Health Clusters and Accountability to Affected Populations

Summary of feedback from Health Cluster Coordination teams working to ensure accountability to affected populations
Contents

Rationale..........................................................................................................................................................5
Purpose .............................................................................................................................................................5
Methodology.....................................................................................................................................................5
Summary analysis of strengths and weaknesses ...............................................................................................6
Key Recommendations .......................................................................................................................................7
Feedback from the survey ....................................................................................................................................8

1. Is your cluster pro-actively encouraging participation of national and local nongovernmental organizations and community-based organizations, MoH and DoHs....8
2. Regarding use of input from local entities and partners to inform and strengthen responses included:...........................................................................................................................................8
3. Increasing awareness of Health Cluster Partners on AAP, gender, protection and diversity.................................................................................................................................................9
4. Regarding how to ensure AAP, gender, protection and diversity issues are appropriately incorporated into the Health Cluster preparedness plan responses:..........................................................10
5. Regarding organised consultations with communities at risk to identify common cultural practices or preferences which would inform / affect relevant and effective emergency health response activities responses included:..................................................................................................................................12
6. Regarding how assessments use participatory methodologies and assessment tools where possible responses included:..........................................................................................................................12
7. Regarding how to ensure that Sex and Age Disaggregated Data (SADD) is routinely collected, analysed and used to set a health baseline, ensuring that age related data is appropriately nuanced responses included:..................................................................................................................................15
8. Have you undertaken community consultation to feed into development of the Health Cluster plan, e.g. the establishment of mechanisms that facilitate feedback and complaints in a sensitive manner so that all groups feel comfortable to engage and the establishment of appropriate health services that meet the needs to all groups?..................................................................................................................17
9. Regarding collaboration with other clusters to establish common multi-cluster accountability initiatives where appropriate responses included:...............................................................................................................17
10. Regarding communication back to the community on how these community engagement and feedback / complaints mechanisms are working and ensuring communities are informed on action that has been taken by the cluster in response to complaints and feedback from affected population(s) responses included:.........................................................................................................................19
11. Do you perform the Health Cluster Performance Monitoring (CCPM) exercise with involvement of national NGOs and community consultation to review collective strengths and weaknesses against AAP, gender, protection and diversity targets – to guide adjustments/ improvements?........................................................................................................................................19
12. Regarding how to ensure that adequate resources for implementing AAP, gender, protection and diversity related actions are incorporated into Health Cluster partner project budgets responses included:.......................................................................................................................20
13. Regarding how to ensure CBOs (Community Based Operations) and community members are included in Health Cluster performance evaluations including IASC Operational Peer Reviews (OPRs) responses included: ......................................................... 22

14. Regarding how to ensure that learning from the Health Cluster evaluation is extracted and built into the next phase of the health response responses included: .............. 22

15. Regarding how to give weight to the views of different affected populations when they conflict and how to weigh these views, responses included: ............................................ 23

16. How Clusters would like to be better supported in AAP work: .................................. 23

17. What is an example that most strongly illustrates your commitment to the accountability of affected populations? Examples may include the establishment of community feedback mechanisms, the organization of meetings with community leaders, the inclusion of individuals from affected populations in the development of strategies. Responses included: .................................................................................................................. 23

18. What were the key improvements to the work of the Health Cluster that occurred as a result of this project? Responses included: ................................................................................................. 25
Rationale

The operational guidance on accountability to affected populations (AAP)\(^1\) was designed by the Global Health Cluster. Its purpose is to assist Health Cluster Coordination Teams in leading, with cluster partners, emergency responses that have strong and robust accountability systems, through which affected populations can increasingly influence the type, delivery and quality of assistance they receive. The formulation process of the guidance involved cluster partners, Country Health Clusters, members of WHO and focal points. Their feedback, comments and concerns were addressed in the document. To accomplish the aim of the tool, it was shared among the Country Clusters, Coordinators, co-coordinators and team leads.

The tool was disseminated through the Health Cluster Coordinators, Co-coordinators and partners: in some cases, recognizing and systematizing the actions that were already conducted towards the improvement of AAP; in some other cases implementing a new element in the action of the clusters.

The tool is designed according to the five phases of the Humanitarian Programme Cycle and its aim is to implement Health Cluster activities for each phase of the cycle and improve participation of affected populations.

Purpose

To capture and share experiences when leading, with cluster partners, emergency responses that have strong and robust accountability systems, through which affected populations can increasingly influence the type, delivery and quality of assistance they receive.

