HEALTH SECTOR COX'S BAZAR

Accountability to Affected Populations (AAP) Framework

August 2021

Introduction

In December 2011, the IASC Principals endorsed a set of five core Commitments to Accountability to Affected Populations (CAAP) signaling their collective agreement to incorporate the CAAP into the policies and operational guidelines of the respective organizations. The endorsement affirmed to promote these commitments with operational partners, within Humanitarian Country Teams and amongst Cluster members[1]. These commitments touch a range of issues on 1) leadership/governance 2) Transparency 3) Feedback and Complaints 4) Participation and 5) Design, Monitoring and Evaluation as the core strategic elements for building and advancing Accountability to Affected Populations (AAP). The CAAP was later revised in 2017[2]. Locally, the Communication with Communities (CwC) Working Group in Cox's Bazar, Bangladesh developed 'The Accountability to Affected Populations (AAP) Manifesto' in January 2019 strengthening Accountability through Communication and Community Engagement.

This AAP framework for the Health Sector recognizes and builds on the various AAP protocols such as those outlined above. It is intended to serve as a practical guide, providing partners with the initial key actions as a first step towards institutionalization and operationalizations of AAP within the context of health care intervention and ensure that the health response is accountable to the affected people[3] in the health programs/actions. It will embolden capacity to enhance program quality, accountability and community trust through safe, confidential, accessible and dependable channels. It is important to point out that, throughout the guide, specific actions will have to be adapted based on local variables at the camps and community level-not only at health facility level due to the heterogeneous categories of the affected people (patients and their community). This diversity influences the AAP mechanisms along the lines of language, culture, access, gender, and respective needs. Therefore, the full extent of the implementation of the guides outlined in

The Cox's Bazar Health Sector AAP Framework

This framework developed in line with the Global Health Cluster Operational Guidance on AAP. It is meant to serve as aid- memoire for health sector partners to mainstream AAP locally. It does not replace individual organization's mechanisms for mainstreaming AAP including feedback and complaint procedures. It rather reinforces and expand on AAP mechanisms beyond capturing complaints and feedback as a component of their strategies to achieve AAP in health care

Objectives of the HS AAP

1.Outline the core AAP components relevant for the health sectors

2.Provide basic guidance for operationalization of AAP commitments within the Health Sector, in line with the GHC Guidance.

3.Enhance quality of health response

[1] IASC. AAP Operational Framework

[2] Inter-Agency Standing Committee. Policy Commitments on Accountability to Affected People and Protection from Sexual Exploitation and Abuse. Available at: https://interagencystandingcommittee.org/system/files/2020-11/IASC%20Revised%20AAP%20Commitments%20endorsed%20November%202017.pdf

[3] Affected populations should not be understood as a homogenous group, but rather differences among population groups based on sex, age, ethnicity, disability and other social markers of exclusion should be acknowledged. This understanding is important as it shapes the way in which communication messages are designed and communities consulted

this document should be determined based on each partner's internal capacity analysis (SWOT), and perspectives of the specific target groups and community in which the health project is implemented. For more detailed information to guide health partner's specific action planning, other relevant materials such as the IASC Accountability Commitment Analysis Tool, the HAP 2010 Standard in Accountability and Quality Management[4], the Minimum Operating Standards for Protection from Sexual Exploitation and Abuse[5] should be consulted. In addition, the local AAP guide 'The Accountability to Affected Populations (AAP) Manifesto for Cox's Bazar[6] can be reviewed in conjunction with the WHO Health Cluster Operational Guidance on Accountability to Affected Populations (AAP)[7], the Core Humanitarian Standards on Quality and Accountability[8] are vital resources.

To be accountable, the Health Sector need to collectively endeavor to consult -throughout the project cycle- the community they serve or plan to serve. Central to increase AAP in each phase of the project; a safe, confidential and accessible mechanism for a two-way dialogue during all phases of the project cycle is integral and fundamental to realizing AAP. Such mechanism for collecting feedback and complaints promotes provision of feedback and responding to issues as recommended in the Core Humanitarian Standard for Quality and Accountability.

