfied', orange if 'somewhat satisfied' and red if 'dissatisfied' with the service they had received. While this adaptation was a positive step in enabling people to use the suggestion box, the information gathered could not be used as it was not specific enough e.g. not naming particular health centres, services etc that they were feeding back on. This is particularly the case as the health facilities provide a range of services and not only maternal and child health, which was the focus of the GPAF project and the intended focus of the feedback. The suggestion boxes were only opened once during the pilot, given the low usefulness of the information. However, 213 people used the mechanism that month which shows interest and further adaptation of the system could have been done in order to make it more fit for purpose as an alternative confidential feedback method.

Key informant interviews were conducted with health staff and district health officials on a regular basis (average was monthly). However, this generated only 32 pieces of feedback between October 2014 and December 2015, of which only two led to further action by AMREF Health Africa. This suggests adaptation of the pre-determined questions was needed to ensure that the information generated was relevant to the GPAF project.

Despite the various channels provided, a significant proportion of endline respondents would give feedback in more informal ways, preferring to provide feedback face to face directly to a government health staff member (21%), or the Community Feedback Officer (14%). In order to capture feedback received in this way, AMREF Health Africa directed people to the formal channels, e.g. set up a Key Informant Interview or encouraged people to raise the feedback again during a focus group discussion. Feedback was then responded to formally.

Community Feedback Officer interviewing health staff

Changes as a result of beneficiary feedback

The majority of feedback was generated through the focus group discussions. However, only 0.5% of feedback received related directly to the GPAF project and required action by AMREF Health Africa. Feedback received was acknowledged, documented and responded to. The exception to this was feedback received through suggestion boxes which was anonymous and un-actionable; although documented, no response could be provided.

The endline survey results revealed that 62.5% of respondents indicated an action or change was made to the MCH services as a result of beneficiary feedback[4]. In response to beneficiary feedback, the District Health Office procured and maintained an ambulance for Fasha Health Centre, supported the improvement of cold chain facilities (vaccines) in some areas and provided additional medical supplies. Beneficiaries also provided important feedback identifying capacity and awareness raising gaps. As a result, training was provided for new Health Extension Workers and family health education made compulsory and comprehensive to enhance awareness of family planning. Additionally, changes were made to the GPAF safe motherhood campaign to focus on raising awareness of the importance of institutional delivery and the services available to pregnant women.

Community Feedback Officer meeting with health centre management

The most significant change made as a result of beneficiary feedback was the construction of two maternal waiting rooms. Maternal waiting rooms allow mothers who live in remote locations to come and stay directly at the health centre during their final stage of pregnancy, where they have access to skilled birth attendants to support a safe delivery. The District Health Office received a significant volume of feedback on the need for these facilities from the community, but there was no budget for this. This is an example of feedback being used to change programme decisions at a higher level. AMREF Health Africa shared this feedback with AMREF UK and following discussions with and approval of the Fund Manager, the project team was able to re-allocate funds to respond to this need. The District Health Team was very positive about this change. The changes made gave them a solution to a pressing need. Furthermore, it fostered a sense of real ownership of the project as they realised that their feedback can influence and lead to changes in activities to meet beneficiary needs. In the long term, these facilities will help to contribute to improved maternal health through increasing institutional delivery.

Integrating beneficiary feedback mechanisms into the GPAF project was low cost, but effective management did involve leveraging on the existing project (e.g. staff time). The feedback channels were free to beneficiaries but involved time commitment, which was a challenge for the target group of vulnerable women. The decision to select and train community volunteers to facilitate focus groups significantly helped in reaching a larger number of beneficiaries and providing more access to this feedback channel.

Despite some of the challenges, the capacity of AMREF Health Africa to gather, analyse and respond to beneficiary feedback improved during the Pilot period. Furthermore, confidence levels to give feedback on MCH services significantly increased from 28% (baseline FGDs) to 47% (endline FGD) & 43% which was confirmed through the gradual increase of feedback during the life of the Pilot. However, the feedback mechanisms would have been stronger and more effective if AMREF Health Africa had further adapted them to mitigate against some of the shortcomings that were identified early on, and ongoing contextual challenges. The period between October 2015 and May 2016 did not see a big improvement in the feedback systems since there was little field work possible during this time due to challenges of disease outbreaks and limited activity during the national elections.