Methodology

A survey was developed based on the Health Cluster Operational Guidance on Accountability to Affected Populations (AAP) and circulated to Health Cluster Coordinators and Co-Coordinators in 24 countries. Questions were largely open-ended allowing for individual input rather than only yes/no responses. Respondents were also asked for specific examples of effective strategies and provided with opportunity to identify further help desired. (Annex 1 Health Cluster AAP Tool

\(^1\) Reference: Health Cluster AAP Tool

(\url{http://www.who.int/health-cluster/resources/publications/AAP-tool/en/})
AAP Survey). The survey was completed by 66% of the Health clusters: 62.5% of the respondents were Health Cluster coordinators while 4.2% were Co-coordinators from 16 cluster countries.

Summary analysis of strengths and weaknesses

The survey results indicate a clear awareness of AAP and a commitment to achieving such accountability from the Health Cluster Coordinators, but there was also a clear recognition that more can be done to improve accountability. This survey is an initial attempt to recognize the work done so far towards the implementation of the operational guidance on AAP.

In each response, there was evidence of the need to involve affected populations in the processes and practices around responses to health needs, particularly in situations of crisis and extreme need. There was awareness of the need to identify the sectors within affected populations determined by gender, age, ability and other relevant descriptors for each situation.

Encouragingly, many respondents indicated that AAP was being mainstreamed with representatives of the affected populations being involved in ongoing planning and implementation. The issue would seem to be becoming integral to operations and attitudes of health providers and partners. Although some specific examples are highlighted, no specific numbers are given to measure community engagement during the whole humanitarian cycle.

Some strategies include ensuring representation in meetings and consultations and involvement in preparation of country programmes, setting of priorities and involvement in trainings and seminars. Community leaders are being consulted with appropriate strategies to enable their contribution to decision making. Governments are being encouraged to recognise the need for accountability to a diverse range of sectors within affected populations. Representatives are being encouraged and enabled to participate in the preparation of project proposals and to identify structures and processes whereby they can hold accountable those with resources and decision-making power. Communication structures and networks are developing in many cases. There is evidence of inter-cluster cooperation.

Roles and relationships with governments differ between countries and each reality must be acknowledged and accommodated when encouraging further

---

2 Central African Republic (CAR); Chad; Democratic Republic of Congo (DRC); Fiji (Pacific alliance covering 22 countries); Iraq; Jordan; Mali; Mauritania; Myanmar; Niger; Nigeria; Nigeria (both coordinator and co-coordinator responded the survey); Pakistan; Sudan; Yemen.
steps for AAP. Government priorities may be different from those perceived by health cluster partners. In the Pacific for example, there is a sense that the Government is not too concerned with AAP. There remains the ongoing need to maximise resources especially by ensuring exchange of information and best practice such as the perceived positive impact of data centres. When situations arise of competing priorities there needs to be a resource or guidance to help countries set priorities when working with diverse sectors to find just solutions particularly regarding allocation of resources.

Respondents have been clear in identifying their needs. These must be taken seriously, and country specific recommendations considered. There is evidence of efforts towards the implementation of AAP strategies.

**Key Recommendations**

(i) There is an ongoing need for training for coordinators and key personnel about the rationale and suggested processes to achieve AAP.
   - This should include support for in-country training which has to be carried out with partners, including government representatives.

(ii) Build capacities of personnel and offices by ensuring availability of existing e-learning and access to a range of new seminars and workshops.

(iii) Develop and distribute advocacy materials and key messages for expanded AAP.

(iv) Develop communications strategies for exchange of best practices which may be of use to other situations.

(v) Develop, pilot, share suggestions for workable mechanisms to establish platforms and organize meetings with the representatives of affected populations.

(vi) Circulate best practices and Standard Operating Procedures (SOP) for establishing complaints and feedback from beneficiaries, providing tips regarding responding to feedback.

(vii) Develop, share strategies for solving problems around differing priorities and respective needs of populations.

(viii) Develop system to collect data from the AAP components in the projects and make it measurable and specific about numbers.
Feedback from the survey

1. Is your cluster pro-actively encouraging participation of national and local nongovernmental organizations and community-based organizations, MoH and DoHs.

Thirteen HCCs reported that they are pro-actively encouraging participation of national and local nongovernmental organizations and community-based organizations, MoH and DoHs. This was achieved by:

- Encouraging local partners to act as implementing partners for UN agencies.
- Involving them in the field activities through the national NGOs consortium.
- Invitations for health sector meetings, workshops, training arranged by health sector.
- Encouraging them to come forward and support affected population
- Engaging them in the funding proposal process for country pool funds
- When deployed to an emergency, advocating for inclusion of relevant INGOs and LNGOs in health sector response coordination.
- Developing integrated approaches for AAP in the context of health emergencies to support health workers establishing processes for engagement with local populations.
- Organizing bilateral and group meetings with organizations which are reluctant to participate.
- Sending follow up calls or emails to organizations absent from cluster meetings.
- Participating in meetings called or held by health cluster members.
- Attending meetings of organizations’ management teams to sensitize them or advocate for participation.
- Where relevant (and resource permitting), holding bi-lingual meetings.

