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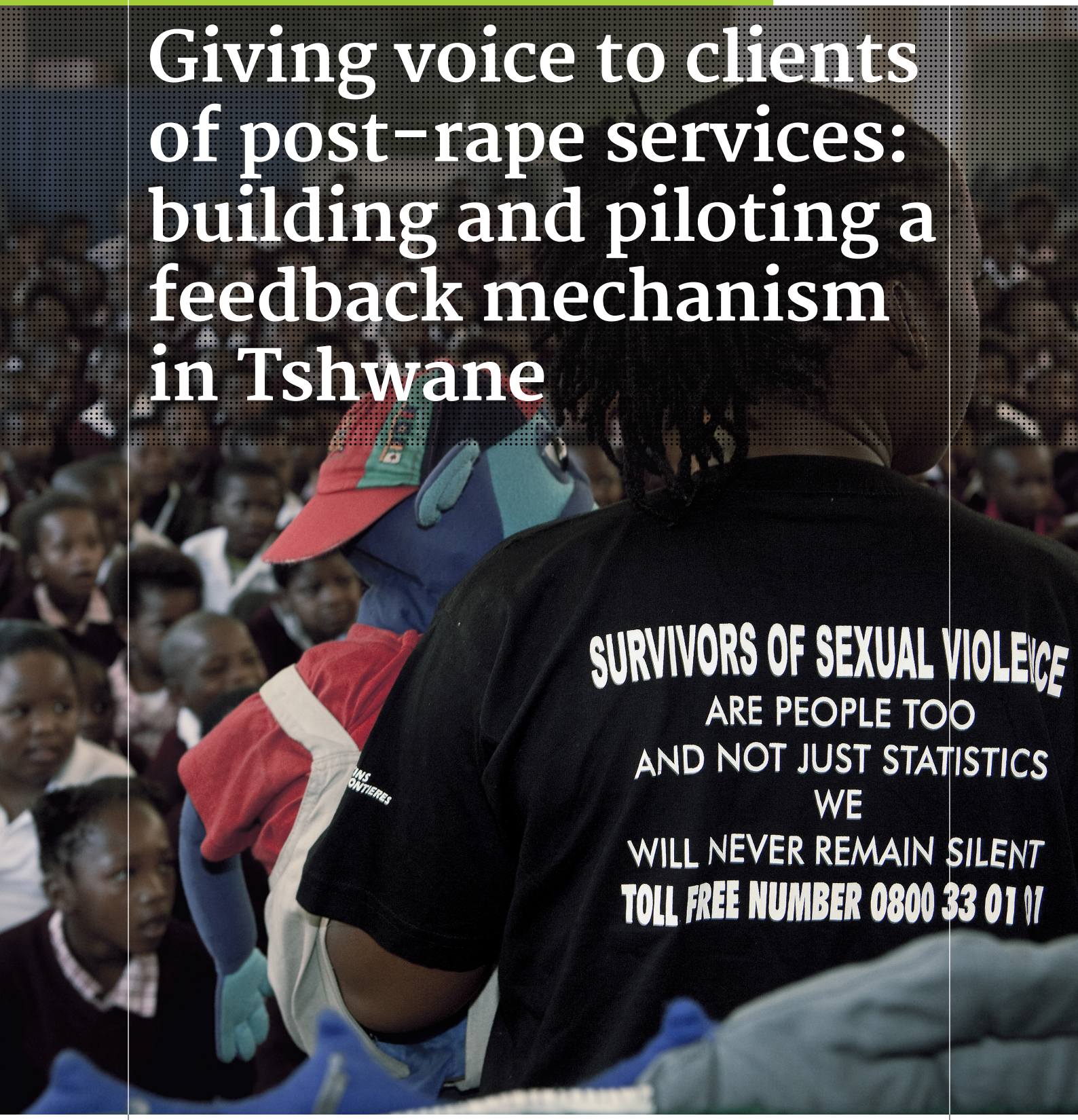
MAKING ALL VOICES COUNT

A GRAND CHALLENGE FOR DEVELOPMENT

PRACTICE PAPER

Giving voice to clients of post-rape services: building and piloting a feedback mechanism in Tshwane



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Ciana-Marie Pegus is a research officer at the Institute of Development Studies, working on the Making All Voices Count programme. She manages a cohort of research grants, and provides technical inputs on their design, methods and stakeholder engagement strategies where needed. She also shares the lessons from these projects with broader audiences. The Foundation for Professional Development practitioner research and learning grant was one of her projects.

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Contents

Summary

Foundation for Professional Development (FPD) is a private South African higher education institution, which received an innovation grant of £39,996 from Making All Voices Count to pilot an appropriate and confidential feedback mechanism for users of post-rape services at Thuthuzela Care Centres / Rape Crisis Centres in Tshwane, South Africa.

Making All Voices Count then provided Foundation for Professional Development with £24,960 to conduct practitioner research to inform the development of a tool to collect information on client experience. Through its research, it sought to unpack key drivers of satisfaction and dissatisfaction in post-rape service delivery, and to understand the feasibility and acceptability of the proposed intervention from the victim's perspective.

Through analysing the findings of FPD's research and reflecting on its experience building and piloting a mobile application, the Practice Paper highlights:

- the disjointed approach to post-rape services, which led to the establishment of Rape Crisis Centres and later Thuthuzela Care Centres
- uneven access to quality post-rape care in Tshwane and client perceptions of services
- how FPD was able to get centre staff to act on client feedback and the limits of such feedback in a resource-constrained environment
- the evolution of the client experience app and reflections on the innovation and co-creation process
- thoughts on striking a balance between reflection and action, and between practitioner research and innovation
- managing the tensions of anonymity, visibility and representation in gathering client feedback.

Key themes in this paper

- The challenges and benefits of a consultative approach to building a feedback mechanism.
- How to get service providers to promote and engage with a new feedback mechanism.
- Tips on how best to work with developers for organisations working to launch a mobile app for the first time.
- The constraints of donor-funded innovation projects, and advice for donors in the field of tech for transparency and accountability.

