HEALTH CLUSTER

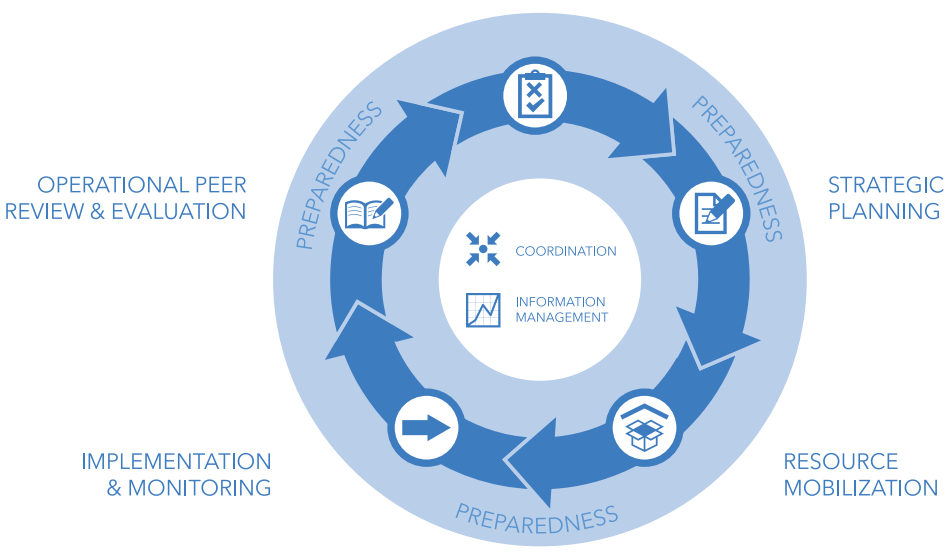
# Operational Guidance on Accountability to Affected Populations (AAP)

August 2017

## Objective of the guidance

This practical guidance is designed 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 guidance is organised according to the phases of the Humanitarian Programme Cycle (HPC), describing the relevant Core Humanitarian Standards (CHS), with proposed Health Cluster focussed activities under each phase, for how participation from affected populations can be improved. Standard indicators selected from the Inter-Agency Committee (IASC) AAP Toolkit[1], are proposed to measure how well these activities are implemented. Each section provides an example of good practice, which can be used by Health Cluster Coordination Teams to lead in designing country specific AAP plans in the cluster.




## Introduction

The Health Cluster aims to ensure a people centred approach to achieve better health outcomes and improve accountability by placing affected populations at the centre of decision-making and at the centre 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. This approach ensures awareness of the different needs and capacities of women, girls, boys and men of all ages, people with disabilities, and other diverse characteristics. Such awareness informs what we do, how we do it and with whom. Building on our collective experience and through these actions, we endeavour to better protect and improve the lives and health of those affected by crises worldwide.

In 2011, the humanitarian system was reformed leading to the Transformative Agenda. The three main pillars of the Transformative Agenda are;

- Empowered Leadership
- Coordination
- Accountability to Affected Populations

To support this reform, an 'Operational Framework for Accountability to Affected Populations' was developed by the Inter Agency Standing Committee (IASC) to assist implementing agencies both individually and in groups to find practical entry points for improving accountability to affected populations.

In December 2011, the IASC Principals endorsed the following five commitments:

## Leaders of humanitarian organizations[2] will undertake to:

**1 Leadership/Governance:**
Demonstrate their commitment to accountability to affected populations by ensuring feedback and accountability mechanisms are integrated into country strategies, programme proposals, monitoring and evaluations, recruitment, staff inductions, trainings and performance management, partnership agreements, and highlighted in reporting.

**2 Transparency:**
Provide accessible and timely information to affected populations on organizational procedures, structures and processes that affect them to ensure that they can make informed decisions and choices, and facilitate a dialogue between an organisation and its affected populations over information provision.

**3 Feedback and complaints:**
Actively seek the views of affected populations to improve policy and practice in programming, ensuring that feedback and complaints mechanisms are streamlined, appropriate and robust enough to deal with (communicate, receive, process, respond to and learn from) complaints about breaches in policy and stakeholder dissatisfaction.

