Client Voice and Choice / Ground Truth Solutions Pilots

Kenya, Kakuma Camp, April to November 2016

Case Study – December 2016

Part 1: Overview, Changes in Responsiveness and Key Lessons Learned

Host Programme and Location

Pilot 4: Internal data collection for Rounds 1 and 2; the Round 3 survey was accompanied by an external consultant and he also facilitated the focus group discussions for the last round.
Dates of Pilot: April 2016—November 2016
Survey Dates: Round 1—April 2016; Round 2—July 2016; Round 3—October 2016

What is Client Responsiveness?

Client responsiveness is an approach to programming in which the IRC takes decisions and implements actions that are informed by the perspectives of the people we serve. Evidence suggests[1] that client-responsiveness is not only 'the right thing to do' for ethical reasons, but it also improves the effectiveness and efficiency of our programming. It does this by providing us with mechanisms through which to understand and act upon information related to the performance of our projects, and it contributes to building trust in the IRC and supports the empowerment of crisis-affected populations.

Summary of Key Learning from this Pilot:

Identify appropriate division of responsibilities and accountabilities: IRC Kenya's Safe Programming team played a leading role in the implementation of the feedback mechanism tested under this pilot. Whilst this team drove the process and drew upon their learning and experience of implementing feedback mechanisms, their eagerness to manage the process perhaps undermined the sense of responsibility which the Health team had over the feedback process and findings. In order for client feedback to systematically inform the decisions made by programme teams, it is important that it is the programme leads themselves who have accountability for and a sense of ownership over the feedback mechanism.

[1] CDA (Time to Listen), ALNAP-CDA Feedback Mechanism Research and Guidance, WV BFM Pilot findings, Andy Featherstone study (Save UK Christian Aid)

Verify internally administered feedback mechanisms: In IRC Kenya the pilot employed IRC staff to administer the survey and focus group discussions. Whilst this was a cost efficient option and benefitted from the close relationship which the teams have developed through routine interaction between staff and clients in the camp, sensitive issues perhaps were not able to surface. When an external consultant was brought in to accompany the surveying process and administer the focus group discussions in round 3, feedback around perceived lack of fairness in treatment and cultural sensitivity was raised. This highlights the importance of verifying internally collected feedback data on a periodic basis to check for a courtesy bias.

More detailed learning from the pilots can be read Parts 3 and 4.

Pre-Existing Responsiveness of the Programme:

Since 2011 IRC Kenya has placed an emphasis on protection mainstreaming in its programming in Kakuma camp (as well as in other areas of the country) through a "Safe Programming" approach. This approach is based on fundamental protection mainstreaming principles of non-discrimination and meaningful access; safety and dignity; and accountability. The Kenya IRC's Safe Programming team have worked alongside the Health team in applying this approach to their work: this has included the establishment and use of complaints mechanisms in the camps to capture client feedback.

The team used a combination of reactive mechanisms, such as suggestions boxes, as well as proactive channels, such as exit interviews at the health centres, and recorded feedback in a ledger. The IRC staff that were interviewed as part of the piloting process felt that the current channels provided an important safety check to ensure that clients have an opportunity to provide feedback. However, the surveys showed quite low numbers of people in the camps were aware of how to use these mechanisms. In 2015 the team also ran a Safe Programming Audit, and circulated a report on their findings which ran to 56 pages. Whilst a valuable exercise in highlighting some of the gaps in current programming, the senior management team found that the feedback and the analysis of its implications were not presented in a way which would aid effective decision making – primarily due to the length of the report. This is a common finding across feedback mechanisms: we collect a lot of information, but its presentation hinders our ability to use it.

While the programme team were implementing a number of channels to collect feedback, the Safe Programming and Health teams were keen to identify ways that they could strengthen these channels. For instance, the current mechanisms were very much focused on complaints, rather than a broader capture of client perspectives. Secondly, whilst the feedback may have been informing minor adaptations in programming, that feedback was not presented in such a way to inform more strategic programming and operational decisions at the programme or country office level.

Thus, at the point of starting the pilot, the programme would thus be identified as being **satisfactory in its level of client responsiveness**, according to the draft Client Responsiveness Performance Matrix (available in Annex 3).