Setting the scene for practitioner learning

Making All Voices Count is a citizen engagement and accountable governance programme. Its Research Evidence and Learning component, led by the Institute of Development Studies (IDS), focuses on building an evidence base on what works in technology for voice, transparency and accountability, how it works, and why (McGee *et al*. 2015). Through practitioner research and learning grants, IDS gives tech for transparency and accountability practitioners grants of around £25,000, together with mentoring support. This provides them with the space and capabilities to explore key questions that will enable them to better implement their governance projects. It is hoped that this real-time applied research will contribute to project learning and improved practice.

The practitioner research and learning grants support grantees to form their own learning and judgements, and the development of Making All Voices Count practice papers series is part of this process. Practice papers document the practitioner research and learning processes from the perspectives of both the grant recipients and the fund managers. They situate the research findings and the reflective processes that led to them in contemporary debates in the field of transparency and accountability.

Making All Voices Count Practice Papers are co-produced and intended to prompt critical reflection on key learning questions. The Making All Voices Count–IDS team does not prescribe research questions and methods; rather, it encourages grant recipients to explore questions that they believe are of importance to the implementation of their project. Some of the practitioner research is embedded in Making All Voices Count's innovation and scaling grants, which are curated and managed by Ushahidi and Hivos.

This practice paper focuses on the work of Foundation for Professional Development (FPD), a private South African higher education institution. Its practitioner research, led by Head of the Technical Assistance Cluster Suzanne Johnson and Senior Research Coordinator Nomsa Brightness Mahlalela, set out to determine the key factors that most influence the client experience of victims of rape[1] at Rape Crisis Centres (RCCs) and Thuthuzela Care Centres (TCCs), and to determine the acceptability and feasibility of using a mobile application to measure client experience.

The paper documents a conversation between Suzanne Johnson, Nomsa Brightness Mahlalela and IDS research officer Ciana-Marie Pegus. It describes: how and why FPD has been involved in understanding client experience at TCCs / RCCs; the questions it sought to answer through the research and how it went about getting answers; the context in which FPD works; what the research showed and the implications of the findings; and recommendations and the way forward for FPD.

1 The authors acknowledge that there is significant debate about the use of the term "rape victim" as opposed to "rape survivor". As is also the case with other publications about this work (see Mahlalela, Johnson and Mills 2017; Johnson, Mahlalela and Mills 2017), this paper uses the term "rape victim" rather than "rape survivor" because the innovation and practitioner research and learning project focused on participants' "first engagement with governmental post-rape service providers, often within days or hours of being raped. At that point in their individual journeys, the participants did not appear to have received adequate support and / or had enough time to feel empowered to self-classify as a survivor… [The] use of the word "victim" draws attention to the harm and violence done to the individual and the service provider's responsibility to mitigate further harm and victimisation" (Maier 2014, cited in Mahlalela *et al*. 2017: 6).

What is FPD?

Foundation for Professional Development was established in 1997 as a department of the South African Medical Association; it was registered as a separate legal entity in 2000. It prides itself on being one of the few private higher education institutions that engages fully in teaching and learning, research and community engagement. FPD's mission is to catalyse social change through developing people, strengthening systems and providing innovative solutions. Its research priorities focus on promoting operational research, and studying health outcomes and educational practice. It encourages and uses action research as a methodology for professional development and transformational practice.

What are RCCs and TCCs?

Over the past decade, the South African government has set up Rape Crisis Centres (RCCs) and later Thuthuzela Care Centres (TCCs). The RCCs are sometimes referred to as medico-legal centres. They manage post-rape forensics and are supported by specially trained house doctors, counsellors, psychologists and social workers. Specialised police officers are supposed to go to the RCCs to interview clients. The RCCs are managed by the Department of Health, and the TCCs are managed jointly by the National Prosecution Authority (NPA) and the Department of Health. The TCCs are intended to be one-stop shops to deal with the medico-legal and psycho-social needs of victims of rape. At these centres, the clients should be able to access the services of doctors, nurses, lay counsellors, a victim assistance officer (a specialist police officer), and a centre administrative manager employed by the NPA. Thuthuzela means "comfort" in Xhosa, and these centres were established to provide good quality holistic care in a dignified, caring environment. The centres seek to lessen the trauma of sexual violence and to reduce secondary victimisation of survivors by providing professional medical care, counselling and access to dedicated investigators and prosecutors, all under one roof, in order to improve conviction rates, reduce the cycle time for finalisation of cases and help victims and their families cope with the aftermath of sexual violence.

What was FPD funded to do?

On 1 July 2014, FPD was awarded £39,996 for a 12 month innovation project to develop a mechanism to facilitate communication between clients and staff of TCCs / RCCs, which enabled victims of rape to give confidential feedback about services.[2] FPD received a no-cost extension to complete the project by the end of March 2016, and this was extended further to the end of September 2016.

In May 2015, Making All Voices Count provided FPD with £24,960 to conduct practitioner research and learning. The aim of the practitioner research was to inform the development of a tool to collect information on client experience.

FPD sought to: (1) unpack key drivers of satisfaction and dissatisfaction in post-rape service delivery, and (2) understand the feasibility and acceptability

2 The scope of the innovation project was reduced – see the section on the relationship between innovation and research for more details.

of the proposed intervention from the victim's perspective in order to inform its design, content and technology platform (Johnson *et al*. 2017: 5).

Dr Elizabeth Mills, a South African gender-based violence (GBV) expert and anthropologist at IDS seconded to the University of Sussex, mentored the team. She helped FPD identify and contextualise relevant literature on post-rape services and provided technical input on the research protocol and on data analysis.

Research focus and methods

FPD employed a cross-sectional mixed methods approach. The study population comprised follow-up clients who were over 18 years old and accessing services at the Tshwane RCC, the Soshanguve RCC, the Mamelodi TCC and the Jubilee RCC.