2. Regarding use of input from local entities and partners to inform and strengthen responses included:

- During the Mosul/Anbar and Hawija operations, local partners were encouraged to operate in hard to reach areas.
- Communities and local NGOS are being involved in implementation of activities.
- During the coordination meetings where possible all local and international partners are enabled to give their updates, sharing knowledge of gaps and who can fill them - WHO is the last resort.
- In the Pacific, NGOs and CBOs engage around specific activities such as communication with affected communities, RH, etc.
- Information regarding health issues and gaps from all partners working in field is shared and used.
- Partners participate in field assessments.
- Partners share input on their activities for health sector bulletin, 4W etc.
- There are meetings with partners to understand their capacity and existing relationships with Government/MOH and to engage them in response planning and implementation. If they are already engaged, meetings review the strategies, actualise information on potential risks, make comprehensive analysis of overriding problems, establish common objectives, set clearly defined targets.

- Inputs are used for situation analysis, needs assessment, gap analysis, response monitoring and coordination.

- The inputs from the local organizations and partners are used to improve the geographic coverage of the humanitarian health assistance and ensure access to remote and inaccessible areas by international NGOs, to assist in planning and appropriate response.

- There is advocacy to international NGOs to collaborate and coach national NGOs.


Thirteen of the HCCs responded when asked if their cluster is increasing awareness of Health Cluster Partners on AAP, gender, protection and diversity through briefings, orientations and trainings. 50% of the respondents (8 coordinators) answered “yes” they were, and 33% (five of them) answered that they do not specifically do anything to increase awareness among partners. Of the training provided, it was mentioned that this was both formal and informal training such as:

- IASC focal points providing Gender Based Violence (GBV) trainings for all partners.

- Requesting international expertise to facilitate gender mainstreaming in program management of cluster partners - coordinated with the GBV sub cluster and protection cluster.

- Coordinating with ICRC and Protection cluster to give orientation of International Humanitarian Law (IHL) and Humanitarian principles respectively.

- A validation workshop on Sector/Cluster Coordination Performance Monitoring (CCPM) where AAP was discussed.

- All training sessions involved national and international NGOs.

- Training on prevention of some diseases, disease surveillance, cholera response, health promotion, how to organize health committees, better community engagement, encouraging community participation through participatory monitoring approaches. There are different types and levels of trainings, including some for hard to reach teams on quality of health service
- delivery, diseases surveillance, cholera response, reproductive health, nutrition, mental health organized by WHO and Health Cluster Partners.
- These trainings include key gender aspects of training topics which include clinical management of impact of raping, anti-natal care, postnatal care, treatment of severe acute malnutrition cases. Equal opportunity is provided to female health care providers to participate in the training sessions. In some security compromised areas, the participation of female staff is very low as only men can work in such tough terrains and security compromised areas.
- There are a few examples of the trainings conducted in Nigeria:
- Trainings conducted for WHO supported Hard to Reach teams: 10
- Participants trained: 264 – 102 Female representing only 38%, 164 are men represents 61%, reason very high security risk areas only men staff can work.

4. Regarding how to ensure AAP, gender, protection and diversity issues are appropriately incorporated into the Health Cluster preparedness plan responses included:

- In Iraq all clusters had to incorporate protection, GBV, into their programmatic plan. This was incorporated in the Mosul as well as in Humanitarian Response Plan (HRP) 2018 training of health cluster partners on gender and protection during workshops and monthly meetings. Iraq health cluster works with the inter sector coordination with UNFPA, UNHCR, UNICEF and INGO. Unfortunately, there is one specific limitation in that the justice systems do not allow survivors to complain.
- These issues are not only in preparedness plan but in all project proposals, health sector/cluster strategy and other health cluster documents in Iraq.
- Currently, there is a process of developing Scenario-based Health Sector/Cluster Contingency Plan in Sudan, ensuring that AAP, gender, protection and diversity issues are addressed appropriately.
- Several countries are updating their national preparedness plans and these themes are included in some, but not systematically in all. There is a section on AAP, gender and protection in the Health Cluster Response Plan and all partners were trained on those issues.
- The Health Cluster Preparedness Plan for Iraq ensured AAP, health protection and diversity are incorporated.

Concrete changes to the Health Cluster preparedness plan responses included:

- During 2018 the Mental Health Psychosocial Support (MHPSS) intervention is one of the main focus areas, for which the MHPSS for women and girls has been further strengthened with support from Co-lead partners like IMC and IOM. They will strengthen the protection and psychosocial services mainstreaming in addition to clinical mental health services. The individuals
who are not covered by government social protection are among the target beneficiaries of the health cluster under the HRP 2018.

