BENEFICIARY FEEDBACK MECHANISMS CASE STUDY
India

MAMTA Institute for Mother and Child, an Indian NGO based in Uttar Pradesh, implemented a GPAF funded project that aimed to improve maternal and child health for the most marginalised (including lowest castes and ethnic/religious minorities), raise awareness of positive healthy behavioural practices among the socially excluded, and link target beneficiaries with government service providers.

The Beneficiary Feedback Mechanisms Pilot (BFM) was integrated into the MCH project about a year after it started and targeted 27,250 beneficiaries and 41 women's groups in 4 villages of Kaushambi District. The BFM Pilot was designed to promote greater participation of the targeted beneficiaries (and wider community) through providing their feedback as to what, when, whom and how the services from the project and government service providers are delivered (Approach 3). The feedback received would enable the implementing team to make improvements to maximise the effectiveness of the interventions.

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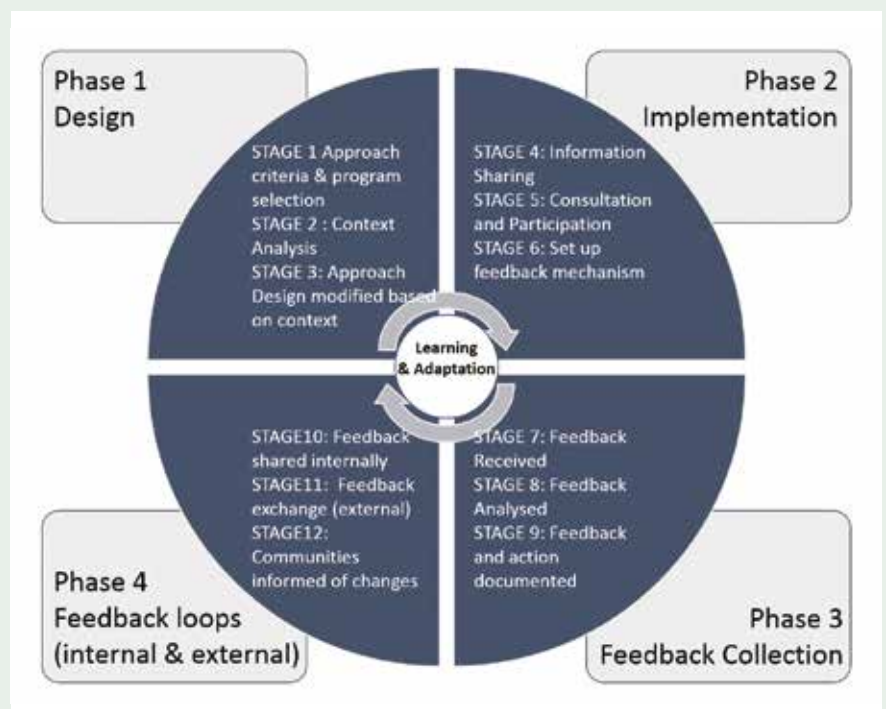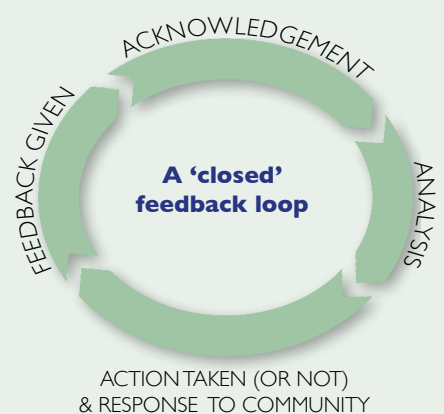
Phase 1: Design – based on a thorough context analysis of the organisation and community. This included talking to communities about how they would prefer to provide feedback and an analysis of any existing mechanisms

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.

ACKNOWLEDGEMENT

FEEDBACK GIVEN

A 'closed' feedback loop

ANALYSIS

ACTION TAKEN (OR NOT) & RESPONSE TO COMMUNITY

Phase 1 Design

STAGE 1 Approach criteria & program selection
STAGE 2 : Context Analysis
STAGE 3: Approach Design modified based on context

Phase 2 Implementation

STAGE 4: Information Sharing
STAGE 5: Consultation and Participation
STAGE 6: Set up feedback mechanism

Learning & Adaptation

Phase 4 Feedback loops (internal & external)

STAGE10: Feedback shared internally
STAGE11: Feedback exchange (external)
STAGE12: Communities informed of changes

STAGE 7: Feedback Received
STAGE 8: Feedback Analysed
STAGE 9: Feedback and action documented

Phase 3 Feedback Collection

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

MAMTA INSTITUTE FOR MOTHER AND CHILD'S EXPERIENCE IN KAUSHAMBI DISTRICT

Raising community awareness

The quality of information provision is a key factor in how effective a feedback mechanism is since it determines awareness of the mechanisms, how they work and what feedback should be about in relation to specific projects. Information needs to be provided regularly to targeted beneficiaries, community members and other stakeholders in a form they understand and can access. This information should cover the implementing partner, the key activities of the project, who the targeted beneficiaries are (and why they were selected), and how beneficiaries can give feedback. MAMTA's information provision was structured with different channels of interaction to communicate to different stakeholders including local leaders, peer educators, beneficiaries and service providers. In addition to group and community meetings, beneficiaries themselves suggested the use of "wall writings" instead of notice boards. This was because of low literacy levels among target beneficiaries. MAMTA also used local community events such as magic shows to share information in engaging ways.