Table 1. Research and pilot timeline and findings

PERIOD	ACTIVITY	PARTICIPANTS	FINDINGS
July – September 2015	Cell phone acceptability survey; paper-based client experience survey	140 respondents from Mamelodi TCC, Jubilee RCC, Soshanguve RCC and Tshwane RCC a median of 21 days after the assault	Most victims lost their cell phone during the attack (55%) but had a cell phone at follow-up visits (86%); 95% knew how to use Unstructured Supplementary Service Data (USSD)[3] technology; varying levels of client satisfaction at different sites (see Figure 1)
September – October 2015	Three focus group discussions (FGDs)	21 clients from Mamelodi TCC and Jubilee RCC	Staff at TCCs / RCCs welcoming, easy to talk to and respectful; complaints about process of referral from hospitals / police stations to RCCs / TCCs, with clients experiencing long delays, waits, pain and discomfort; overwhelmingly negative experiences with the police
December 2015	FGD on pilot application	Nine clients from Mamelodi TCC and Jubilee RCC	Client experience app usable and understandable
April – July 2016	Pilot of client experience app	470 attempted responses and 207 completed responses out of 939 walk-ins at Mamelodi TCC, Jubilee RCC, Soshanguve RCC and Tshwane RCC	Feedback led to increased client satisfaction

Source: FPD (2016)

3 USSD is a communication technology that is used to send text between a mobile phone and an application programme.

Research focus and methods

The USSD client experience app was piloted in the four sites. Through free-to-use codes, it enabled participants to rate health-care staff at the centres, the police, court support staff, or a combination of all three service providers. On a scale of one to five, respondents could rate: (1) the quality of services, (2) staff, (3) the physical environment and (4) the quality of information and advice at the centres. The app also allowed clients to provide free-form comments.

The preliminary research findings and pilot results were shared with a broad range of stakeholders.

Table 2. **Sharing findings with key audiences**

DATE (2016)	AUDIENCE
Sharing pre-pilot findings	
March 10	Staff of the clinical medico-legal unit (unit responsible for overseeing clinical post-rape services) of the Tshwane District Department of Health
March 15	Staff of Tshwane RCC
March 17	Staff of Soshanguve RCC
March 30	National Prosecution Authority
April 4	Staff of Mamelodi TCC
April 5	Staff of Jubilee RCC
April 5	Civil society organisations involved in the Increasing Services for Survivors of Sexual Assault (ISSSASA) project
Sharing pre-pilot findings	
July 2	FGDs for participants in September, October and December 2015 FGDs
July 27 – July 28	Workshop for staff at four pilot sites
August 10	Tshwane District Health Management Team (28 health managers)
August 17	Two oral presentations at the First South African National Conference on Violence

There is a void in leadership on gender-based violence, and it's not at the top of any government department's agenda.

The context – a disjointed approach to post-rape services

Ciana-Marie:

South Africa has high rates of sexual assault and rape, low rates of prosecution and even lower rates of conviction (Johnson *et al*. 2017). Can you tell me more about the political, legal and social context in South Africa, and how they shape post-rape services?

Suzanne:

I think South Africa has a supportive policy environment for gender equity. The Constitution and the Sexual Offences Act (2007) do go a long way to protect the rights of women and children, and to make them less vulnerable. Work to combat GBV doesn't have its own institutional home, strategic vision and mission, and this is a big gap. There have been technical working groups on GBV, but this has never amounted to a national strategic plan, which is very much needed. There is a void in leadership on this issue, and it's not at the top of any government department's agenda. The NPA has created the Sexual Offences and Community Unit, which focuses on prosecution of GBV, and GBV features in the Department of Health's HIV / AIDS response strategy and its plans to tackle maternal health and nutrition, but as an issue it lacks frontline visibility. There's no framework holding these disparate pieces of work together.

Even when guidelines do exist, an endemic problem in South Africa is a failure to translate policy into plans into reality on the ground. The Department of Health has created guidelines on how to manage rape from a medico-clinical perspective,[4] but there has been uneven implementation, not all staff have been sufficiently trained and not all centres are well resourced. As for the coordination platforms that do exist, they don't always function as well as the stakeholders want and the clients need.

Ciana-Marie:

In the FGDs, it was noted that client experiences with police officers were largely negative. A female FGD participant in Mamelodi said that "some police members are very rude. They will ask you what were you doing at the street by *[sic]* that time, why were you not at home? Simply because they [will] never experience what you went through" (Johnson *et al*. 2017: 17). TCCs / RCCs should be the first port of call after rape, and people should be interviewed by specialised victim assistance officers there. This is often not the case – victims go to police stations and are treated poorly. What do you think needs to be done to address these frequent lapses in quality post-rape care by the South African Police Service (SAPS)?

Nomsa:

Looking at the research and the findings, and the mistreatment of victims of rape by SAPS, the TCCs / RCCs must be the first point of contact, but most people just don't know about them. I feel that there's a need for greater awareness of these centres, highlighting where they are and the special services they offer. In terms of the police, they need to be sensitised and trained to deal with rape cases better.

4 For more information see: Maternal, Child and Women's Health and Nutrition Cluster (2003)

Suzanne:

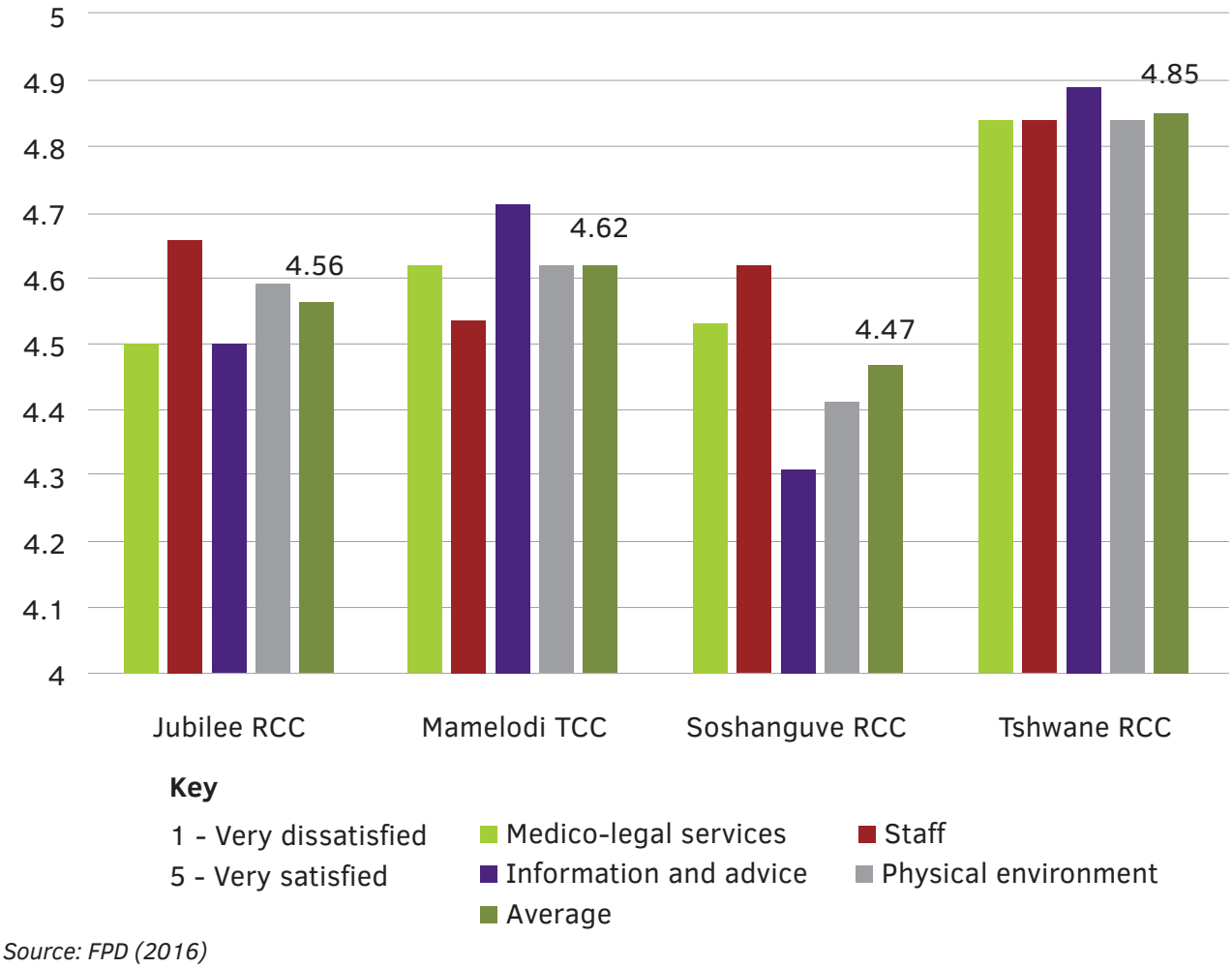
I read the transcripts from the FGDs over and over again and the most traumatising part of the process [of accessing post-rape services] for victims was opening a case with the police. Several FGD participants found the police to be rude, harsh and judgemental, and they felt like they were being blamed.

Post-rape health care and psycho-social support are often needed before a case is opened; the policies and guidelines on post-rape services make this clear and the police don't know that. Without training and appropriate sensitisation, the police struggle to overcome their own prejudice and stigma about rape and sexual assault. Not everyone is a specialist, nor does everyone have to be. But they need to understand the importance of rapidly linking rape victims to the specialists who are trained to provide high quality post-rape services. To do this, the police need to escort people who have been raped to the TCCs / RCCs as quickly as possible, as the centres may be far and costly to get to, and victims may be afraid to use public transport right after rape. Targeted interventions with the police are needed, as they need to know that their actions at the time have long-term implications for victims' recovery processes.

What did the research show? Uneven access to post-rape care

The data from a paper-based survey conducted at the four sites from July to October 2015 demonstrate that there were differential levels of client satisfaction at the four sites (Figure 1), which indicates unequal access to care.

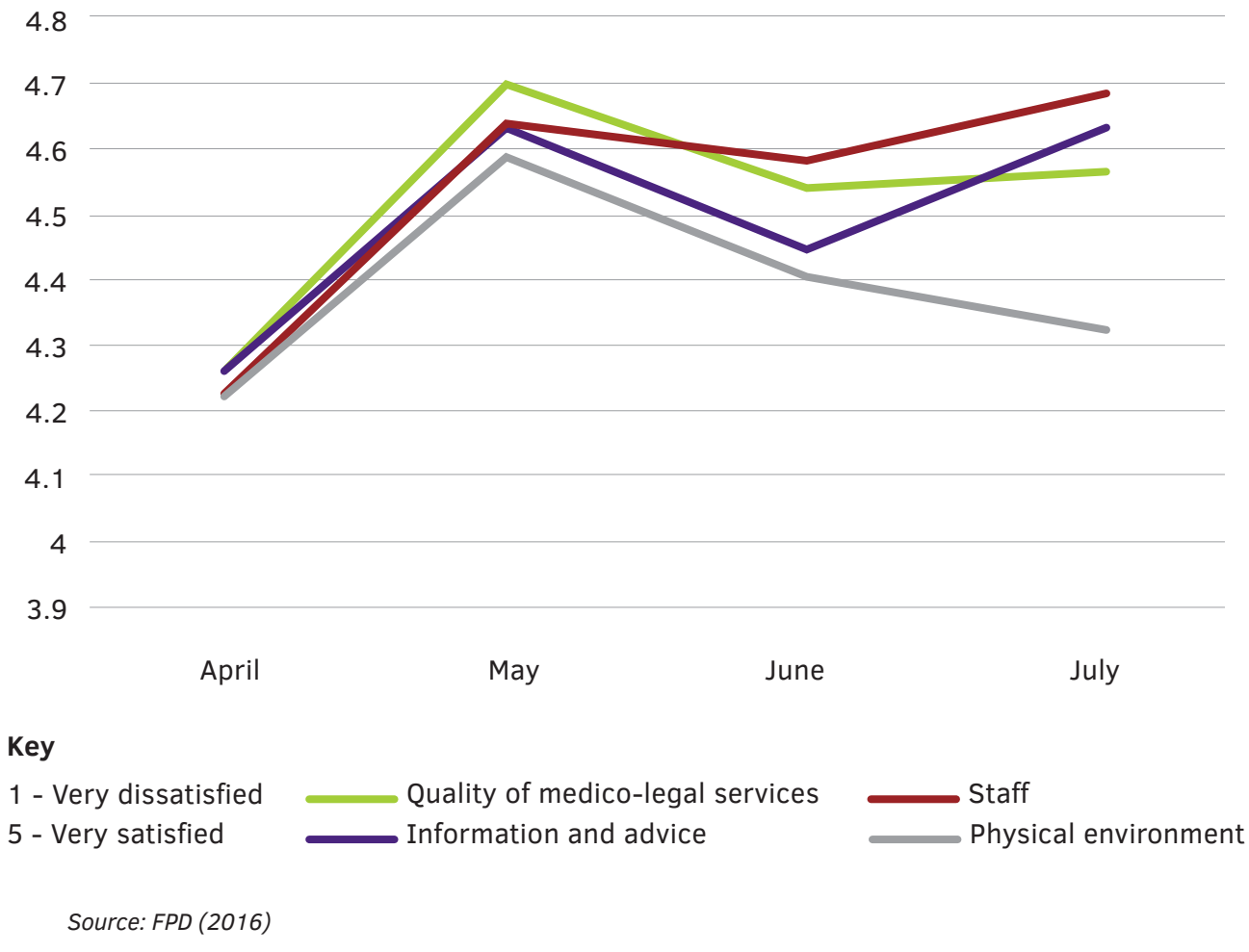
Figure 1. Client experience rating per site