- The OCHA supported Internally Displaced Persons (IDP) call centre in addition to the two-way feedback mechanism implemented by partners serve as an accountability mechanism for affected and vulnerable population.

- Protection and gender are taken into account in the preparedness plan and all projects from health cluster partners. Currently trying to be involved with UNDP which has a staff dedicated for gender justice issues.

- Opening up existing humanitarian information systems with affected communities and other local actors.

- Increased number of organizations deploying dedicated resources for communications with affected communities and staff capacity at field level in humanitarian emergencies.

- Documentation of established feedback mechanisms and of complaints and response mechanisms.

- Ensuring that means of communication are appropriate and tailored to local circumstances so affected populations have the opportunity to register complaints, provide feedback and to get a response.

- Developing one strengthened coordination and collaboration system with a wide range of partners, but not specifically around incorporation of AAP, gender or protection.

- A section on AAP, gender and protection has been included in the Health cluster response plan ensuring that the affected population participation in planning and their needs are adequately reflected in HPC and all individuals affected have access to the health services.

- Using Gencap checklist to capture all the issues related to AAP and other themes.
5. Regarding organised consultations with communities at risk to identify common cultural practices or preferences which would inform / affect relevant and effective emergency health response activities responses included:

If yes, how have you used this information to ensure responses are underpinned by an understanding of the affected population?

- Invite representatives of local community to participate in the assessment.
- Allow for separate and confidential discussions with different community groups (including gender and age disaggregated groups).
- Design and implement feedback mechanisms in consultation with local communities and inform all stakeholders how they function.
- Share findings of assessment within the cluster, humanitarian community and with affected communities and local authorities.
- Include findings in the plan for continuity of the basic health services in the refugee camp and in the host community.
- Use sensitive cultural information to tailor interventions and monitoring (disaggregated data). Issues such as ethnic groups in community conflicts, languages in communication, specific vulnerabilities.

6. Regarding how assessments use participatory methodologies and assessment tools where possible responses included:
If yes, how do you ensure that the assessment practice accommodates the limitations/special requirements of these groups?

- The quality of care is being assessed during 2018. One of the components is patient satisfaction, which facilitates accountability to the affected population.
- Health cluster is also part of the assessment working group and has provided feedback in terms of indicators and questions to be used in the nationwide Maternal and Neonatal Care assessment, the result of which will feed into the HNO/HRP 2019. This assessment includes specific questions for special groups and targets patients and health workers. The last assessment included men, women and children, enquiring about their satisfaction with the specific treatment received. The current assessment focuses on technical competence, patient care, infection prevention, communication skills, problem solving, etc. The first phase of the assessment was conducted in August 2018 and was done to create a baseline so partners can conduct their self-assessment and improve on the results obtained in the baseline survey. The results of the August survey were not shared with the wider audience however, another assessment is planned for December 2018, the results of which shall be shared with all. Indicators related to Women of Child-Bearing Age (WCBA) and children were provided to REACH in order to assess some aspects of their health and psychosocial needs.
- Design and implement feedback mechanisms in consultation with local communities and inform all stakeholders how these can function as part of review and assessment of actions undertaken.
- Guidelines or Terms of Reference (ToRs) for those undertaking the assessment note relevant requirements.
- Assessment report outlines information gained from affected communities.
- Reaching out to all community groups – gaining an understanding of community leadership and dynamics.
- Creating an environment where people/groups can speak openly
- The most recent assessment was done to guarantee basic health services to the refugees based on previous models.
- Focus groups for women, youth, aged people and at-risk communities are organized separately
- Rapid assessments and other relevant surveys indicate the extent and nature of involvement of specific groups – and gaps where these exist.

If yes, how has this assessment approach prevented particular vulnerable groups being overlooked?
- Currently these assessments are in progress and the results will indicate how the previously overlooked people have been reached.
- Not as such but it is still difficult to reach population living in inaccessible or security risk areas.
- By not discussing with particular vulnerable groups in the presence of other groups.
- By taking into considerations the views and needs from the communities.

