COMPLAINT MECHANISMS & COVID-19:

THE IMPORTANCE OF PREPAREDNESS AND COMMUNITY ENGAGEMENT

CHSAlliance

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SUMMARY

The COVID-19 crisis has posed a major challenge, not only to humanitarian operations, but also to vital accountability mechanisms. This report is based on a quantitative online survey with 76 responders and eight qualitative follow-up interviews. The research has shown that complaint mechanisms were highly impacted, but that this impact has also been strongly context dependent.

The sudden lockdowns and travel restrictions created many challenges in all stages of the complaint mechanisms. In-person and face-to-face modalities were highly affected, especially in areas that were disconnected by phone. More emphasis was placed on remote modalities, but some communities that did not trust their complaint to reach the organisation. Furthermore, remote modalities were not always preferred by the communities as they felt more accountability though in-person interactions. Movement restrictions particularly impacted more marginalised groups, such as women without access to phones, people with a disability or low literacy, and people in remote areas. Community meetings stopped, but often home visits continued.

Organisations made changes to the protocols for face-to-face modalities, and interaction with project implementation teams became increasingly important in Complaint Response Mechanisms (CRMs). When relying on local focal points or volunteers, confidentiality was seen as a risk. Local Civil Society Organisations (CSOs) were increasingly engaged in closing cases. When organisations did not already have remote modalities, the changes required additional resources. In terms of data protection and confidentiality, responses were mixed; if these were not already in place, then it was challenging to establish them at short notice. This problem was increased due to the unavailability of staff, who were busy with the COVID-19 response. Still, for some organisations, the remote modalities were seen as an opportunity for more direct contact, but generally, there was a decreased attention to referrals.

The research findings present a snapshot of how organisations struggled to meet the sudden changes forced onto the sector by COVID-19 in the spring of 2020. While some aspects require more research and understanding, others highlight key recommendations that the sector can take forward to be better prepared as the COVID-19 crisis continues and in the future. These touch on the importance of hybrid approaches, multiple channels, inclusion, community participation, and both pro-active and re-active approaches. The conclusion is structured as recommendations for (1) future learning (2) operational actors, and (3) donors.

INTRODUCTION

COVID-19 poses immense challenges to humanitarian operations. The virus has continued to spread throughout 2020 and is disproportionately affecting vulnerable and marginalised people. Aid agencies have faced imposed lockdowns and have been forced into a situation where personal interaction with affected populations had to be minimised, both for their protection and that of their staff. At the same time, they have had to scale up operations to respond. The CHS Alliance maintains a repository of resources on how to uphold accountability standards in humanitarian operations during COVID-19.

CHS Verification Data shows that Commitment 5 on welcoming and addressing complaints is the one that organisations have the most difficulty implementing.[1] With the addition of the challenges posed by COVID-19, it became necessary to understand whether and how complaint mechanisms were affected.

Complaints and feedback mechanisms, when they are well integrated into humanitarian and development practices, play essential roles in helping organisations be (more) accountable to the people with whom – and for whom – they work. These mechanisms serve an important role in surfacing suggestions, ideas, concerns, and (potential) cases of sexual exploitation and abuse (SEA), harassment, fraud, or corruption. Both reactive and proactive approaches are needed, especially to reach more vulnerable or marginalised groups and enabling effective two-way communication.