Source: FPD (2016)

An analysis of data from the pilot of the client experience app demonstrates that feedback led to improvements over time in overall client satisfaction (Figure 2). The data from 2016 suggests that staff discussion and reflection on client feedback facilitated by FPD led to improvements in the quality of services, resulting in an increase in citizen satisfaction. In May, there was industrial action by lay counsellors who were the champions of the client experience app, and this had a noticeable impact on the uptake of the client satisfaction app. Following the resolution of the industrial dispute, there was an uptick in client satisfaction. While there was an overall decline in client satisfaction with the physical environment, this could not be remedied by improvements in staff behaviour.

Figure 2. Change in client ratings over time for TCCs / RCCs during 2016 pilot of client experience app



Source: FPD (2016)

A strong recommendation from this project is to increase awareness and knowledge of the types of services that victims should receive at TCCs / RCCs so that they can provide more meaningful feedback through the app.

Contextualising client feedback

Ciana-Marie:

According to the data from the client experience app, clients were generally satisfied with the standard of care at the pilot sites, which had a high average level of satisfaction of 4.63 out of 5. However, these high ratings for TCCs / RCCs were inconsistent with some of the previous lapses in care that were identified in the FGDs and that came through in the written feedback on client experience. This inconsistency suggests that clients may have had low expectations, may have been expecting to be disbelieved or treated poorly, and were surprised by the warmth and professionalism of TCC / RCC staff. Why do you think clients are largely happy with the care received at these centres? And what were some of the frustrations with the current care available?

Nomsa:

I see what you're saying. In most instances victims of sexual violence expect to be blamed and judged. But what's key here is that victims don't know which services should be provided and what the proper standards of care are. They don't know what to expect, so they're ok with whatever services they receive. A strong recommendation from this project is to increase the awareness of and knowledge of types of services that victims should receive at TCCs / RCCs so that they can provide more meaningful feedback through the app.

Suzanne:

In my experience working in public sector health programmes, people don't tend to complain. They think that complaining isn't effective, or that they need the service or that they don't have a right to complain because it's free. There's a vocal minority who complain – the "squeaky wheels". And these squeaky wheels are important: we need to cultivate them, listen to them because they're pointing out lapses in care that need to be addressed. Also, I think if clients have low expectations, but they get into the habit of providing feedback and expressing their voices, they may start demanding better quality services.

Nomsa analysed the client satisfaction data on the "quality of medico-legal services" and "staff" dimensions, and there was a very strong correlation between these dimensions (see Figure 2). Respondents found it hard to distinguish the quality of services received from the individuals giving them those services. I think what people are rating in these dimensions on the app is human engagement, the quality of interpersonal interactions. I see satisfaction as experience versus expected experience.

Timing also plays an important role in the high ratings received by the TCCs / RCCs. The most common entry pathway to the TCCs / RCCs for FGD participants, who are not so different from the average client profile, was through the police. Within hours of encountering the police, they find themselves at centres where staff have been trained and sensitised to deal with victims of sexual violence. For them, the centre staff then seem so great. When going to police stations, it's a real lottery. It depends on who's on duty, and most police officers don't open rape cases every day. At the centres, there is a self-selection that has already happened: people who work at these centres have chosen to do so and are equipped with the right skills, so they fared well on the app. It's important to stress that, in FGDs, clients expressed deep gratitude for and satisfaction with the professional, courteous, caring staff who work at TCCs / RCCs.

In terms of frustrations with the care received, in FGDs where participants were in an environment in which they were encouraged to speak up, it was felt that there was not enough counselling and psycho-social support. They had a desire to talk more about their assault, as their friends and families didn't make them feel comfortable discussing it. People needed a space where it was ok for them to vent, be angry, be upset. There was a huge sense of frustration with the criminal justice process. Participants felt that things were taking way too long, didn't know what was happening with their case and couldn't determine whether the delays were legitimate or not.

Ciana-Marie:

The results of the client experience pilot demonstrated that there were discrepancies in the standard of care among different RCCs / TCCs. The Tshwane RCC had an average rating of 4.85 and the Soshanguve RCC received 4.47 (see Figure 1). What do you think accounted for the variation in ratings? And what do you think can be done to improve quality care across all RCCs / TCCs?

Nomsa:

There were fewer walk-ins in Tshwane RCC. Also the variation in the ratings in Tshwane and Soshanguve is directly related to the availability of resources. In Soshanguve, the RCC is next to other consulting rooms, and there are only two nurses who are constantly roving. The Soshanguve RCC serves several communities, and there are long wait times. In Tshwane, the RCC is situated outside the main building, and there's more privacy and it's a more dignified environment. There's also more staff at the Tshwane TCC – a psychologist who comes in twice a week, a full-time doctor, nurses and lay counsellors. All centres need to be fully resourced to ensure that the same quality of care is received across the board.

Suzanne:

The difference in the results in the Soshanguve RCC and the Tshwane RCC highlight the face validity of the client experience app. Complaints are justified, clients aren't just nit-picking and we can get accurate reliable insight on what's happening on the ground at these centres.

I do think we need to be cautious though about how we go about soliciting feedback from clients. For example, we asked for feedback on satisfaction with the rooms and physical environment, but it's hard to make these changes without additional resources, and the decisions on whether more resources are allocated to the centres don't rest with centre staff. We have to be careful about building up client expectations too much and putting them off from speaking up in future.

Ciana-Marie:

What do you consider to be the key limitations of the research and your findings?

Suzanne:

We're only telling some client stories. The research was conducted with follow-up clients, so we were only hearing the stories of the people who stayed within the system. I think we didn't reach the people with the worst experiences, as there's a lot of drop-off as clients move from one stage in the process to the other. And because we're working with follow-up clients, we're also hearing about client experiences mid-stream, not from their first interaction with service providers.