If yes, what existing capacities and gaps have you identified?
- Gaps have been identified in the service provision particularly in IDP camps and technical feedback is provided to the partner supporting that facility in order to address the identified issues
- Community feedback and engagement of community volunteers helped a lot in identifying gaps and also areas not covered by the ongoing response.
- Existing capacities: infrastructures, logistics, human resources
- Gaps have been identified in the provision of trainings of health professionals, EWARS.
- Capacities and gaps vary from one group to another depending on the context. Most often, women and aged people have less resilience capacity
- Need of more experienced data manager and analytical platform to support the implementation and analysis of such assessments.
7. Regarding how to ensure that Sex and Age Disaggregated Data (SADD) is routinely collected, analysed and used to set a health baseline, ensuring that age related data is appropriately nuanced responses included:

- The individual needs of men, women, boys and girls were identified based on the SADD along with feedback from camp management and protection. These needs were then addressed in the most appropriate manner based on the Iraqi context.
- The response is based on the relevant population identified on monthly basis through 4/5 WEWARS system line listing of cholera outbreaks.
- In the Pacific, the data is collected and managed solely by Ministries of Health. Health cluster is really a surge support function for all of the Ministries/Department of Health. There are 22 Ministries/Departments of Health in the Pacific. Different MOHs use different assessment/reporting tools. Most collect/use SADD, but the cluster has not mapped this out for each country/territory.
- By helping to identify specific needs and gaps in the response for each Sex and Age groups, SADD data is helpful in developing plans and ensuring that the needs of all age groups and gender are well addressed.

If yes, what specific changes have you made to your response in order to meet specific needs in light of the disaggregated data?
- Currently there has been no major change to meet specific needs in line with SADD. We simply follow the humanitarian principles of emergency response.
- During measles epidemic, a vaccination campaign was organized for children under 5 because they are most vulnerable.
- Asked teams to share sex and age disaggregated data for line listing - cholera, measles etc. It helped the planners to plan women centered programs. For example, in the line listing of cholera cases where SADD reports this data it can help other actors like UNFPA or other agencies working on reproductive health who can use the SADD for designing their interventions for pregnant or lactating women and similarly nutrition and food security sectors can give more attention and priority to female patients suffering from cholera or other chronic diseases.

- In different health operations, the SADD is reported. Starting from Humanitarian Needs Overview (HNO) and HRP the SADD is mentioned for the planning of the health response. Nutrition component of WHO collects SADD data. Partners also report SADD through 5W. Mental health program also report SADD for the referral cases which they refer to the federal Neuro Psychiatric hospital. MHPSS working group working under health sector also collects data from partners working for MHPSS services.

- Sensitization messages are designed to promote access to health services or intervention to women, girls, boys and men. Certain activities only target children under 5-years-old, pregnant women and lactating women.

- The specific needs of women of child bearing age, pregnant women or children at different age groups, elderly etc are highlighted and plans made accordingly to address their needs.
8. Have you undertaken community consultation to feed into development of the Health Cluster plan, e.g. the establishment of mechanisms that facilitate feedback and complaints in a sensitive manner so that all groups feel comfortable to engage and the establishment of appropriate health services that meet the needs to all groups?

<table>
<thead>
<tr>
<th>Yes (5)</th>
<th>N/A (5)</th>
<th>No (7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>41%</td>
<td>30%</td>
<td>29%</td>
</tr>
</tbody>
</table>

9. Regarding collaboration with other clusters to establish common multi-cluster accountability initiatives where appropriate responses included:

62.5% of the respondents reported that they did collaborate with other clusters:
- Feedback received from protection, camp management, IDP call centre and civil military forums helped assist cluster partners in identifying and promptly addressing the needs and gaps as they arose.
- During 2018, the health cluster will participate in the Community Resource Centres (run by the Governorate Return Committees (GRCs) whose function is to provide information to returnees and local residents on the services being delivered by both government and humanitarian partners.
- The health cluster is also coordinating with the Real Time Accountability Partnership mechanism to investigate and address violations of IHL and humanitarian principles including clinical management of Clinical Management of Rape (CMR)/ Gender based violence (GBV) this has facilitated and reinforced the implementation of relevant projects.
- The protection sector is collecting data and the aim is sharing with health and other relevant sectors specially with Water Sanitation Hygiene (WASH), Nutrition and Camp Coordination and Camp Management (CCCM). Food
Security & Livelihoods, Protection Cluster, Education, Recovery, Return & Reintegration (RRR) clusters
- Clusters and partners established baselines and targets for the six components in the AAP framework and then defined cluster actions to support partners to reach the commitments through inter-cluster coordination group.

What are the specific needs this enabled you to successfully accommodate?
During Mosul operation, faced with incidents where the affected group (women and children) were not able to receive health services due to IS actions, health cluster was informed by protection cluster to provide services for this group, which was successfully done. People with chronic illness and those who required elective surgeries were referred to secondary health facilities out of the governorate where they received free of charge services.