**4 Participation:**
Enable affected populations to play an active role in the decisionmaking processes that affect them through the establishment of clear guidelines and practices to engage them appropriately and ensure that the most marginalised and affected are represented and have influence.

**5 Design, monitoring and evaluation:**
Design, monitor and evaluate the goals and objectives of programmes with the involvement of affected populations, feeding learning back into the organisation on an ongoing basis and reporting on the results of the process. (IASC, 2012)

These five areas of accountability focus on downward accountability and aim to increase the input of affected populations in responding to and shaping the assistance following a disaster.

AAP puts the affected persons and their needs at the heart of the emergency response, often referred to as people-centred approach. Rather than seeing the community as a homogeneous entity, AAP takes into account the needs and the capacities of different groups in the community; women, men, girls, boys, elderly, people with chronic medical problems, people with mental health problems, etc. The different needs and capacities of all these groups will shape the response plan and how cluster partners and affected populations interact through all the phases of the Humanitarian Programme Cycle (HPC).

AAP is divided into three dimensions of accountability;

- **Taking account;** giving people the opportunity to influence decisions which need to be made at different phases of the HPC, taking into account the diversity of the community and the views and opinions of the most vulnerable being equally weighed and considered. Vulnerability analysis being conducted to include universal factors such as sex and age and other issues such as ethnicity, religion, disability and race which have enormous influence on a person's visibility, opportunities and power. This means actors should go to the community to solicit opinions and thoughts from a broad spectrum of women, girls, boys and men of different age groups. It is not a passive exercise, where agencies might expect the population to give an opinion if they so desire. This assumes that everyone has the same freedom of expression which we know to be untrue.

- **Giving account;** refers to actors 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. It includes what beneficiary selection criteria are, how these were agreed, but also what programmatic objectives are and how these were set.

- **Being held to account;** allows 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.

All of these dimensions should be informed by a gender and an age analysis, because people's visibility, voice, opportunities and constraints are very much affected by their sex and age. Assessments that involve all segments of the affected communities across gender, age, disability and diversity are essential to enhance the Health Cluster knowledge base and to inform programme decision making. Targeted vulnerability analysis will assist in tailoring activities to location-specific considerations (including security and access), community mobilization and the presence of partners.

[1] *IASC 2012, Accountability to Affected Populations, Tools to assist in implementing the IASC APP Commitments. IASC*

[2] *Excepting the Red Cross and Red Crescent movement, who have their own commitments in place*

Data should be disaggregated by sex and age as a minimum. As appropriate, each indicator should be further disaggregated by pregnant and lactating women, people living with HIV, disability, diversity, geographic areas. The more disaggregated the data, the more useful it is for identifying the most vulnerable people.

### Prevention of Sexual Exploitation and Abuse (PSEA)

Upholding and promoting policies on Sexual Exploitation and Abuse (SEA) is critical in all operations in all countries.

"Sexual exploitation and abuse violates universally recognized international legal norms and standards. WHO staff and collaborators shall work and behave in beneficiary countries in a manner that respects and fosters the rights of the people they serve. For this reason, and because there is often an inherent and important power differential in the interactions between WHO staff and collaborators and the most vulnerable populations in the beneficiary countries, particularly so in emergency settings, staff must be vigilant and rigorously refrain from any action that may suggest or imply that a sexual act may be demanded as a condition for protection, material assistance or service.[1]"

The WHO Policy on the Prevention of Harassment provides mechanisms to prevent sexual exploitation and abuse from happening from the outset by defining the conduct expected from WHO staff and collaborators, and to react and sanction it at any point. An act of sexual exploitation and/or abuse is serious misconduct and must be immediately reported to WHO whether it involves directly a WHO staff member or collaborator, another staff member of a UN agency or has been witnessed or otherwise brought to the attention of a WHO staff member, collaborator or UN partner[2].