Improvements to the Responsiveness of the Programme Following Piloting:

Both the Safe Programming and the Health teams were very receptive to the learning generated through the experience of piloting the Ground Truth methodology. The teams have reflected on the different ways that they currently collect feedback (the channels in use) and on how to broaden and strengthen their proactive engagement with clients. The Health and Safe Programming teams both reviewed the feedback reports in advance of the calls with the CVC team and GT and offered some interpretation of the findings and possible course correction. Going forward, it will be important for the Health team to establish a standing action point in their programme management meetings to review client feedback, discuss its implications for programming and take decisions and make action plans for how to respond. There is a risk otherwise that the structure of the decision making process offered by the calls with CVC and GT during the pilot would otherwise be lost. Given the need for further measures to be put in place to ensure the sustainability of decision making fora around the feedback received, we would conclude that the level of responsiveness remains **satisfactory in its level of client responsiveness**, whilst noting the potential for improvement.

Annexes to Reference:

1. Background on IRC's Commitment to Client Responsiveness
2. Background on Ground Truth Piloting
3. Client Responsiveness Performance Matrix (to be later surpassed by the Client Responsive Programming Framework)
4. Pilot Feedback Reports from the GT Surveys (3 rounds of externally collected data) pilot 4.

Part 2: IRC's Programming and the Kenya, Kakuma Camp Context

Host Project Description:

Since 2007, the IRC has been the lead agency in Kakuma, providing all healthcare and nutrition assistance, and services to persons with special needs, as well as protection services. The aims of its programming are to ensure the health, nutritional wellbeing and protection status of the population is improved and maintained within acceptable SPHERE, UNHCR and World Health Organization (WHO) standards. The pilot focused on IRC's primary healthcare assistance which is provided through a network of Community Healthcare Practitioners and though health facilities.

The project clients are refugees from South Sudan, Somalia, DRC, Rwanda, Burundi, Uganda, Ethiopia and Sudan. There are also small percentages of refugees from other locations.

The project is funded primarily by UNHCR, but much of this funding is released through the UK Government Department for International Development (DFID), the European Commission Humanitarian Aid and Cooperation department (ECHO) and the United States Government Bureau of Population Refugees and Migration (PRM).

Context Enablers to Responsiveness:

+ The IRC Kenya programme had already been taking a Safe Programming approach to its health programming in Kakuma camp, so had some foundations for the collection of feedback already in place. Providing and receiving feedback was familiar with clients and staff.

+ The Kakuma camp population is relatively stable, and we have good predictability of programming needs and our abilities to be able to respond. These conditions enable continued and reliable access to the camp, for staff to develop relationships with clients and to engage them easily in feedback mechanisms.

Context Inhibitors to Responsiveness:

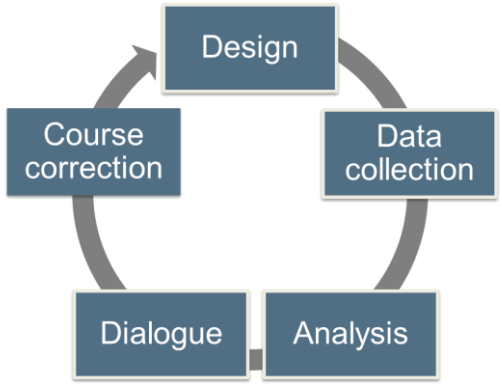
- The current feedback mechanisms are very much owned and directed by the Safe Programming team. Whilst this team flies the flag for protection mainstreaming and accountability, ensuring that it stays on the agenda in our health programming in Kakuma, it has resulted in the Health team taking on less of an active responsibility for theses aspects of the work, including the collection and use of client feedback.

- More than 22 languages are spoken in the camp, with residents originating from over 20 different countries. This has implications for the IRC team's ability to communicate with clients and to design feedback channels which are appropriate to all the different cultures represented in the camp. While the team works through "incentive staff" hired from the camp population who speak the languages and understand the cultural norms of the community they represent, there is a risk that they can play a role in skewing the feedback provided (by influencing the responses of clients) or heard (by recording and sharing only that feedback which reflects favourably upon their performance).

- Many of the camp residents in Kakuma have spent their whole lives in the camp, and have been used to having their basic needs met by NGOs. This creates the potential for clients to try to gain additional benefits by sharing only the feedback that they think might qualify them for additional services or assistance.

Part 3: Designing the Feedback Mechanism: What We Did, Question Design and Lessons Learned

GT Cycle:



Description of GT Methodology:

Ground Truth's approach is to collect the views of affected people at regular intervals on key aspects of a humanitarian program, analyse what they say, and help agencies to understand and communicate the resulting insights back to affected communities. The objective is to provide agencies with real-time, actionable information from people at the receiving end of aid that can be translated into program improvements, while empowering people to express their views.

For further information of how we implemented these stages, see Annex 2.