Improved capacity on advocacy.
- We are hopeful this will inform about the trend of different diseases in different age groups yet it is too early to be sure of the efficacy of the strategy. There are specific needs to address WASH, Nutrition and Protection related issues and working with sector coordinators and partners, in addition to health sector partners including Sexual Reproductive Health (SRH) partners.
- Recognizing community priorities do not always include health, and that in some cases offering health services without addressing lack of food and water can be problematic and even dangerous.
- The need for more field missions to monitor and evaluate the implementation of partners’ projects.
- Lack of multi-cluster accountability initiatives.
10. Regarding communication back to the community on how these community engagement and feedback / complaints mechanisms are working and ensuring communities are informed on action that has been taken by the cluster in response to complaints and feedback from affected population(s) responses included:

37.5% of the respondents reported that they do communicate back to the community and this helped improved community engagement through:

- The IDP call centre has been the main platform for two-way communication with the affected population, both in-terms of their needs and response provided by cluster partners.
- Health messages were distributed to IDPs through CHW (Community Health Workers) IOM to prevent/manage communicable diseases, chemical exposure, rodent control (snakes/Scorpions).
- During cholera response engagement of community elders, Bulamas, religious leaders helped in better sensitization and awareness on cholera-related risks.
- Through the Supportive Supervision mission to health sector partners engaging the communities, in close collaboration with OCHA.
- Community members and leaders are more involved in monitoring and evaluation.
- The health cluster partners (some) have health committees where complaints are discussed, addressed and feedback given.

11. Do you perform the Health Cluster Performance Monitoring (CCPM) exercise with involvement of national NGOs and community consultation to review collective strengths and weaknesses against AAP, gender, protection and diversity targets – to guide adjustments/ improvements?

- 31% of the respondents reported “yes” they do.
12. Regarding how to ensure that adequate resources for implementing AAP, gender, protection and diversity related actions are incorporated into Health Cluster partner project budgets responses included:

- GBV and protection mainstreaming and accountability to affected population are compulsory components to be included in every health project.
- AAP is a mandatory component in different project proposals for different donors like NHF, CERF, ECHO. In these proposals risk communication and social mobilization is the key pillar for the outbreak response specifically cholera outbreak in our operations here in NE Nigeria. Partners plan their activities for containment of cholera outbreak and further prevention of infection through strong community engagement and social sensitization. Funds are allocated in donor proposals for WHO, UNICEF, and other partners. Social mobilization and risk communication teams closely work with the surveillance teams to identify cholera hotspots, dissemination of health and hygiene messages and better community engagement through meetings, group discussion with community elders, Bulamas etc. Community elders are engaged.
- Community engagement is part of risk communication and social mobilization in most of the project funding proposals.
- These are addressed during the on-line project submission stage in by the health sector/cluster partners. Subsequently, the projects in OPS were evaluated and approved by sector/cluster coordinator and also during reviewing the proposals that are submitted by health sector partners to secure funds through Sudan Humanitarian Funds (SHF) etc.
- We had made a global plan and partners mobilise resources, as well as WHO.
- Recommendations are made to partners to incorporate budget lines to support the implementation of AAP, gender, protection and diversity related actions.
- Specific guidelines will be prepared to guide the health partners to include budget in the projects.
Regarding how has this enabled partners and communities to carry out activities that strengthen and maintain community capacities and resources responses included:

- Partners were required to adhere to the initial project planning which included these components. Health cluster and OCHA monitoring missions ensure that these interventions are adequately incorporated in their project implementation.

- By strengthening advocacy on resources mobilization particularly when responding to the cholera outbreak prevention and control.

- The approved 2018 SHF project implementations are ongoing and 2017 projects showed that the activities definitely strengthen local capacity. The SHF funds are mainly meant to be accessed by partners, especially, by International and National NGOs. The ISCG (sector coordinators are part of this) decided to implement multi-sectoral projects i.e. health sector with other sectors such as nutrition, WASH, Protection. For health sector, it is also mandatory to engage national NGOs in planning and implementation, in addition to engaging the Federal and State Ministry of Health during planning process. Health sector/cluster partners are also encouraged to engage target communities as well.

- AAP, gender, protection and diversity related actions are gradually increasing in the field. Monthly meetings with community leaders (including representatives of women and youth) share information about the implementation of projects and receive the complaints and observations of the beneficiaries. Initially women were not consulted and involved in project monitoring and evaluation. This approach helps to empower women and better design the project to target the needs of women, girls, boys and men.