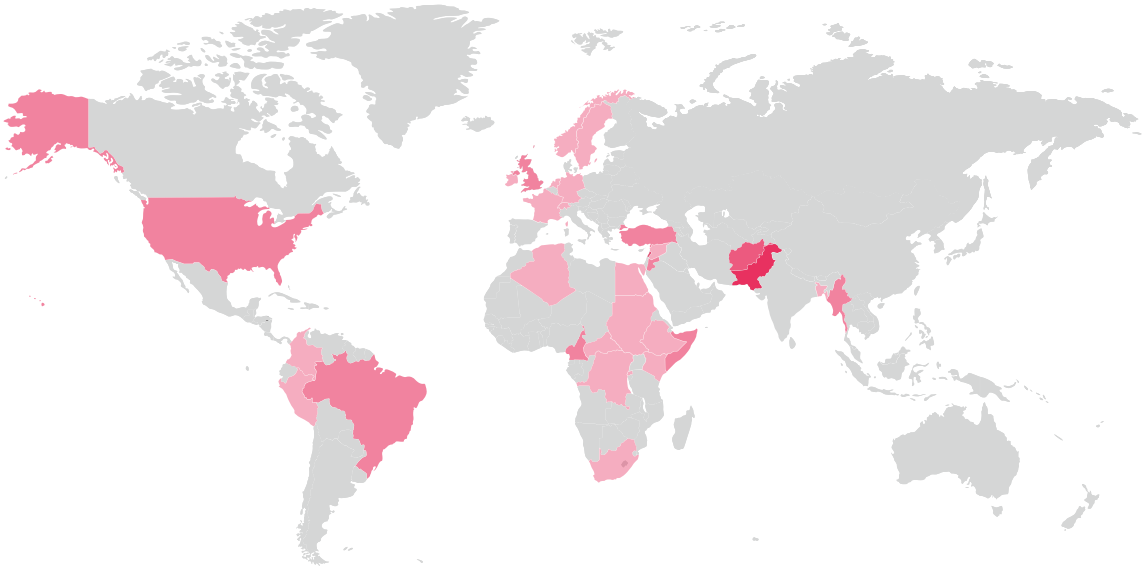
This research set out to understand more about how organisations are adapting these mechanisms and their services in the midst of COVID-19, to see how best to tailor support. An online survey was conducted from May to July 2020, circulated through relevant inter-agency networks,[2] supported by eight follow-up qualitative online interviews. Finally, a draft version of the report was shared for discussion prior to the finalisation of the report.

[1] https://d1h79zlghft2zs.cloudfront.net/uploads/2020/10/01450-CHS-2020-HAR-Report-FA2-WEB2.pdf
[2] IASC Results Group2 on Accountability & inclusion, CHS Alliance Membership, Safeguarding Resources and Support Hub

BACKGROUND OF RESEARCH PARTICIPANTS

In total, 76 participants from 41 countries (shown in Figure 1) were included in this analysis. Although more partial responses were received, only participants who consented to the use of research outcomes were included in the report.

Figure 1. Map of the research participants



Additionally, eight online interviews were held to further engage on identified issues. These interviews aimed to capture different geographical perspectives and experiences, and for the collected data to be further interpreted.

Five participants identified working in a field office and two identified working at the HQ of an international organisation. One participant was a researcher.

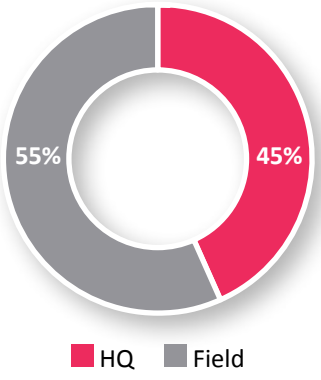


Figure 2. Percentage of research participants from HQ or field-based office

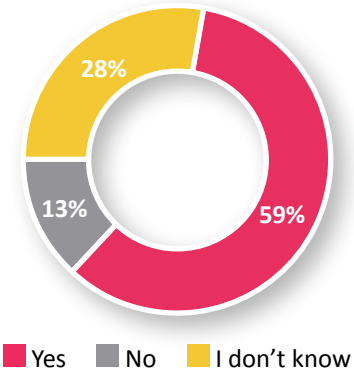


Figure 3. Percentage of research participants who are member of the CHS alliance

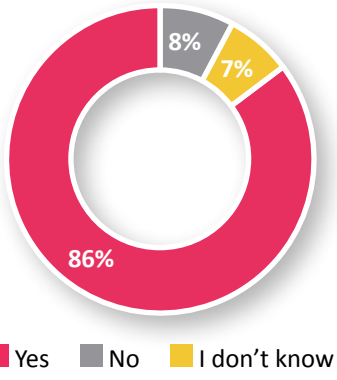


Figure 4. Percentage of research participants who had a complaints mechanism before COVID-19