[1] *The WHO Code of Ethics and Professional Conduct: http://www.who.int/about/ethics/en/#principles*

[2] *WHO Policy on the Prevention of Harassment: https://intranet.who.int/homes/ios/documents/policy%20of%20the%20prevention%20of%20harassment%20at%20who-sept2010.pdf*

## Core Humanitarian Standards (CHS)

During the World Humanitarian Summit in 2016 many organisations, including governments, donors and NGOs committed to the nine Core Humanitarian Standards (CHS). The CHS set out guidelines on how organisations and individual humanitarian aid workers can improve humanitarian aid and make it more effective and efficient. The Standards further facilitate accountability to affected populations and provide mechanisms to implement Prevention of Sexual Exploitation and Abuse (PSEA).

When affected populations participate, influence and actively engage in the emergency response, activities and services will be better tailored to the needs of the population and are likely to be better accessed and better support sustainability in the long term. When committing to AAP, organisations commit to use and manage the power and resources they have in a responsible and ethical way (CHS Alliance, 2014).

| CORE HUMANITARIAN STANDARD | | QUALITY CRITERION |
|---|---|---|
| **CHS1** | Communities and people affected by crisis receive assistance appropriate and relevant to their needs. | Humanitarian response is appropriate and relevant. |
| **CHS2** | Communities and people affected by crisis have access to the humanitarian assistance they need at the right time. | Humanitarian response is effective and timely. |
| **CHS3** | Communities and people affected by crisis are not negatively affected and are more prepared, resilient and less at-risk as a result of humanitarian action. | Humanitarian response strengthens local capacities and avoids negative effects. |
| **CHS4** | Communities and people affected by crisis know their rights and entitlements, have access to information and participate in decisions that affect them. | Humanitarian response is based on communication, participation and feedback. |
| **CHS5** | Communities and people affected by crisis have access to safe and responsive mechanisms to handle complaints. | Complaints are welcomed and addressed. |
| **CHS6** | Communities and people affected by crisis receive coordinated, complementary assistance. | Humanitarian response is coordinated and complementary. |
| **CHS7** | Communities and people affected by crisis can expect delivery of improved assistance as organisations learn from experience and reflection. | Humanitarian actors continuously learn and improve. |
| **CHS8** | Communities and people affected by crisis receive the assistance they require from competent and well-managed staff and volunteers. | Staff are supported to do their job effectively, and are treated fairly and equitably. |
| **CHS9** | Communities and people affected by crisis can expect that the organisations assisting them are managing resources effectively, efficiently and ethically. | Resources are managed and used responsibly for their intended purpose. |

### List of acronyms

| | |
|---|---|
| AAP | Accountability to Affected Populations |
| AP | Affected people |
| CC | Cluster Coordinator |
| CHS | Core Humanitarian Standards |
| CLA | Cluster Lead Agency |
| CCPM | Cluster Coordination Performance Monitoring |
| GBV | Gender Based Violence |
| GHC | Global Health Cluster |
| HCC | Health Cluster Coordinator |
| HCCT | Health Cluster Coordinator Team |
| HCP | Health Cluster Partners |
| HCT | Humanitarian Country Team |
| HPC | Humanitarian Programme Cycle |
| HRP | Humanitarian Response Plan |
| IASC | Inter-Agency Standing Committee |
| ICC | Inter Cluster Coordination |
| ICCG | Inter Cluster Coordination Group |
| IMO | Information Management Officer |
| INGO | International Non-Governmental Organization |
| MIRA | Multi Cluster Initial Rapid Assessment |
| NGO | Non-Governmental Organization |
| OCHA | Office for the Coordination of Humanitarian Affairs |
| SADD | Sex and Age Disaggregated Data |
| SAG | Strategic Advisory Group |
| SOP | Standard Operating Procedure |
| TT | Task Team |
| TWG | Technical working group |
| WG | Working Group |
| WHO | World Health Organization |