The Global Health Cluster Operational Guidance on AAP[7]

The Health Sector aims to ensure a people centered approach to achieve better health outcomes and improve accountability by placing affected populations at the center of decision-making and at the center of action to promote meaningful access, safety and dignity with a desire to meet humanitarian needs, to systematically reduce those needs, and to increase resilience.

The GHC APP guidance provides key actions in the five areas of accountability (Leadership and Governance, Transparency, Participation, Feedback and Complaint mechanisms; Design, Monitoring, and evaluation) identified by IASC to increase the input of affected populations in responding to and shaping the assistance following a disaster

These actions support people centered approach through all phases of humanitarian program cycles. It is closely aligned to the Core Humanitarian Standards to improve humanitarian response to be more effective and efficient, facilitate AAP and provide mechanisms to implement PSEA.

[4] The 2010 HAP Standard in Accountability and Quality Management. Available at: https://reliefweb.int/report/world/2010-hap-standard-accountability-and-quality-management-enar

[5] Inter-Agency Standing Committee. Minimum Operating Standards for Protection from Sexual Exploitation and Abuse by own personnel (2012). Available at: https://interagencystandingcommittee.org/iasc-task-team-accountability-affected-populations-and-protection-sexual-exploitation-and-abuse/minimum-operating-standards-mos-psea

[6] https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/accountability_manifesto_cwc_wg_20190801.pdf

[7] Health Cluster. Operational Guidance on Accountability to Affected Populations (AAP). August 2017. Available at: https://www.who.int/health-cluster/resources/publications/AAP-tool.pdf?ua=1

[8] https://corehumanitarianstandard.org/files/files/Core%20Humanitarian%20Standard%20-%20English.pdf

Rationale

Like in many humanitarian response and protracted crises globally, the context in which partners deliver health and other programs in Cox's Bazar is dynamic, requiring timely decisions to adjust activities and remain appropriate and relevant. In Cox's Bazar, the acute phase of the humanitarian response (including health sector response) following the dramatic influx from Myanmar in August 2017 may have been chaotic with reasonable accounts-given the magnitude and capacity at the time. However, more than 3 years on, it is imperative that in addition to current improvement in leadership, coordination and infrastructure; health actors aim to improve quality and effectiveness by meaningfully engaging with the communities. A study that attempted to assess AAP in Cox's Bazar revealed pertinent issues summarized below.

A study by Christian Aid (2018) described current accountability systems in Cox's Bazar as largely ineffective with a large dependence on complaint boxes and phone lines for feedback and complaint. Yet, communities had the least preference and lowest level of trust in these mechanisms therefore rendering them redundant. To the contrary, people appear to prefer face-to-face communication such as verbal or voice recording. Less than 25% of the people, according to the report, were aware of the feedback and complaint mechanisms in their areas. Though it has significant limitations, the Majhi system ranked well in preference partly because it is the primary known system[9]. Overall, women were disproportionately ranked poorly in their access, utilization and awareness of these mechanisms. These observations have not changed significantly overtime.

A recent study explored the thoughts of refugees about the services they receive. A Focused Group Discussion and Key Informant Interview elicited a mixture of trust issues in health care providers, perceived poor quality of health care and communication breakdown. For instance, people felt they received the wrong medicine or medicine that did not solve their problems, poor medical consultations, behavior of doctors in clinical care. Lack of explanation from doctors on these issues compounded negative perceptions and mistrust[10]. These are issues that may arise out of misperception, lack of communication which should underpin the client interaction with the health systems.

Many protracted crises are increasingly facing funding challenges[11] with further deteriorating humanitarian conditions. As outlined in the Grand Bargain, actors are required to improve the use and availability of data to inform prioritization of needs and choice of intervention to achieve efficiency and effectiveness of the response. Integrating AAP mechanisms within the project cycle will avail ways to systematically identify community concerns and perspective that is required for prioritization to create efficiency, achieve quality and set in motion progressive accountability. Through AAP, partners may benefit from increased program quality, assurance of program relevance that reduces health vulnerability, increased resilience through disaster and emergency preparedness, and doesn't not harm the people.