When organisations reported they did not have a complaint mechanism, reasons differed; either the system was just recently set up in the previous month, the intention to set up a system has not yet been actualised, the organisation was not an implementing agency itself, or it was not a priority before COVID-19 because donors only required a report with testimonies at the end of the project. Overall, 63% of CHS Alliance members indicated that they are certain about having a complaint mechanism, against 33% of the non-members.

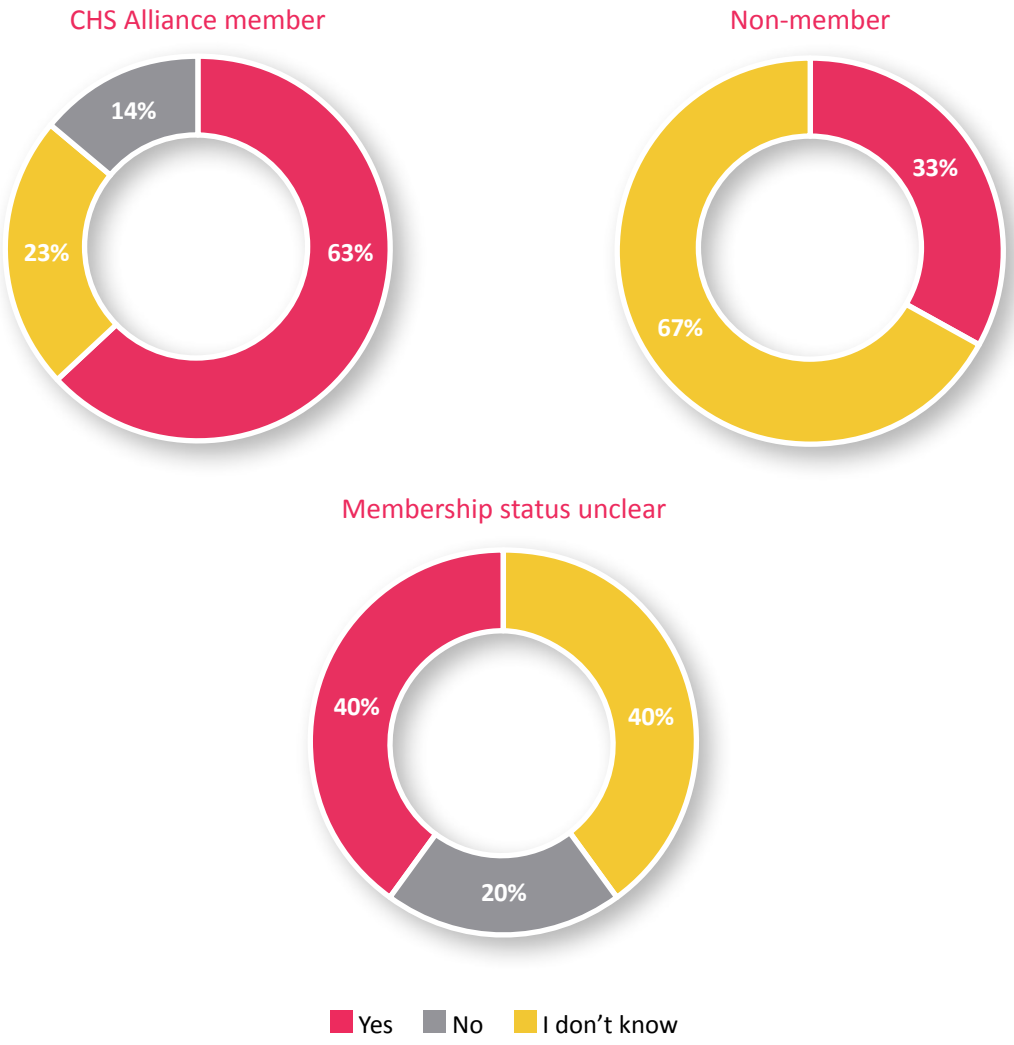
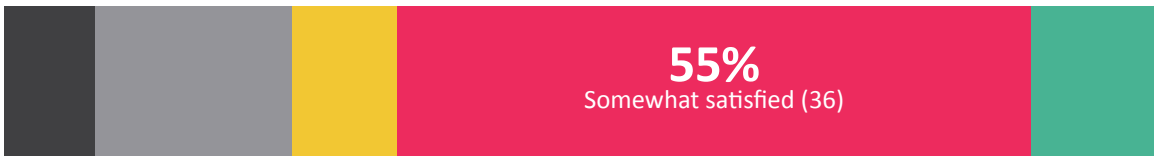