Based on our research, we also took the decision to measure client satisfaction with different actors (health care staff, NPA, SAPS), but the client experience app was only rolled out at the TCCs / RCCs so naturally most of the feedback pertained to staff at the TCCs / RCCs, and few respondents chose to rate SAPS or the NPA.

With regard to the app itself, a reason why people declined to participate was a lack of time. The app was only available in English, so language and literacy affected uptake.

Nomsa:

Through the FGDs, we collected a lot of data on participants' experiences with the police, but we never got the opportunity or had the platform to present the findings to SAPS. It was a challenge though, as FPD didn't have pre-existing relationships with SAPS.

FPD has a longstanding relationship with the Department of Health. It's a very strong, deep relationship and, like all development relationships, it's sometimes positive and sometimes negative. But it's a real relationship. That initial layer of trust is needed if you want to innovate, push the boundaries.

Getting centre staff to act on client feedback

Ciana-Marie:

Many governance projects that create feedback mechanisms assume that providing feedback on government services would incentivise behaviour change by government officials and institutions, but this doesn't always happen in practice. In your pilot, you worked closely with staff at the centres, and feedback over time did lead to improvements in overall client satisfaction, which presumably was the result of better staff performance. How did you work to get the buy-in of centre staff and the Department of Health? And why do you think that in this instance feedback led to improvements in service delivery and an increase in satisfaction?

Suzanne:

FPD has a longstanding relationship with the Department of Health. It's a very strong, deep relationship and, like all development relationships, it's sometimes positive and sometimes negative. But it's a real relationship. That initial layer of trust is needed if you want to innovate, push the boundaries. It's very important if you want to clean someone's house, you should have been invited to their house before! Buy-in and support at the level of district management certainly helped with implementing the pilot at the centres.

Nomsa:

There was extensive consultation with the NPA and district management staff before we initiated the pilot and, even when I first presented the idea of the project, centre staff were very open to participating. We provided a stipend to lay counsellors who were already volunteering at the centres to champion the client experience app and to show clients how to use it. Centre staff really understood the purpose of these sessions, and they knew that it was not to blame them for poor performance, but rather to highlight strengths and weaknesses relating to service provision. During the pilot, every Friday I analysed data from the app and on Monday I shared information from the client experience app with staff, and these formed the basis of discussions on areas for improvement. Staff were able to get real-time feedback on their work and to learn what mattered to their clients. I think this research and the pilot reinforced the importance of their work, and it underscored the need for them to give the best quality care possible.

Suzanne:

From the very beginning, staff at the centres were fully engaged. At the start, we framed the client experience app as a tool for them to measure themselves. We let them know that we weren't planning to monitor them, we were just offering them a mechanism to understand their own performance. They also knew that both the NPA and Department of Health supported the pilot. How these tools are introduced and how they are perceived by staff ultimately determine their longevity and sustainability.

Evolution of the client experience app: innovation and co-creation

Ciana-Marie:

An area of work that you focus on is tracking a victim of rape's journey from the first contact with a relevant authority to conviction. In order for a victim to receive proper medico-legal assistance, this requires the police and health and justice departments to coordinate with each other effectively. As part of the initial innovation grant, FPD was meant to develop a case management tool to help track survivors of sexual assault through health, justice and psycho-social support services in order to improve coordination and continuity of care and improve access to justice. What happened and how did your approach change?

Suzanne:

Tracking a rape victim's journey through the system requires a multi-sectoral response. The Department of Health, centre staff, the NPA and SAPS know they should be collaborating – but, like many other actors in the sector, they are pressed for time.

In the beginning, we wanted to build a case management app, and we consulted different institutions. Through our conversations with the NPA, the Department of Health and the care centres, we became aware of the real requirements of a case management system, and we quickly realised that we didn't have the funding or the timeframe to do this work any real justice. After discussing the scope and needs of this project with the Making All Voices Count project manager at Hivos, we agreed to separate the client experience app and the case management system. We focused on building the client experience app, and we shared the findings of our scoping exercise on a case management system with the ISSSASA project and the NPA, who took over development.

The case management app has been developed and is currently being trialled in several facilities across the country. The case management app and the client experience app are most powerful when they're used together. The case management app tells you which services clients have or haven't received, so it gives you a better idea of what these clients are actually rating on the client experience app.

Ciana-Marie:

The innovation grant awarded by Making All Voices Count represented an opportunity for you to trial a mechanism of getting feedback on client experience, something which you have never done before. The implementation of the innovation project was slower than expected and there were periods of technical difficulties with the USSD string, which meant that at times client feedback couldn't be captured through the app. What advice would you give to other organisations thinking about developing a mobile application for understanding client experience?

Suzanne:

When we first tried to find an organisation to build the client experience app, we were engaging with external service providers that were giving us high quotes. We'd say what we wanted and they would show us something different and fairly costly. In the end, we went with USSD, and we're happy with our choice of technology, and with the affiliate partner we worked with. The cell phone acceptability survey showed the majority of respondents knew how to use USSD and that clients who had lost their phone during the assault quickly sought to replace it (Mahlalela *et al*. 2017). I'm less happy with the choice of service provider for the USSD chain. In South Africa there's not enough competition.

As relates to advice for other organisations, there's a need for a translator, someone who can build a bridge between programme staff who know the work and what needs to be done, and app designers who see and think in code. In house, we've seen that monitoring and evaluation staff are able to use their strengths to play this role well. Through trial and error, we've developed policies that ensure programme staff are as explicit as possible in communicating their needs and stay closely involved in the design process.

Also, the budget was much smaller than other projects FPD is used to working on, so we were very conservative, and didn't include sufficient staff time in our original innovation budget. If I could start again, I would have hired Nomsa from day one. The project needed a full-time champion to bolster support for the work internally, to manage app development and to push uptake of the app by centre staff.

Nomsa:

The main advice I'd give another organisation trying to develop a USSD platform is for them to engage with the target audience. You need to work with them to define the purpose of the platform and to really try to understand what their needs are.