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[9] Christian Aid et al. Accountability Assessment Rohingya Response Bangladesh. Available at: https://www.christianaid.org.uk/sites/default/files/2018-03/Response-Accountability-Assessment-Feb-2018.pdf

[10] ACAPS/IOM. Añárar Báfana/Our Thoughts-Rohingya share their experiences and recommendations. Available at: https://www.acaps.org/sites/acaps/files/key-documents/files/20210427_acaps_npm_cxb_iom_anarar_bafana_our_thoughts_summary.pdf

[11] Barney Tallack. 5 existential funding challenges for large INGOs. (July 2020). Available at: https://reliefweb.int/sites/reliefweb.int/files/resources/5%20existential%20funding%20challenges%20for%20large%20INGOs%20_%20Bond.pdf

If as a service provider we do not know the needs, priorities and issues that affected people face, how can we effectively address their issues? This question is a practical emphasis on the relevance of an effective AAP mechanism including two-way communication with the people that are targeted for assistance. AAP should not be viewed as additional work[12] but a practical expression of the commitments we make to the people we serve.

To remain accountable, the appropriate participation of the affected people in all phases of the project through a two-way communication is important through sustained transparent community engagement. The Health Sector Coordination is committed to offer Technical Guidance and support to its partners to establish a response with strong and robust accountability systems in the sector to hold stakeholders accountable to their commitments, to the quality of health services we provide, and the conduct of our health workers and staff supporting health care delivery. By providing affected communities with mechanisms for direct communication with an organization about the health actions; we provide a safe avenue for the most vulnerable members of a community to communicate their needs, provide input, raise protection concerns, reveal coping strategies, and give feedback. On the other end, as health service providers, we can harness this as an opportunity to transparently respond to concerns, sensitize and mitigate risks from misinformation. As a result, both parties can gain a common understanding on expectations, roles, capacity, decision making to increase trust. The AAP is organized to facilitate an institution's decision-making process for effective programming, quality and accountability.

[12] https://emergency.unhcr.org/entry/42554/accountability-to-affected-people-aap

General processes to achieve AAP.

AAP is not a distinct concept about morality, but rather part and parcel of effective and efficient programming that leads to program quality. UNHCR defines AAP as a commitment to the intentional and systematic inclusion of the expressed needs, concerns, capacities, and views of persons of concern in their diversity; and being answerable for [the] organizational decisions and staff actions, in all protection, assistance and solutions interventions and programmes[13]. The key components of AAP are closely linked and build on each other and feed into other community-based engagement approaches. As outlined in the revised CAAP and PSEA[14]policy; Leadership, Participation and Partnership; Information, feedback and Action, Result measurement are the core tenets that deserve attention in the project cycle to achieve APP. The key actions listed in this framework draws on the key guidance and commitments from the CAAP and other materials already described above. The actions are organized around the various phases of the project cycle. For accountability, programs require systems to collect, record and transmit expressed needs, recognize capacity and desires of the community.

Key AAP Components: Applies through all the phases of the Humanitarian Program Cycle.

Participation and Inclusion: Everyone is meaningfully engaged and consulted on assistance

- People are aware of the rights- display patient rights at facility, sensitize community on rights
- Establish means for continuous participation during assessment, planning, implementation, monitoring, evaluation
- Documented community consultations to inform decisions
- Formal meetings with community collect feedback, provide response, participate in decision making, etc.

Communication and Transparency: Everyone has access to timely, accurate and relevant information on their roles, entitlement, rights and mechanisms to provide feedback and complaint

- Share information in local language- waiting times, process and procedures at facility,
- Share information updates on programs and assessment with community representative
- Inform community in available systems for complaint and feedback including contacts
- Inform community on staff conduct and expectations, channels for reporting complaints

Feedback and response Mechanism: Establish mechanisms to systematically collect and respond to feedback (formal, informal) and ensure corrective action

- Actively receive, record, analyze and respond to feedback and complaint
- Establish context appropriate (safe, accessible, trusted) Community Based Feedback and Response mechanism
- Clear procedures for handling PSEA