# Coordination actions
## to support a people-centred approach

## All Core Humanitarian Standards apply
**(CHS1-CHS9)**

**Coordination**
"The principal objective of international humanitarian action, and the purpose of coordination, is to meet the needs of affected people by means that are reliable, effective, inclusive, and respect humanitarian principles."
(https://www.humanitarianresponse.info/system/files/documents/files/cluster_coordination_reference_module_2015_final.pdf).

| Action | Responsibility | Indicators | Rationale |
|---|---|---|---|
| Pro-actively encourage national and local NGOs and CBOs to participate in the Health Cluster | HCC & HCP | There is an organisation policy or equivalent guiding the practice of communityParticipation (IASC 4.1.1.). | Appropriate responses will be strengthened by input from local entities and partners from a broad participation and membership in clusters. |
| Organise Health Cluster meetings in consideration of issues which impact national and local NGO and CBO engagement – location, interpretation needs, translation of materials, etc. | HCC | All interest groups have a voice, including women, children, the aged, minority cultural groups and people living with disabilities (IASC 4.1.2). | Attendance at meetings is regular and productive. |
| Consult with specialised agencies and available focal points to ensure AAP, gender, protection and diversity issues are appropriately addressed by Health Cluster, including prevention of sexual exploitation and abuse (PSEA) | HCC | | Informed expert input to plans and implementation of responses and AAP can help address diverse sectors specific needs that require specialised knowledge. |
| Identify experts within Health Cluster and facilitate these individuals to take on leadership role for the relevant aspects within the Health Cluster. | HCC | The organisation collaborates with other stakeholders, such as peer agencies, clusters, partners and local authorities, government social protection and gender machineries to fulfil this commitment (IASC 2.5.2.). Including stakeholders working on evelopment issues. | Diverse sectors with specific needs for information on AAP etc, that is specific to their sectoral/cluster needs, often require specialised knowledge from outside their 'normal' group of actors. This knowledge once adapted and articulated, must be shared. |
| Consider / explore options to engage specialist staff to work collectively with partners on supporting a people centred approach through standby partners or secondments from specialised agencies. | HCC | | |
| Establish a TWG to support the Health Cluster to implement a people centred approach – mainstreaming AAP, gender, protection and diversity into the emergency health response. | HCC | | |
| Increase awareness of Health Cluster Partners on AAP, gender, protection and diversity through briefings, orientations & trainings. | HCC with support from specialised agencies / expert focal points | Staff and partners are confident that information flows effectively between representatives and the people they represent (IASC 4.1.5). | The diverse needs of affected populations require demonstrable skill and capacity of partners through trainings, workshops and regular briefings. Zero tolerance for SEA and meeting the AAP commitments requires that all actors responding to a crisis are aware of what they need to do and what the affected communities need to do. |
| Build a shared vision among Health Cluster Partners on what it means to provide an emergency health response that ensures the safe and equal access to quality health services and accountability to affected populations, women, girls, boys and men of different age groups (including giving, taking and being accountable). | HCC with support from specialised agencies / expert focal points | The organisation has a policy for implementing and monitoring its commitment to the five Principles of Partnership[3], highlighting mutual respect, transparency, consultation, results orientation, skills and capacity to deliver on commitments, prevention of corruption and abuse, complementarity and supporting local capacity (IASC 6.1.1) | AAP is not a single entity issue. All partners have documented and taken seriously the needs of diverse populations in planning and programming. Equally the required expertise to address AAP, gender, protection and diversity issues may not fall within the remit of the cluster, therefore the HCC and cluster staff should know who to does what and where on these issues in country. |