Suzanne:

Our app development process was protracted because we went about developing the app in a very participatory way. We had formal and informal meetings with key stakeholders throughout the research and innovation process including staff at the TCCs / RCCs, the Department of Health and the NPA. We wanted to know what, from their perspectives and experiences, were the most important drivers of quality post-rape care. We weren't planning to include a dimension on rooms and physical environment, but senior management at the NPA and Department of Health told us that it was important for clients to be in comfortable, safe and private spaces. We conducted a cell phone acceptability survey to see if a USSD application would be an appropriate mechanism for soliciting feedback on RCCs / TCCs. Asking clients to rate interactions with SAPS was not on our radar, but after the FGDs, where clients highlighted how negative some of their experiences with the police truly were, we had to give clients the opportunity to rate the police. We also realised that only asking clients to rate their overall experience of post-rape care was meaningless as they had vastly different experiences with different actors. We then sought advice on survey design from Yowzit,[5] a social enterprise that runs ratings and reviews platforms that's part of the South African Making All Voices Count Community of Practice. We considered including an additional dimension of waiting time, but Yowzit advised us to limit the number of options to prevent drop-off. Nomsa then convened an FGD to test out the app and promotional flyers to make sure the questions were understandable. We had to make sure that the USSD app was structured in a way that clients could make sense of it.

It's important when developing a citizen feedback mechanism to make sure that it's something people want, need and use and not to go ahead and create a tool because donor funding is available.

The challenge of embedding practitioner research in an innovation project

Ciana-Marie:

We've heard from Yowzit, another Making All Voices Count grantee that received a practitioner research and learning grant and an innovation grant, that balancing both can be challenging (see Pegus 2016). How did you manage the demands of both streams of work? And how did they build off each other? And in hindsight would you do anything differently?

5 For more information see: 'Yowzit: Online ratings service for public services in South Africa': www.makingallvoicescount.org/project/yowzit-to-improve-public-service-delivery-in-south-africa/ and 'Connect-Tech: Connecting citizens and government through technology': www.makingallvoicescount.org/project/yowzit-scaling/

Suzanne:

The sequencing of the practitioner research and the innovation was a big challenge. First of all, initially our innovation grant was only for 12 months – that's just not enough time. Several months into the innovation grant we were given the opportunity to embed a practitioner research and learning grant. There wasn't sufficient time for us to build, test and adapt the client experience app in a meaningful way.

Qualitative research is laborious and to go really deep is time consuming. Due to the timeline of the innovation grant, we didn't have enough time to fully analyse the results from the FGDs and our preliminary analysis informed the pilot. It was only after the close out of the grant that Nomsa and I... really had the time to properly tease out all the findings. After poring over the FGD data now, I can see that clients found it difficult to separate their experiences of staff from how they viewed the services offered by those staff, so I wouldn't have separated the two and included both the "quality of services" and "staff" dimensions, which the client experience app later demonstrated were highly correlated (see Figure 2).

In Making All Voices Count, there's a focus on learning and reflection; this isn't a priority for many donors. Many donors don't foster the space to reflect on challenges with implementation, but at the end of the day there's a need for a fixed period of funding, a timeline, a beginning and an end. The timeframe of this learning-focused project didn't allow for multiple iterations of the app – we're sorry that we couldn't take the app through three or four iterations. The potential of the app is huge, but the time to consult, develop, learn through our research, and implement was limited. It's ambitious to expect a partner to conduct research, analyse the findings and use the findings to inform practice in such a short period of time.

Nomsa:

Furthermore, our recruitment of research participants was slow too, and we wish we could have built more time into that part of our project. The recruitment of paper-based survey respondents, which aimed to inform the development of the actual client experience app, took more time than we had initially anticipated for the project. For instance, in a period of four months, which was allocated to pilot the client experience questions on paper-based client experience surveys, we were only able to recruit 140 respondents. Thus the timeframe of the project and the four-month period allocated for piloting paper-based client experience surveys were very limited, and did not allow for significant consultation with target participants. However, we learned that for future workplans it's very important to build in more time for fieldwork, especially for projects with slow recruitment.

Suzanne:

When I reflect back, there are things that could have moved faster, but there are things that really could not, like taking the time to get buy-in from stakeholders that new innovations need. It really did take six months to get the NPA to agree to trial the app in a TCC. In development programmes, especially in the health systems space, we can't really see if interventions are going to yield results in the first year or two. There's a need for faith and patience on the part of donors and implementers that they will see the fruits. In the rush to demonstrate quick results, key foundational steps like building relationships, interest and consensus get deprioritised. The pressure to deliver *now* can be detrimental in the long term.

Ciana-Marie:

As part of this project, Making All Voices Count also provided mentorship from Dr Elizabeth Mills, a qualitative researcher and anthropologist with significant experience in the field of gender-based sexual violence. Nomsa and Suzanne, you both have backgrounds as quantitative researchers in public health. Can you comment on what it was like to work with Beth and what was the added value of an interdisciplinary team?

Suzanne:

Beth was wonderful. She really understands the role of the mentor. She never tried to take the wheel and drive the car. She asked us questions that made us think, helped us plan our next steps. She ensured that we owned our research, and it was really an empowering experience. She helped move the research forward when we were stuck. And pushed us to develop research outputs that we are proud of, which help us give a platform for the voices of the women at the centres who participated in our research.

Nomsa:

I think having a mentor was fantastic. It was a bonus for us in terms of personal development and in terms of the project. I do have a basic background in qualitative research, but I learned a lot. I really believe that having different backgrounds improved our research and enabled us to bring and share different skills.

Managing the tensions between anonymity, visibility and representation

Ciana-Marie:

Protecting the privacy and anonymity of clients, while ensuring that their voices were heard, were key drivers of your research and the development of your client experience app. On the issue of the tension between anonymity, visibility and representation, research funded by Making All Voices Count notes that the "introduction of technology is never straight-forward, predictable or easy" (Ganesh, Deutch and Schulte 2016: 7). Can you tell me about some of the steps you took to encourage clients' free expression of their experiences while trying to protect their identity, both in your research and while building the client experience app? Also, can you comment on how you see the relationship between tech-enabled citizen voice and anonymity?

Suzanne:

In our FGDs, no individual identifiers were sought or recorded and we used a sexual violence expert from Sonke Gender Justice[6] to facilitate so that clients could feel comfortable talking about their experiences. One of the reasons we decided to use a USSD chain for the pilot was because messages do not appear in the outbox of a phone, and the cell phone acceptability survey showed that 24% of respondents shared a cell phone with another person (Mahlalela *et al.* 2017).