Designing the Feedback Mechanism—What We Did:

Question Development and Testing: CVC and GT facilitated a workshop with management from the Health and G&R teams and with field staff from the Kakuma health programme. Through the workshop, the team was invited to suggest themes upon which they were interested in obtaining their clients' perspectives. GT subsequently drafted proposed questions which were verified by the programme team. Questions were tested by the Safe Programming team in Kakuma during the visit, and changes subsequently made where questions hadn't been understood, answers implied questions overlapped or additional ones needed to be posed. GT made the final revisions to the questions.

Designing the Feedback Mechanism—What We Learned in the Pilot:

A broader focus than complaints: Through the safe programing methodology the Kenya team felt that they already had a good understanding of client satisfaction with the services, and so wanted to focus the CVC GT Pilot enquiry primarily on more relational aspects of programme delivery. The IRC's approach to client responsiveness and the GT methodology both place emphasis on *how* services are delivered as well as *what* services are delivered. Typically, feedback mechanisms tend to focus quite narrowly on complaints, whilst monitoring and evaluation (M&E) efforts focus on that data which verifies the contents of the logframe. Taking the broader perspective on the range of topics to consult clients upon will provide the Kenya team with a deeper understanding of their clients' preferences, aspirations and expectations and of how to deliver effective programming.

Leadership support: The IRC Kenya country management were heavily invested in and supportive of the piloting process from the outset, and engaged in the preliminary design discussions offering their perspectives on what was currently working and what needed to be improved. This set the tone for this exercise to be prioritised by the teams participating in the piloting process, and moving forward this kind of leadership and messaging of the importance of responsiveness will likely result in teams prioritising efforts to strengthen their programming in this area.

Survey Questions and Themes for the Pilot:

1. **Safety:** "To what extent do you feel safe when the CHP visits your home?"
2. **Respectful and Dignified Service Delivery:** "To what extent does the CHP treat you with respect and dignity?"
3. **Respectful and Dignified Service Delivery:** To what extent are the CHP sensitive of your culture and tradition?
4. **Trust in the IRC and Services:** "To what extent do you trust the CHP with your confidential information?"
5. **Trust in the IRC and Services:** "To what extent do you trust the health messages the CHP shares with you?"
6. **Agency and Empowerment:** "To what extent do you have the information you need to make health choices for yourself and your family?"
7. **Service Access and Protection Mainstreaming:** "To what extent are the CHP services in this camp offered fairly without discrimination?" "If not, which of the follow groups are excluded (multiple choice)?"
8. **Agency and Empowerment:** "To what extent do you feel you have a say in how the CHP services in this camp are offered?
9. **Trust in the IRC and Services:** "Do you know how to make a complaint about the CHP?" "If so, which mechanisms do you feel most comfortable using (multiple choice)?"
10. **Service Impact:** "How important is the CHP service in meeting your health needs?"

Part 4: Implementing the Feedback Mechanism: What We Did, Survey Responses and Lessons Learned

Implementing the Feedback Mechanism—What We Did:

Survey Administration: The first two surveys were administered by the Community Healthcare Practitioners, with the supervision of the Safe Programming Officer based in Kakuma. Round three was accompanied by an external consultant, who was brought in to test whether the use of the CHPs in administering the survey was causing a courtesy bias or otherwise skewing the data.

Preparation of the Report: The data from the survey was passed from the Safe Programming Team onto Ground Truth, who prepared the Feedback Reports for each of the Pilots after each survey round (see Annex 4). The Feedback Reports ranged from 2-5 pages (IRC management had specifically asked for shorter reports), providing breakdown of question responses where relevant, and including some narrative interpretation of the data to prompt the Safe Programming and Health teams in their review of the report. The reports can be seen here.

Internal Dialogue: The Safe Programming and Health teams joined a Skype call with CVC and GT to discuss the feedback report; what issues they would like to explore further in the dialogue; and how to adjust the survey for the next round, where applicable. A standard set of questions were used to facilitate the discussion.

External Dialogue: The Safe Programming team arranged dialogue sessions with members of the community in the camp, relaying the feedback that they had heard from the surveys to the refugee population and seeking their insights into reasons for certain pieces of feedback, and prompting discussion about possible options for course correction. The team prepared a brief report back.

Course Correction: The Safe Programming and Health teams identified what course correction they could take straight away: this is covered in a subsequent section of this case study.

Adaptation of the Feedback Mechanism: After each round of feedback, CVC and GT agreed with the Safe Programming and Health teams how survey questions might need to be changed, added or removed; this was reflected in the next round.