[3] *https://www.icvanetwork.org/principles-partnership-statement-commitment*

# Coordination actions
## to support a people-centred approach

## All Core Humanitarian Standards apply
**(CHS1-CHS9)**

| Action | Responsibility | Indicators | Rationale |
|---|---|---|---|
| Ensure AAP, gender, protection and diversity issues are appropriately referenced in all Health Cluster documents. | HCC | • Community participation takes place during needs assessment and programme planning (IASC 4.1.3).<br>• Community participation takes place during programme planning where possible, implementation, distribution and service delivery phases (IASC 4.1.4).<br>• Community participation takes place during monitoring and evaluation (IASC 4.1.5). | The importance of AAP must be reflected in policy and practice. All partners have documented and taken seriously the needs of diverse populations in planning and programming. |
| Regularly review AAP, gender, protection and diversity issues in Health Cluster meetings:<br>i. Discuss key issues around community engagement, identify challenges and barriers to community engagement/participation – discuss potential solutions and identify & share best practice to enhance representative participation of the community<br>ii. Discuss key issues emerging from complaints and feedback mechanisms, and identify collective solutions for the Health Cluster, as possible based on consultation with women, girls, boys and men in the affected population; and track progress on addressing complaints<br>iii. Discuss key issues in terms of meeting needs of various and diverse groups in communities, women, men, girls, boys, older population, people with disability, and other specific groups at risk of discrimination or who are particularly vulnerable - identify challenges – discuss potential solutions and identify & share best practice<br>iv. Invite relevant speakers to attend Health Cluster meetings to stimulate debate and discussion on AAP, gender, protection and diversity – including experts and representatives of women, girls, boys and men from the communities we are assisting. | HCC with support from specialised agencies / expert focal points | • The organisation [or cluster] has a policy for implementing and monitoring its commitment to the five Principles of Partnership[4], highlighting mutual respect, transparency, consultation, results orientation, skills and capacity to deliver on commitments, prevention of corruption and abuse, complementarity and supporting local capacity (IASC 6.11).<br>• Staff ensure that, whenever possible, community members and interest groups have a chance to speak free of the presence of those who might purposefully or inadvertently prevent them from speaking their mind, such as elders, committee members, men, government authorities, etc. depending upon the circumstances (IASC 4.4.1.). | The importance of AAP must be reflected in policy and practice. Health Cluster meetings should include these issues on agendas, in working documents and in decision making. For more information on setting up feedback and complaints mechanisms on delicate issues such as SEA please see:<br><br>Best Practice Guide - Inter Agency Community Based Complaint Mechanisms https://interagencystandingcommittee.org/node/17836 |
| Invite representatives from other clusters and from the ICCG to attend the Health Cluster meeting to update Health Cluster partners on experience from other clusters, to promote harmonisation of the approaches (as appropriate) and to explore options to establish common multi-cluster accountability initiatives where appropriate. | HCC | • The Health Cluster collaborates with other stakeholders, such as peer agencies, clusters, partners and local authorities, to fullfill this commitment (IASC 2.5.2.).<br>• The Health Cluster works effectively in coordination and collaboration with others, including both UN and non-UN actors (IASC 6.2.1). | AAP is not a single entity issue. Learnings from one cluster to another is valuable. Representation and attendance reflects broad attention and concern for AAP. |
| Proactively engage in discussion on AAP, protection and diversity in ICCG meetings- sharing the experience of the Health Cluster and learning from the experience of other clusters. Explore options to establish common multi-cluster accountability initiatives where appropriate. | HCC | | AAP will be strengthened by multi – cluster focus and coordinated consideration and approaches should become common practice. |

[4] *https://www.icvanetwork.org/principles-partnership-statement-commitment*

# Preparedness actions
## to support a people-centred approach

"The term 'preparedness' refers to the ability of governments, professional response organisations, communities and individuals to anticipate and respond effectively to the impact of likely, imminent or current hazards, events or conditions. It means putting in place mechanisms which will allow national authorities and relief organizations to be aware of risks and deploy staff and resources quickly once a crisis strikes".
(https://www.humanitarianresponse.info/fr/node/129181).

## Core humanitarian standards

**CHS3:** Communities and people affected by crisis are not negatively affected and are more prepared, resilient and less at-risk as a result of humanitarian action.
**Quality criterion:** Humanitarian response strengthens local capacities and avoids negative effects.