Among staff at the centres, results from the client experience app were discussed at the district level. It's a challenge to find the right balance between the detail needed to make feedback actionable and anonymity. FPD could have played the role of the middleman, asking for the names of clients and the centres they used and anonymising the data before we passed it along to the TCCs / RCCs. But we chose not to do this, because we always intended to hand over the management of the app and lapses in care need system-wide responses, so we didn't see the point in naming and shaming a facility. We weren't trying to fix the quality of service for one person, we wanted to fix future services for all clients.

The need for anonymity and privacy is directly informed by the vulnerability of the person you want to hear from. Vulnerability is heightened when the power dynamic is not equal. And in our case there's an imbalance of power between the clients and the institutions to which they are providing feedback. The last thing we'd want to do is to enable further victimisation of people who speak out. We don't publicise individuals who complain; the opposite is true for a platform like Yowzit, which deals with less sensitive matters and so people are proud to speak out in their own name and are rewarded and incentivised to do so.

6 For more information on Sonke Gender Justice, see: www.genderjustice.org.za

The way forward – what's next for FPD?

Ciana-Marie:

Following your pilot, the District of Tshwane now wants to solicit information on the client experience at clinics more broadly, and the District's Primary Health Care Manager has approached you for help. What factors led you to maintain such a productive working relationship with the District of Tshwane? What do you think is driving the district to champion innovation in the health-care sector? And how do you see your relationship with the District of Tshwane evolving?

Suzanne:

We had a great working relationship with the District Manager for the TCCs / RCCs. The feedback coming in from the client experience app was largely positive and didn't unearth painful revelations. She took pride in how well clients rated the TCCs / RCCs in her purview. The broader district health management team was excited by the idea of expanding the USSD client experience app to all clinics in Tshwane in line with key quality assurance standards, but we have no donor funding for the expansion and we're constrained by that.

At the district management level, health-care officials realised that using a client experience app is a viable way of collecting anonymous feedback that can be used to track staff performance and to ensure that the best possible care is being provided. Currently, we're collaborating with the Department of Health to use USSD tech to enable managers to monitor the daily productivity of FPD-hired HIV testing counsellors, as well as FPD-hired doctors and nurses who are working to increase antiretroviral initiations. Later in the year, we hope to help the District of Tshwane to roll out the client experience app in clinics to measure patient satisfaction as part of their yearly plans to implement the Department of Health's Ideal Clinic initiative, which establishes standards on the delivery of health services.[7] I think it's important in future to include a whistle-blowing service too.

Ciana-Marie:

The NPA has agreed for ISSSASA, a network of organisations working on sexual assault, to manage and scale the client experience app at TCCs. This will mean that soliciting feedback from clients will be embedded in post-rape care services. This scale-up project is meant to happen over the course of the next two years (FPD 2016), and this seems like quite a tight timeline. What have you learned from the pilot that you'll be taking forward in the scaling of the app? And what do you think will be the key challenges in scaling the app? What do you think is needed to ensure that ISSSASA is able to carry forward and sustain this work?

Suzanne:

We thought that it was logical to hand over the client experience app to ISSSASA because they work with the NPA to support the TCCs nationally. Under ISSSASA funding, the case management app is being rolled out in a phased approach and it's currently being tested in 16 centres in four provinces. Our USSD client-experience app is being piggy-backed onto the roll-out of the the case management app. However, lay counsellors haven't been directly hired to promote the client experience app, or to help clients use it and explain its purpose. We only handed over the project right before December after an audit of the 53 TCCs was conducted. While clients are still using the app, as far as I know there hasn't been as active a push to encourage people to use the app. Just because it's built, and there's a flyer advertising it, doesn't mean it will be used. And if there isn't a new champion at ISSSASA, pushing staff at the TCCs to promote the app and to reflect and act on feedback, then I fear this incredibly useful tool might end up being a neglected piece of the puzzle. So far, it has been handed over to a collective, and

7 For more information on the Ideal Clinic initiative, see: www.idealclinic.org.za

more ownership and championing is needed. And this is something that Nomsa and I will be following up in 2017.

In the long term, though, the sustainability of this app in the context of the NPA and the Department of Health rests on the ability to mainstream data and reports from the app and incorporate them into their routine management structures.

Client feedback needs to be used to help develop budgets, workplans and interventions.

Nomsa:

I think for ISSSASA to make the app sustainable, they need to work closely with TCC staff to ensure they have bought in to the process and are keen to use it to monitor their own performance.

Key recommendations from the research

- Information should be provided to clients on the standard of care and the types of services they should expect at RCCs / TCCs as per guidelines.
- Champions should be identified and designated at RCCs / TCCs to promote the use of the app.
- A costed national strategic plan on GBV should be developed.
- Donors need to be lobbied to provide more support for work on GBV.
- Police should be sensitised and trained, and awareness raised of the need to provide rapid and supportive escort of victims to RCCs / TCCs.
- Cross-institutional learning and sharing should be promoted among RCCs / TCCs and other service providers.

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About Making All Voices Count

Making All Voices Count is a programme working towards a world in which open, effective and participatory governance is the norm and not the exception. It focuses global attention on creative and cutting-edge solutions to transform the relationship between citizens and their governments. The programme is inspired by and supports the goals of the Open Government Partnership.

Making All Voices Count is supported by the UK aid from the UK Government, the US Agency for International Development (USAID), the Swedish International Development Cooperation Agency (SIDA) and the Omidyar Network, and is implemented by a consortium consisting of Hivos, IDS and Ushahidi.

Research, Evidence and Learning component

The programme's Research, Evidence and Learning component, managed by IDS, contributes to improving performance and practice, and builds an evidence base in the field of citizen voice, government responsiveness, transparency and accountability (T&A) and technology for T&A (Tech4T&A).

About Making All Voices Count Practice Papers

The Research, Evidence and Learning component has produced a series of practitioner research and learning grants to support a range of actors working on citizen voice, T&A and governance to carry out self-critical enquiry into their own experiences and contexts. The main output of each grant is what the practitioner learns and applies to their own practice. Practitioners can also decide to produce their own written outputs. The purpose of the practice paper, written on completion of each grant, is to capture the essence of that learning process through a reflective dialogue between programme staff and funded partners, to share with a wider audience of peer practitioners and policy-makers.

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