Design, Monitoring and Learning: P**rogram prioritization, design, implementation and modifications are informed based on continuous views of the affected people**

- Include community feedback in program design and planning
- Program monitoring data includes both quantitative and qualitative data
- Include community feedback in evaluation exercise
- Provide resources for feedback collection and analysis

[13] UNHCR, Operational Guidance on AAP, Sept 2020

[14] https://interagencystandingcommittee.org/system/files/2020-11/IASC%20Revised%20AAP%20Commitments%20endorsed%20November%202017.pdf

Fig 1: Schematic presentation of AAP actions in the project cycle- Adapted from IASC AAP Framework.

Table 1: Summary of potential AAP actions in the project cycle and guidance notes Adapted from IASC AAP Framework

Phase of Project Cycle	Key Action	Guidance Notes	Suggested Indicators
Throughout the Project Cycle:	System wide learning and establishing means of mainstreaming and verification	At an organizational level, actors should aim at mainstreaming AAP into appropriate organizational systems. Notably, policies and staff development process should include awareness and responsibilities to promote AAP. Relevant actions include health worker training and support supervision on AAP mainstreaming	Organization level AAP training plan. Number of staff trained in AAP Organization Policy documents, agreements, job descriptions,

	Systematically document good practices		procurement contracts, partnership agreements, etc. contain references/guidance to promote AAP
	Systematically communicate with affected populations using relevant feedback and communication mechanisms	Collaborate with existing multi-agency/multi-sector communication mechanisms e.g., the CwC staff/volunteers at camp level to receive, respond or relay feedback about health care. Within the catchment area, ensure that people from host communities and camps are aware of humanitarian Codes of Conduct and how to raise concerns about violations e.g. develop key messages disseminated through IEC materials, health committees, CHWs, posters, etc. Partners to consult with community on acceptable, accessible and relevant mechanism for collecting feedback and complains. The choice of the mechanism e.g., suggestion boxes, complaint box, FGD, use of telephones, questionnaire, face-to-face discussions, communication through trusted channels such religious leaders must be discussed and decided by communities.	Evidence of health facility leaders/in charges coordinating with CwC, camp-based coordination to receive and provide response to feedback Number of awareness sessions related to AAP at the community level conducted by Health Sector partners
Before assessment	Ensure that accountability to affected populations is effectively integrated within	Train assessment teams on relevant AAP aspects and ensure that there I adequate resources and plan for AAP in scheduled health needs assessment.	Assessment planning meeting/notes outlining AAP intentions in community mobilization

	systems for planning needs assessment and response	Ensure all segments of the community (including the most vulnerable, gender) is equitably represented and prepared to participate in health needs assessment through appropriate community engagement strategies-assessment tools translated in local languages, adequate considerations to local culture and social norms, safety, community representative informed the planned assessments.	
Health needs assessment	Ensure that AAP is effectively integrated within needs assessment methodology, including joint needs assessments	To ensure health care assistance is appropriate and relevant to the affected people to the best extent possible, health needs and access concerns must be identified through assessments that are coordinated amongst sectors and partners to avoid burdening communities with multiple assessments.[15] The assessment exercise should include all vulnerable groups including vulnerable group including women, girls, people with disabilities, and the elderly, and promote equitable participation of these various groups in needs assessment. Assess community communication needs and channels to provide feedback and receive response	Notes describing how respective vulnerable groups were identified, involved in the health needs assessment
Project design or response planning	Ensure that accountability to affected populations is effectively integrated within	When designing health programs, ensure complaints and response mechanisms are planned for considering local input. The inclusion of such mechanisms during project design will secure	AAP mechanism identified during project design and planning and an AAP action plan