As MAMTA was implementing a community designed feedback system (Approach 3) which solicited specific feedback, information provision could be much more targeted in line with project activities. Group meetings were very important in grounding the concept of beneficiary feedback amongst beneficiaries and stakeholders, and in gaining their support for the mechanisms.

Collecting and responding to feedback

MAMTA established well defined processes for capturing, recording and responding to feedback. Feedback from beneficiaries was collected every 15 days through the feedback boxes and through the daily diaries of MAMTA Outreach Workers and peer educators. On a weekly basis, feedback received was categorised into thematic areas (such as maternal health, child health, family planning, hygiene, water and sanitation). The feedback was then referred to the relevant stakeholders for redress (eg. Auxiliary Nurse Midwife, Accredited Social Activists, health centre staff, MAMTA outreach workers, MAMTA district level team or MAMTA head office). Relevant action was then taken as a result.

The feedback approach fitted well into the existing MCH project in which community mobilisation and women's group formation were the key activities to improve the maternal and child health outcomes by linking them to the employment schemes of the Government of India. Communities were consulted in the initial feedback stages which both engaged them in the BFM processes but also established the credibility of BFM among them and created the foundation of a supportive environment for collecting feedback in the community.

Suggestion boxes were the least preferred and used mechanism due to low literacy levels and the time taken to receive a response (15 days), compared to much quicker response to feedback through other channels. Suggestion boxes were installed in strategic locations where beneficiaries could access them conveniently, and use increased when they were more widely promoted, showing their relevance as an alternative mechanism. In particular, this mechanism was preferred by adolescent girls, (who have a higher literacy level), to give confidential feedback on their way to school. They liked using the suggestion box because they did not feel comfortable sharing personal problems in front of family members also participating in the group meetings.

Meeting collecting feedback against community selected indicators for maternal and child health

During the pilot, the volume of feedback received across the four villages increased from 10-20 pieces of feedback a month to approximately 80. The majority of the feedback received was on maternal health, family planning, general health and child health. MAMTA Outreach Workers were able to respond to most of the feedback received directly (about 75%), thus the feedback loop between beneficiaries and MAMTA was effective. Communities were informed of changes from feedback at 3 levels: 1) community meetings; 2) interface meetings between community members/leaders and key stakeholders; and, 3) with zonal and district officials from line departments.

Beneficiaries' experience of giving feedback and receiving responses was positive. Satisfaction levels among mothers and adolescents were very high (79% very satisfied and 20% fairly satisfied) as they themselves were involved in the process. Almost half of the respondents in the endline survey (45%) had given feedback multiple times because of their satisfaction with the response they had received.

Despite relatively high volumes of feedback, the endline survey found that 44% of the total respondents had not used the feedback mechanisms. The primary reasons given for non-use were not being informed (38 %), illiteracy (32 %) and hesitancy to give feedback (16 %). Secondary stakeholders, such as men, and adolescent girls gave much less feedback than women. Another challenge was that the purpose of the BFM in addressing the quality of services as a whole for the community was not fully understood. The majority of beneficiaries used the feedback channels to address their personal health issues (such as questions on nutrition). However, the CFO states an alternative perspective, "Much of the feedback received is personal in nature and shows the trust level of beneficiaries with the project staff and the ability to gather feedback".

Changes as a result of beneficiary feedback
The Beneficiary Feedback Mechanisms Pilot resulted in building relations between the community and front line government service providers. Beneficiaries' knowledge of their entitlements to government services and how to access these has increased, which was also a key objective of the MCH project. Service delivery is now reaching the most marginalised due to follow up based on feedback undertaken by MAMTA's Outreach Workers and project staff.

The number of women and children using the government health services has increased during the Pilot period and behaviour change in the community has been observed regarding health, nutrition and immunisation.

"The BFM program run by the organization in the community has changed people's thinking... As well, women's health and children's health has improved. Like – immunisation and prenatal check rate is increased, as well as increased participation of women at health nutrition day" (Auxiliary Nurse Midwife, Kaushambi)

Front line service providers including Accredited Social Health Activists (ASHA), nurses, midwives and Anganwadi (health workers) from Kaushambi district have stated that BFM has supported them in achieving their targets as the feedback collected informs them about the problems and therefore they can work to resolve these.