Implementing the Feedback Mechanism—What We Learned:

Division of responsibility and accountability: IRC's approach to client responsiveness recommends that the responsibility and accountability for analysing and deciding how to act upon client feedback should sit with the management of the particular programme upon which the feedback was captured. In most cases, an M&E team would be perfectly suited to supporting the programme team in administering the collection, compilation and presentation of client feedback to aid decision making. Given the historical role of the Safe Programming team in driving forward IRC Kenya's efforts towards a range of protection mainstreaming and associated objectives – including accountability – the team played a central role in the pilot. However, whilst their learning about and dedication to feedback mechanisms was of added value in driving the process, their leading role in the pilot seemed to reduce the sense of responsibility of the Health team for the process and for leading efforts to decide how to respond to the feedback. When designing a feedback mechanism, it is important to identify how roles should be best divided amongst the country programme in order to ensure appropriate division of responsibilities for decision making and accountability: programme teams should have ultimate responsibility for responsiveness to clients, as it is they who take decisions about what interventions to design and deliver. Teams with specialist skills and knowledge – such as Kenya's Safe Programming team, or a country M&E team – should provide a supporting role to them in the process.

External data collection can reveal more about perceptions of fairness and respectful treatment: The feedback scores during the first two rounds of the survey, where the feedback was collected by the Community Healthcare Practitioners ("incentive staff" drawn from the camp community) showed very positive responses to all the questions across the board. Given the pattern over rounds one and two, CVC and GT agreed with the Safe Programming and Health teams to bring in an external consultant to oversee the last round and provide support to ensure the quality of data collection by the CHPs, as well as having him run the focus group discussions. Without the Health team having reported any change in the programming in those areas, the scores for perceived fairness of the services and cultural sensitivity of the scores dropped in the third round. Whilst we cannot draw a definitive conclusion, it would suggest one or both of two things: (1) the potential that

clients felt more comfortable in revealing their perspectives on more sensitive issues – such as trust and treatment – when the person administering the feedback channel is seen to be independent; and / or (2) the possibility of staff had not been so willing to record and share more negative feedback in rounds one and two in case it reflected negatively upon their performance. Of course, the change in scores may also indicate greater confidence of the client group to share feedback. However, one might have then see other scores changing also. Suggested lessons from this include: (1) bringing in a third party on a periodic basis to test the quality of the data being captured internally; and (2) communicating to staff that negative feedback is not to be feared, but rather provides the opportunity for learning and improvement.

Summary of Client Feedback over Three Rounds:

The feedback received in the first round indicated that some clients were not aware of how they could access the existing complaints mechanism in place in Kakuma. The team responded to this by conducting outreach about the purpose of the complaints mechanism, how it could be accessed and what would be done with the feedback. The course correction was reflected in a notable upward turn in scores in rounds 2 and 3, providing a measurable impact of a simple response to client feedback. The greater awareness of the feedback mechanism may have also prompted clients to be more open with their feedback to the survey in later rounds.

As indicated above, the scores for the perceived fairness of services and cultural sensitivity also dropped from rounds two to three, when accompanied by the external consultant. The programme team did not report any change in their activities between the rounds, so it is likely that the external consultant's oversight and perceived independence from the CHPs may have had an impact upon the scores.

Detailed feedback and summaries of changes in responses over the three rounds can be read in the Feedback Reports in Annex 4.

Part 5: Next Steps and Recommendations

Reflect and apply the Client Responsive Programming Framework: We recommend that the Kenya programme review the guidance provided in the IRC's new Client Responsive Programming Framework and assess their current practice against the standards presented therein in order to identify priorities for improvement. With the Safe Programming work, the experience of engaging in the CVC / GT pilot and the strong level of leadership support for responsiveness at the country programme, we are confident that the programme can make significant gains in its responsiveness to clients.

Continue to use a combination of feedback channels: For the IRC Kakuma Health team, we recommend that they continue to use a combination of (1) their existing reactive feedback channels; (2) proactive methods such as the surveys and focus group discussions used in the pilot; and (3) finding ways to capture the feedback that their staff are hearing in the camp on a routine basis.

Internal Responsiveness: Efforts should be placed by programme management at all levels to ensure that staff feel empowered and comfortable to pass on any feedback that they hear from clients and to share their own ideas with decision makers about how the feedback can be addressed. Creating an internal culture of responsiveness, where staff across the hierarchy feel confident to communicate with each other in proactively identifying problems and ways that we can together improve programming will be important for the team. With an ongoing presence in the camp, the Health team also has a great opportunity to engage clients themselves in open listening exercises, and in participating in decision making over programme design and delivery.

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