- Recruitment of girls and women for community-based activities (disease surveillance, malaria care, communication, mosquito nets distribution) The proportion of women among community health workers has increased from about 10% to 30%. Partners are encouraging recruitment of at least 30% of their community health workers among women.
13. Regarding how to ensure CBOs (Community Based Operations) and community members are included in Health Cluster performance evaluations including IASC Operational Peer Reviews (OPRs) responses included:

- Organizing a workshop on the topic and share the document or the link with partners.
- They are part of the CCCPM process and also participate in different online surveys launched by cluster.
- CBOs are included in the process of heath cluster/sector performance evaluation, engaging during the planning stage.
- They are involved at all the phases of the process.
- The representatives of the community and some CBOs can be involved in evaluations and reviews by having focus group discussion or individual interview.
- Inviting CBOs to health cluster performance evaluations.
- Encouraging hub leads/co-leads to do so.

14. Regarding how to ensure that learning from the Health Cluster evaluation is extracted and built into the next phase of the health response responses included:

- The identified gaps and Lessons Learnt from the health cluster performance evaluation were used in developing the HRP to improve performance.
- This a continuous process, including lessons learned from last year are part of the review process with operational review as well as HNO and HRP for the next year.
- In the context of the New Ways of Working (NWOW) and Humanitarian Development and Peace Nexus (HDPN) in Sudan, the Health Sector/Cluster is focusing on health sector Prevention, Preparedness, Response and Recovery in line with Disaster Risk Management (DRM) for Health. The awareness of AAP is increasing although still to be fully realised.
- No formal process, as clusters are nationally led. Regional HCC can offer suggestions to Ministries of Health.
- A feedback of the Health Cluster evaluation is shared with all cluster members and used to develop the health sector response plan, and the follow up by the strategic advisory group.
- By collating the best practices from CCPM and sharing with all the HCCs.
- Learning from health cluster evaluation is integrated into health cluster strategy.
15. Regarding how to give weight to the views of different affected populations when they conflict and how to weigh these views, responses included:

- Responses were mostly based on the information provided by the protection cluster. These events were then further investigated and were addressed where the cluster could respond.
- Maintain dialogue with all partners.
- The conflict so far was between refugees and host community. In the evaluation, we met with representatives of both communities. What the host community claimed was found legitimate. They asked to have adequate basic health structures with the same quality as the refugees. Agencies agreed on providing it. Adaptation has been made to provide free drugs to the host population, to strengthen technical capacities of health professional staff working in the host community and increase staff number with partners’ funds in the public structures.
- Weight the views of different affected populations and those of the agencies at equally (50%).
- In conflict situations the affected population could have different views. The needs of all the groups or parties should be assessed and an impartial, neutral and independent position should be taken while planning a response and delivering services. The views against the agencies should be addressed positively and impartiality should be ensured.

16. How Clusters would like to be better supported in AAP work.

- GHC could provide us with updated SOPs and guidelines and HR on AAP.
- Build capacities through e-learning or within workshops.
- More training and sensitization sessions with partners- specific training on AAP.
- Develop more advocacy materials and key messages.
- Sharing material, trainings, finding strategies and processes to improve staff mobility, regular TC, reviewing our productions.
- By setting up a functional mechanism for complaints and feedback, and to involve the beneficiaries in all phases of a project.
- Providing guidance notes on implementation.

17. What is an example that most strongly illustrates your commitment to the accountability of affected populations? Examples may include the establishment of community feedback mechanisms, the organization of meetings with community leaders, the inclusion of individuals from affected populations in the development of strategies. Responses included:

- ISIS afflicted families were provided with medical care: it is estimated that approximately 500 people (women and children) of different nationalities received attention. They are supposedly affiliated to ISIS and were brought into Hammam Al Alil Camp during Eid holiday. Health Cluster was able to
coordinate with one of the cluster partners (Dary NGO) to provide a female physician to give them attention, although this was difficult for her due to language barriers.

- A mentally unstable female was referred for further treatment. This was a case of a woman who was mentally unstable as a result of having been allegedly raped by the security of the camp and was much talked about at the time. She was apparently having a lot of partners in the camp including IDPs and security men. She had to be transferred to a psychiatric hospital in Baghdad by a partner (IHAO) for treatment and (as we were told) to keep her safe from the society.

- Unaccompanied children in need of medical care were treated and were referred to protection cluster to reunite them with families. In fact, Cluster and CCCM both have regular presence in the refugee camps and were involved in giving attention to children as well as with unaccompanied children, GBV survivors, etc.

- The participation of communities in the preparation of the HRP. Sub cluster had some consultations with communities in the field and then made a consolidated report.

- Community engagement during outbreak cholera response for better prevention and control of outbreak.

- Organization of meetings with community leaders and inviting individuals from affected populations.

- In Papua New Guinea (earthquake), we aimed to localize response coordination to the Provincial level (PHEOCs) and conducted community assessments (meetings) to capture community priorities/needs, often finding that health was not a primary concern.

- The process is quite new in Mauritania. However, we are working now on the community-based surveillance with participation of the refugee community. Some meetings have been organized with community leaders to know their view and their needs in the new health system being put in place.