**CHS4:** Communities and people affected by crisis know their rights and entitlements, have access to information and participate in decisions that affect them.
**Quality criterion:** Humanitarian response is based on communication, participation and feedback.

| Action | Responsibility | Indicators | Rationale |
|---|---|---|---|
| Consult with specialised agencies and available focal points and experts on appropriately incorporating AAP, gender, protection and diversity in the Health Cluster Preparedness Plan. | HCC | The Health Cluster works effectively in coordination and collaboration with others, including both UN and non-UN actors (IASC 6.2.1.). | A range of perspectives forms the basis for going forward. Taking account must include hearing as many stakeholders as possible when gathering data, information and knowledge. |
| Ensure AAP, gender, protection and diversity issues are appropriately incorporated into the Health Cluster preparedness plan. | HCC & HCPs with support from specialised agencies / expert focal points | There is an accountability framework that has an implementation plan outlining activities, responsibilities and timelines that is relevant to the context to which it relates: Health Cluster, consortium, cluster, for example (IASC 1.2.2.). | This is the outcome of consultations and demonstrates taking account of voices and implementing information gathered and assessed during consultations |
| Facilitate training and orientation for Health Cluster Partners on AAP, gender protection, mental health and diversity - to ensure skill within the cluster to implement AAP, gender, protection and diversity related activities throughout the HPC. | HCC with support from specialised agencies / expert focal points and OCHA | All interest groups have a voice, including women, girls and boys of different ages, older women and men, minority cultural groups and people living with disabilities (IASC 4.1.2.) | AAP must be based on the capacity of partners to implement all stages and processes relating to AAP. |
| 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. | HCCT & HCP | Programme design is based on an analysis of the specific needs and risks faced by different groups of people (IASC 5.1.1.). | Recognising diversity of needs must have a strong reliable foundation of data on the demographics affected to be able to determine the differentiated needs and appropriate response. |
| Organise consultations with communities at risk to identify common cultural practices or preferences which would inform / affect relevant and effective emergency health response activities. | HCC & HCPs | All interest groups have a voice, including women, girls and boys, older women and men, minority cultural groups and people living with disabilities (IASC 4.1.2.). | AAP requires sensitive cultural recognition to ensure responses are based on practice and process which maximise impact and are not impeded by a lack of understanding of the populations affected. Responses should reflect understanding of cultural aspects likely to have an impact – either positively or negatively – on particular sectors of affected populations. |
| Identify the most appropriate communication channels for communities, taking into account the preferences of the various groups within the communities and the various languages that may be in use, as well as issues of literacy. | HCC & HCPs | A two way dialogue routinely occurs to obtain information regarding local culture, customs, beliefs, capacity and strategies to survive with dignity first hand, as well as through other sources (IASC 4.3.1.). | Effective information flow between partners and sectors of the affected population is an integral part of taking account, giving account and building capacity to hold partners to account. |
| Engage with national and local health organisations to determine resources required to enable their active engagement in the Health Cluster – (eg. translation and interpretation services) | HCC & HCPs | The Health Cluster makes sure that resources are available to translate relevant information into local languages and for context appropriate information dissemination (IASC 2.4.1.). | Planning and response should utilise and maximise available resources in appropriate ways. AAP requires that all sectors of a community are enabled to contribute effectively – and that all available partners are recognised and appreciated. |

# Needs assessment and analysis
## to support a people-centred approach

Assessments and the analysis of the data are the first steps in the Humanitarian Programme Cycle (HPC), where needs of affected populations are identified and analysed. It is important to remember that affected populations are not a homogenous group and people are not affected by the crisis in the same way. Assessments should take into account sex, age, host/IDP/refugee status, ethnicity and other relevant social markers. Increasingly data gathered in assessments is disaggregated by sex and age and there may be a need to disaggregate data by other relevant social markers (e.g. access to latrines for people with a disability).

## Core humanitarian standards

**CHS1:** Communities and people affected by crisis receive assistance appropriate and relevant to their needs.
**Quality criterion:** Humanitarian response is appropriate and relevant.

**CHS2:** Communities and people affected by crisis have access to the humanitarian assistance they need at the right time.
**Quality criterion:** Humanitarian response is effective and timely.