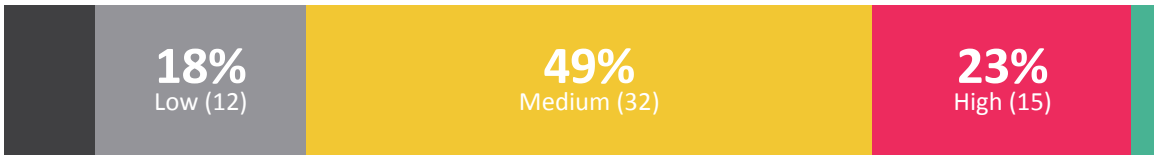
Figure 5. Percentage of organisations that normally has a public facing complaint mechanism by CHS Alliance membership status

COMPLAINT MECHANISMS PRIOR TO COVID-19

Before the COVID-19 crisis, the majority of the research participants were somewhat satisfied (55%) with their complaint mechanism, with 11% even reporting that they were extremely satisfied. The usage was also estimated to be average to high.



Extremely dissatisfied (8%) Somewhat dissatisfied (17%) Neither satisfied (9%)
Somewhat satisfied (55%) Extremely satisfied (11%)



Very low (8%) Low (18%) Medium (49%)
High (23%) Very high (2%)

CHS Alliance member

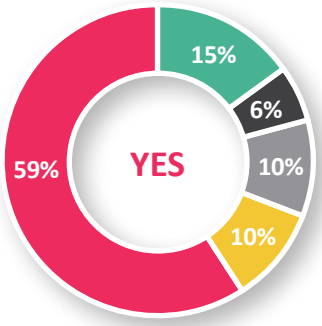


Figure 6. Level of satisfaction

Non-member

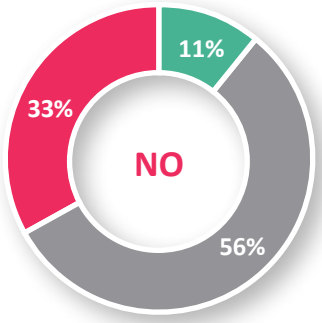


Figure 7. Level of usage

Membership status unclear

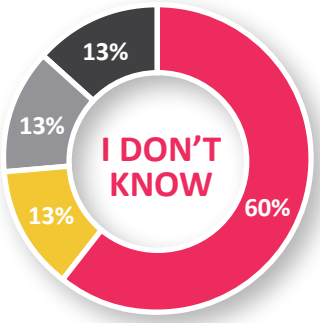


Figure 8. Level of CRM satisfaction by membership

Extremely dissatisfied (8%) Somewhat dissatisfied (17%) Neither satisfied (9%)
Somewhat satisfied (55%) Extremely satisfied (11%)

Overall, non-CHS Alliance members, were less satisfied with their complaint mechanism than CHS Alliance members or research participants who were not sure about their membership. 56% of the non-CHS Alliance members were somewhat dissatisfied.

IMPACT OF COVID-19 ON COMPLAINT MECHANISMS

How were people informed about complaint mechanisms before the COVID-19 crisis?