The local government structure (Gram Pradhan) also observed that now beneficiaries raise village development and individual issues directly to them. In particular, before the introduction of the BFM pilot, the voice of women was not being heard. Receiving feedback directly enables local government to channel support to the most pressing issues such as road construction, repairing hand pumps, new installations etc. However, there is still some apprehension from some local government representatives that the community might use the suggestion box to raise complaints against them.

These changes speak to the fact that the functioning feedback loop at the higher level (i.e. between MAMTA and local authority) was strengthened through the Pilot. The feedback received enabled MAMTA to initiate evidence based advocacy with local authorities, and as such, impact at the local level includes more women getting benefits under the Government JSY scheme (which encourages women to have institutional deliveries) and increased immunisation in target villages. However, there was no major impact noted at higher levels such as district government from the BFM Pilot.

The endline survey results corroborate these observations: 64 % of respondents observed positive changes in government service delivery after the introduction of the beneficiary feedback mechanism in their area. The changes included increased frequency of visits by front line workers. Furthermore, 72 % of the respondents observed changes in project delivery by MAMTA.

According to MAMTA, *"installing beneficiary feedback mechanisms will definitely help your project performance by making it more effective and efficient, as mobilisation processes and trust of the community together will enhance project outcomes. The implementation of BFM is easy, acceptable to the community and easy to use."*

Mother providing feedback against community selected indicators for quality maternal and child health

Continuous adaptation to context enhances effectiveness and value for money

At the beginning of the Pilot, there was some hesitancy by project staff given their unfamiliarity with the concept of beneficiary feedback and fears that communities would complain about their implementation strategies. However, once it was clearly understood that field staff would not be assessed based on the outcomes of the pilot, they were confident to try different approaches which enabled them to find out which were effective in their context. This contrasted with some of the other Pilots where the BFM was viewed as donor driven.

MAMTA successfully integrated beneficiary feedback mechanisms by building on existing community and project structures and working to generate buy-in among beneficiaries, health workers and government stakeholders. This meant that by the end of the pilot, the feedback mechanisms were being led by the women's groups and will continue after the project has closed (examples of sustainability and value for money). Community members are eager to sustain it with the help of the group leaders and can do so at minimal cost. They feel they have the capacity to undertake the programme and run it successfully in the community given what they have learnt.

Organisational structure and culture influences ability to close feedback loops

The only staff member funded by the Pilot was a full time Community Feedback Officer (CFO). However, MAMTA integrated the Pilot effectively into its Maternal and Child Health project by also involving 4 skilled community based staff members and engaged 41 peer/women's group leaders in the targeted villages. This ensured a shared responsibility of feedback collection and response, guided by the CFO. It also made the system very community based, visible to community members and not completely dependent on the CFO.

There was involvement of staff at all levels: the role of Outreach Workers was critical in initiating the feedback mechanisms at field level, while the CFO had responsibility for overseeing the entire process (collection, analysis and response to feedback). MAMTA's Program manager was key in coordinating feedback with government officials, while the Assistant Director and Strategic advisor of the organization are also involved in the decision making process and integrating the BFM into MAMTA's monitoring and evaluation system.

Community sensitisation and stakeholder buy in are essential

At the community level, most of target beneficiaries (through their group representatives) were engaged in the planning process at higher levels of BFM. All the 41 peer educators (group leaders) were involved in identifying indicators on which feedback are to be given, the location of suggestion boxes and so on. In addition to that other stakeholders such as frontline government functionaries were also consulted in the planning process. This resulted in the high levels of buy-in essential to its success and sustainability. A clear example of this is the front line health workers doing things differently due to feedback received, which contributed to the satisfaction of the beneficiaries with the process.

The community also benefited from the programme as women and girls became aware of their entitlements. The services improved and the confidence level of the women increased tremendously in terms of making decisions and speaking in public, and to government officials.

MOVING FORWARD

MAMTA Institute for Mother and Child has decided to continue and expand the beneficiary feedback mechanisms pilot, with the support of a corporate donor, for the next 3 years. The Assistant Director stated that within a very short span of time BFM has become the most visible project of the organization. "At organizational level we are incorporating BFM in our strategic planning. BFM is also included in the vision 20-20 document of MAMTA". BFM has been described as a stepping stone for MAMTA as it helped the organization to assess the work done in the field through the GPAF project and was able to improve the programmes. It also helped MAMTA to take their relationship with the community to a deeper level due to the development of trust.

Given the success of the Beneficiary Feedback Mechanisms pilot, the Punjab government (National Health Mission-Punjab) has entrusted MAMTA to implement a project based on community monitoring for their services provided at CHCs, PHCs and sub centre level. MAMTA intends to implement further projects with BFM mainstreamed in future.

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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