**CHS3:** Communities and people affected by crisis are not negatively affected and are more prepared, resilient and less at-risk as a result of humanitarian action.
**Quality criterion:** Humanitarian response strengthens local capacities and avoids negative effects.

**CHS4:** Communities and people affected by crisis know their rights and entitlements, have access to information and participate in decisions that affect them.
**Quality criterion:** Humanitarian response is based on communication, participation and feedback.

| Action | Responsibility | Indicators | Rationale |
|---|---|---|---|
| In multi-cluster assessments - ensure health data should be disaggregated by sex and age as a minimum. As appropriate, each indicator should be further disaggregated by pregnant and lactating women, people living with HIV, disability, diversity, geographic areas<br><br>For Health Cluster assessments- consult with specialised agencies and available focal points on AAP, gender, protection and diversity in the design of the assessment to ensure assessment tools, data collection modalities and analyses incorporate AAP, protection and diversity issues effectively. | HCC & HCPs with support from specialised agencies / expert focal points | The cluster routinely employs stakeholder and context analysis to ensure appropriate targeting, programme planning and implementation (IASC 1.3.2). | Regularly updating stakeholder and context analysis will flag any changes in circumstances and the need to change any activities. This ensures ongoing taking of account. |
| Agree that all assessments use participatory methodologies and assessments tools where possible (e.g. Hesper). | HCC & HCP | • Assessed needs are explicitly linked to the capacity of affected populations and the state to respond.<br>• There are strategies in place to allow for community members to participate in conducting assessments where appropriate (IASC 4.2.2.). | This promotes processes and activities which identify all vulnerable groups and seek out their voices on their own needs, to which activities can be tailored. |
| Include questions on information needs such as "what are the main sources of information for people now" and "what do you need to know now".<br><br>Agree to include questions to identify information needs, preferred and trusted channels for communication; protection concerns, preferred/potential solutions to address these concerns; and preferred trusted ways to give feedback/make complaints safely. | HCC &HCPS<br><br>HCC & HCPs | • All interest groups have a voice, including women, girls and boys, older women and men, minority groups and people living with disabilities (IASC 4.1.2).<br>• There is a policy or guidance on the establishment and operation of feedback mechanisms (IASC 3.1.1). | This is a way of ensuring effective giving of account as well as setting a basis for being held to account. Trusted and preferred communication channels can be identified and utilised. |
| During the assessment – consult separately and sensitively with girls, boys, men and women including older people, those with disabilities and other specific groups at risk of discrimination or who are particularly vulnerable are represented in the needs assessment. Ensure that the assessment process, accommodates the limitations / special requirements of these groups – eg. language, literacy, mobility, confidentiality. | HCC &HC,Ps | Staff ensure that, whenever possible, community members and interest groups have a chance to speak free of the presence of those who might purposefully or inadvertently prevent them from speaking their mind, such as elders, committee members, men, government authorities, etc. depending upon the circumstances (IASC 4.4.1.) | Strategies provide a clear focus and well thought through process on how to engage with the community. It works to prevent any particular vulnerable groups being overlooked, requiring a focus which differentiates needs and therefore providing data to facilitate response in which all needs are more likely to be implemented. This can help identify existing capacity as well as gaps. |