- During the last cholera outbreak in 2016, community based surveillance and social mobilization activities were set up in 4 at high risk villages in Ndjoukou health district. Prior to the design of the project, a meeting was organized with community leaders to inform them and select CHW who will be trained to implement the project. Some community leaders were provided with cell phones to give complaints and receive feedback actions or orientations from the project manager (WHO staff), the HCC and the EOC coordinator.

- A few NGOs have developed complaint and feedback mechanisms, while a few NGOs also conduct focus group discussion with the affected population that feeds into the projects.

- This is not widely implemented practice in Yemen due to insecurity and access issues.

- Inclusion of volunteers from affected population in implementation of the health activities.
- Working with the humanitarian working groups in North East Syria, who in turn work with communities in their project implementation.

18. What were the key improvements to the work of the Health Cluster that occurred as a result of this project? Responses included:

- The cluster demonstrated to the partners the value of neutrality and impartiality in addressing the needs of all vulnerable population groups irrespective of ethnic differences.
- The needs of communities had been taken into account.
- It resulted in one of the best examples of cholera outbreak control through active community engagement efforts and interventions.
- The Monitoring and Reporting/Supportive Supervision visits definitely improved the work of the health sector/cluster in Sudan.
- Integration of health/WASH/food response in Papua New Guinea to ensure that community priorities were accounted for (i.e. food over health).
- A common plan for the health sector.
- Discussions on partnership for activities.
- The activities of the CHW were easily monitored even in a remote-control area.
- Feedback was provided to community leaders and the project was implemented with successful results.
- Improved community mobilization in immunization.

How did it strengthen your ‘taking account’ of key populations i.e. giving people the opportunity to influence decisions which need to be made at different phases of the Humanitarian Programme Cycle, taking into account the diversity of the community and the views and opinions of the most vulnerable being equally weighed and considered? Responses included:

- In most incidents, the people whose needs were addressed were not in a position to influence decisions, given that they were discriminated against in some manner. Therefore, it was of prime importance to provide them with services as per the perceived need at that point in time.
- This kind of work facilitated the choice of the area of intervention and assisted with engaging the population in decision making regarding where to put focus.
- Working fully with the partners directly involved.
- So far, the decision has been made by the Government but there seems to be a change in approach to take more account of AAP.
- It gave the opportunity to community leaders to see what the CHW were doing and helped to better plan the response and monitor and evaluate the project.
- Unfortunately, AAP is still more theoretical, and its implementation is slow and has many challenges.
How did it strengthen your ‘giving account’ to key populations i.e. providing information to the community throughout the HPC and outlining what plans and commitments are and how and why decisions were made and what the process was? Responses included:

- The partners serving these population groups were asked to offer the services to them as per need, as well as to provide them as much information as possible on what to expect, for e.g., where they would be referred, what services they would receive, etc.
- It helped to provide information and receive feedback from the community during all the phases of the project.
- The NGOs (few) involve the community in HPC. The community needs assessments are done before HNO.

How did it strengthen your ‘being held to account’? i.e. giving affected people an opportunity to assess the quality of the response of an agency and how relevant activities have been, to assess how these activities have been implemented and to provide feedback on how well the activities have been addressing their needs? Responses included:

- During regular operations of the emergency response, two-way feedback mechanisms were in place such as FGDs, Complaint Box, etc. so that partners providing services to the affected people (mainly IDPs) were aware of whether/not their interventions were in line with the needs of the people. Where gaps were identified, corrective measures, such as tailoring the services according to the needs, were implemented.
- Involving them in all the assessment phases.
- Working fully with the partners directly involved.
- An ongoing built-in process at different levels.

In what ways would you alter this example you have cited as useful in order to more effectively improve accountability to affected populations? Responses included:

- We do not see a big area to make change to the measures implemented. However, any updated guidelines/SOPs provided by the Global Health Cluster are very welcome to help us to further streamline our interventions.
- To continue to strengthen capacity of health cluster on AAP to improve their capacities to involve community better than before.
- Working fully with the partners directly involved.
- Develop a regular mechanism through establishing a platform and organize meetings with the representatives of affected populations.
- AAP is not generally viewed as an urgent gap in the Pacific. Community feedback mechanisms are generally in place and strong, and because of small populations and mostly small-scale emergencies, issues/gaps tend to be
identified and addressed quickly/easily, with space for local NGOs and CBOs to engage and vocalize their priorities. In the new plan for continuity in the provision of basic health, an advisory board is established. Its role is to verify in future that all population needs are taken into account based on their specific characteristics.

- By involving increasingly community members in decisions making
- Guidance in Arabic languages.
- Improve knowledge by training from GHC.