[15] Sphere Standard. Core Commitment on Humanitarian Standards for Quality and Accountability-Commitment #1:

	systems for project design and planning	the resources and set the strategy for its roll out during project implementation. Donors recognize the significance of mainstreaming AAP through appropriate strategies Ensure that health actions address the priorities of the community determined during the need's assessment Plan to deliver health care in a timely and effective manner. For example, ensure waiting time is reasonable for each service and clients are duly informed of the expected waiting times, clients are aware of the triage systems and aware of the facility-based mechanism for feedback and complaint	developed/integrated
Implementation:	Ensure that accountability to affected populations is effectively integrated throughout the implementation of projects	Based on findings from community communication need assessment, establish appropriate and relevant complaint, feedback and response mechanisms to facilitate two-way communication in a safe, accessible and acceptable channel[16]. Partners can leverage on existing CwC initiatives within the camps and adapt health programming to improve quality. At the HF or service delivery points, actors to keep a log of feedback and complaints received, response actions. Support the community to know the roles, rights[17] and responsibilities regarding health care. Education on affected people's rights in humanitarian	Evidence of complaint and feedback collection channel at health facility, community center Record of complaints received and responded with action and follow notes Availability of trained staff responsible for AAP at a health facility or network of health facilities

[16] Sphere Standard. Core Commitment on Humanitarian Standards for Quality and Accountability-Commitment #5:
[17] Sphere Standard. Core Commitment on Humanitarian Standards for Quality and Accountability-Commitment #4:

		assistance is a main component of accountability efforts in the humanitarian response. Awareness of individual rights and entitlement is an essential precondition for holding responders accountable-AAP. For instance, at the health facility post in local language-patient rights; during health education, sensitize the clients on their rights, roles, and mechanism for providing feedback and complaint. In the health sector, the CHW is an important resource in creating awareness about the AAP mechanism. Knowledge about the mechanism predates their utilization. Where existing, health committees can be trained to facilitate collection of feedback and provide response appropriately (considering the type of issue and their capacity). Partners can explore community confidence and role of Health Committees in ensuring community perspective is represented into the health programs cycle.	
During service delivery:	Ensure that accountability to affected populations is effectively integrated in at health care service points	Where distribution of commodities is considered e.g., Mama kit, hygiene kits, nutrition supplies; inform communities in advance of the items to be distributed, eligibility criteria, purpose, composition, mechanisms to complain or provide feedback about the items Plan for Post Distribution Monitoring to understand	

		utilization, relevance, and consumer concerns to adapt the composition appropriately. Train health personnel, including midwives on AAP, including how to listen and provide safe, voluntary quality care services – as part of human rights - to clients, including pregnant women and anyone who wishes to access family planning services.	
During monitoring:	Ensure that accountability to affected populations is effectively integrated throughout the implementation of projects	Conduct internal learning sessions e.g., periodic project performance review aimed at aligning select program activities to address emerging concerns from the community Coordinates with individual MEAL units and quality assurance focal points to ensure perspective of affected people are included in overall program monitoring. For instance, monitoring exercise should include representatives from all relevant groups of affected people, conduct patient exit interviews, etc. Review and analyze complaints and feedback received from established complaint, feedback and response mechanisms. Conduct health quality monitoring, partners conduct self-assessment and reflections to adjust programing based on monitoring results.	

Monitoring Framework

Selected/Sample indicators

	Indicator	Comments
1	Proportion/Number of Health facilities that has a SOP for collection, recording, analyzing and responding/referring feedback at facility or organization level	Measured at the Health Sector level, through Quarterly HF monitoring exercise
2	Number/proportion of organizations that has conducted initial AAP self-assessment	Partners should conduct an internal AAP assessment to inform organization/facility-based approach to AAP. The Health Sector will periodically assess this process starting 3-months after
3	Proportion of HF with a translator to facilitate communication with Rohingya speaking patients	
4	Number of community meetings, FGD, Community dialogue, etc	
5	Number of mechanisms existent for CBFRM	
6	Availability of Patient's Rights displayed in local language at HF	
7	Availability of appropriate mechanisms for CBFRM (SOP, feedback log/register/data base)	Each facility should consult communities in the catchment area to determine the preferred CBRFM
8	Number/proportion of health facilities that conduct client exit Interviews	Each facility can set its target and frequency of client exit interview

Annex 1:

Health Cluster (WHO). Operational Guidance on Accountability to Affected Populations.

IASC. Tools to Assist in Implementing the IASC AAP Commitments