# Needs assessment and analysis
## to support a people-centred approach

| Action | Responsibility | Indicators | Rationale |
|---|---|---|---|
| Conduct an analysis of AAP, gender, protection and diversity related findings – taking into account the differing health needs of women, men, girls, boys older people, persons with disabilities and other specific groups at risk of discrimination or who are particularly vulnerable. Where available use sex and age dosaggregated data (SADD). | HCC & HCPS | Assessed needs are explicitly linked to the capacity of the affected populations and the state to respond (IASC 4.3.1). | Strategies provide a clear focus and well thought through process on how to engage with the community. It works to prevent any particular vulnerable groups being overlooked, requiring a focus which differentiates needs and therefore providing data to facilitate response in which all needs are more likely to be implemented.<br><br>This can help identify existing capacity as well as gaps. |
| Work with partners to develop a coherent strategy on targeting and selection of affected populations for assistance, taking diversity into account. | HCC & HCPs | | |
| Ensure the results of the health assessments are fed back to the communities including information on potential next steps. | HCC & HCPs | | |
| Ensure inclusion of key AAP, gender, protection and diversity issues in the Health Cluster context analysis and advocate for their inclusion as appropriate in the wider country context analysis within the Humanitarian Response Plan. | HCPs | | |
| Where Health Cluster partners decide not to establish a programme in the area of assessment, ensure that this information is communicated to the community concerned | HCC | Information is routinely provided on an appropriately updated basis to the communities the Health Cluster seeks to assist, by both the Health Cluster and its partners (IASC 2.2.1). | There needs to be awareness among AAP sectors and donors of which areas can/will not receive specific response. This essential part of giving account and provides information which can be the basis for being held to account. |

# Strategic planning
## to support a people-centred approach

The Strategic Planning phase is the step in the HPC where objectives are set and activities are designed to be implemented with the aim to reduce excess morbidity and mortality. While in some instances activities need to be implemented rapidly to save lives (e.g. communicable disease outbreaks) with little opportunity to consult with communities, in designing the Strategic Response Plan opportunities should be used to seek input from the community and their agreement on priority objectives. CHS 4 states that affected communities and people participate in decisions that affect them. As the SRP sets strategic objectives and priorities, communities should be consulted during this process.

## Core humanitarian standards

**CHS1:** Communities and people affected by crisis receive assistance appropriate and relevant to their needs.
**Quality criterion:** Humanitarian response is appropriate and relevant.

**CHS2:** Communities and people affected by crisis have access to the humanitarian assistance they need at the right time.
**Quality criterion:** Humanitarian response is effective and timely.

**CHS4:** Communities and people affected by crisis know their rights and entitlements, have access to information and participate in decisions that affect them.
**Quality criterion:** Humanitarian response is based on communication, participation and feedback.

**CHS5:** Communities and people affected by crisis have Access to safe and responsive mechanisms to handle complaints.
**Quality criterion:** Complaints are welcomed and addressed.

**CHS6:** Communities and people affected by crisis receive coordinated, complementary assistance.
**Quality criterion:** Humanitarian response is coordinated and complementary.

| Action | Responsibility | Indicators | Rationale |
|---|---|---|---|
| Consult with specialised agencies and available focal points on AAP, gender, protection and diversity to provide inputs into the Health Cluster response plan to ensure that AAP, gender, protection and diversity issues are appropriately incorporated into the Health Cluster plan. That objectives, narrative and activities address these issues effectively and that AAP, gender, protection and diversity related indicators are included in the response plan. | HCC & HCPs with support from specialised agencies / expert focal points | Programme design addresses the gap between people's need and their own or the state's capacity to meet them (IASC indicator 5.1.2). | All potential and actual partners need to be aware of the emphasis on AAP and have the opportunity to be recognised as capable of contributing effectively. |
| Support partners to ensure that AAP, protection and diversity related issues are incorporated into health partner project proposals. This includes but goes beyond ensuring that the AAP, IASC Gender and Age marker (forthcoming) are appropriately referenced in project documents. | HCCT with support from specialised agencies /expert focal points | Strategic response planning is based on an analysis of the specific needs and risks faced by different groups of people (IASC indicator 5.1.1). | The contributions and needs of diverse partners and affected populations must be demon-strably recognised in plans and programmes. |
| Undertake community consultation to feed in development of the Health Cluster plan, including for:<br>i. the establishment of mechanisms that facilitate feedback and complaints in a sensitive manner so that all groups feel comfortable to engage, and for<br>ii. the establishment of appropriate health services that meet the needs to all groups | HCC & HCPs | Community participation takes place during strategic response planning (IASC indicator 4.1.3). | AAP requires taking into account the knowledge, opinions and capacity as well as the needs of diverse sectors of AP. |