[4] INTRAC Endline Report – survey respondents were selected from those participating in AMREF's regular FGD to collect feedback

LEARNING FROM AMREF HEALTH AFRICA'S EXPERIENCE

Continuous adaptation to context enhances effectiveness and value for money

The content analysis identified significant challenges to the pilot in the high levels of illiteracy, poor communication networks, and dispersed target population. AMREF Health Africa adapted the beneficiary feedback mechanisms design to help mitigate these barriers.

The introduction of coloured papers for suggestion boxes is an example of this. That 213 people used this method shows that the adaptation had some success in improving access to this feedback channel. However, when it was discovered that it was not possible to analyse or respond to the feedback received due to the lack of detail, no further innovations were put in place and the boxes were not opened again. This is perhaps a missed opportunity to further explore ways of using non-written means to reach illiterate people and enhance their voice- including with community members themselves.

An adaptation that was innovative and cost effective was the decision by the AMREF project team to recruit and train community volunteers to facilitate the focus group discussions. This both enhanced access to feedback opportunities for target beneficiaries, and reduced the burden on the Community Feedback Officer posed by the large distances and high target numbers. There were challenges in the extent of community volunteer facilitators understanding their role.

Changes in the context slowed and even stopped project activities for certain amounts of time during implementation, including: a diphtheria epidemic, national election campaigns and district level instability. It is likely the feedback systems would have been better embedded without these challenges that delayed project implementation.

Community sensitisation and stakeholder buy in are essential

Introducing the feedback mechanisms component of the Project took considerable time in terms of raising awareness among the community and government stakeholders. This, in addition to some of the contextual challenges of illiteracy, insecurity, diseases outbreaks and poor communication networks prevented the Pilot from reaching its potential. This was particularly acute given that it was introduced after the health project had started rather than integrated into the project design which may have had a very different outcome.

During the context analysis, staff were concerned that AMREF Health Africa's government partners would not be receptive to hearing feedback on their services. As a result, the pilot concentrated only on feedback received that related directly to the GPAF funded activities. This meant than in practice there was no formal way of closing the loop from feedback collected in focus groups related to government services, such as conduct of health workers and support staff.

However, the experience of the district health authorities in engaging with the beneficiary feedback mechanisms has been positive. Indeed, the endline reported that the District Health Office would be very happy to replicate feedback mechanisms in the future, should funding be available. This suggests that the buy-in of the district authorities was higher than expected, and further adaptation could have taken place to include referring relevant feedback to the district authorities and supporting them to establish a system for closing the loop.

Organisational structure and culture influences ability to close feedback loops

A unique challenge of the Ethiopia Pilot was the organisational structure of the implementing organisation (given the rural context) which slowed communication from World Vision to AMREF UK to the different levels of AMREF Health Africa. The Community Feedback Officer was based 165km from the Project Manager and given poor communication infrastructure, this prevented quick resolution of issues. The Senior Management were based in Addis, 750km from the project office, creating a time delay in decisions referred to them.

Furthermore, the huge geographic spread and large target beneficiary numbers of the GPAF project meant that project staff were very stretched. While the pilot was only focused on a small percentage of this target area, it was still far too large in practice given the challenges of topography, communication and number of staff. (Approximately 1,800 people participated in the feedback mechanisms out of a target 20,000).

MOVING FORWARD

AMREF Health Africa's experience of the Beneficiary Feedback Mechanisms pilot has led them to include beneficiary feedback mechanisms in other projects in Ethiopia. They are keen to take forward learning from this pilot when the opportunity arises. As the local authorities also expressed interest in scaling up, it is hoped that their partnership with AMREF Health Africa will help create more avenues for beneficiary feedback in those targeted districts.

A suggestion box at a health centre

Supported by

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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).