Before the COVID-19 crisis, most research participants primarily relied on face-to-face interactions and awareness raising, such as feedback sessions, community meetings and campaigns, meetings with local leaders or sensitisation sessions. Some research participants underlined the importance of the participation of the community in deciding the details and process of the system. And others were concerned with the sensitivity of PSEA complaints requiring the sensitisation of partners and other personnel involved in managing the projects in some communities (such as shelters). Furthermore, regular activities were used to spread information, either through informal interactions with field staff, volunteers or partners, during distributions or more systematically through M&E activities, such as surveys, focus groups and assessments. The distribution of information materials, such as flyers, posters, brochures, information cards and leaflets were also frequently mentioned. Besides these more traditional and in-person methods, a group of research participants shared information remotely, through social media, websites, phone calling/messaging or the radio.

Figure 9. Channels of information

How were changes to complaint mechanisms communicated?

When the COVID-19 pandemic started, the majority of research participants (59%) indicated that they communicated changes to the current CRM to affected people. In general, these were communicated through the usual means explained in the previous section; especially by awareness raising in meetings, distribution kits, flyers, or partners and community leaders. In addition, some research participants underlined the importance of following COVID-19 health protocols, such as wearing a mask and respecting a certain distance.

In addition, remote means (either online – WhatsApp - or by phone – and SMS) became increasingly important, especially in those settings with strict lock-downs. When changes were not communicated, it was mostly because it was not necessary because remote systems had already been established. Others were working through partners who hold the responsibility for communicating these changes. Some research participants reported technological problems or that the remote systems had not yet been fully developed. Others were still in the process of making changes; such as translating documents and texts.

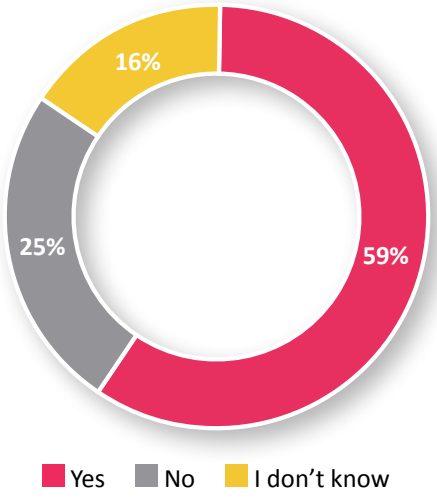


Figure 10. Percentage of organisations that communicated changes

How much has the COVID-19 crisis impacted complaint mechanisms?

The COVID-19 crisis impacted the vast majority of research participants' CRMs. 42% indicated a moderate impact and 30% a substantial impact. 3% even saw their complaint mechanism to be heavily impacted by the crisis. The following sections will elaborate on how their complaint mechanisms were impacted.

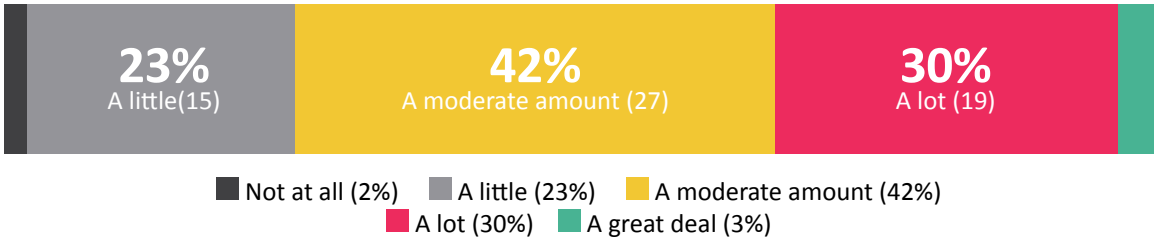


Figure 11. Impact of COVID-19 on complaint mechanisms

SUBMITTING COMPLAINTS

The submission of complaints was impacted the most; only 2% of the research participants did not experience an impact, while 64% of the research participants indicated a moderate to a great level of impact.

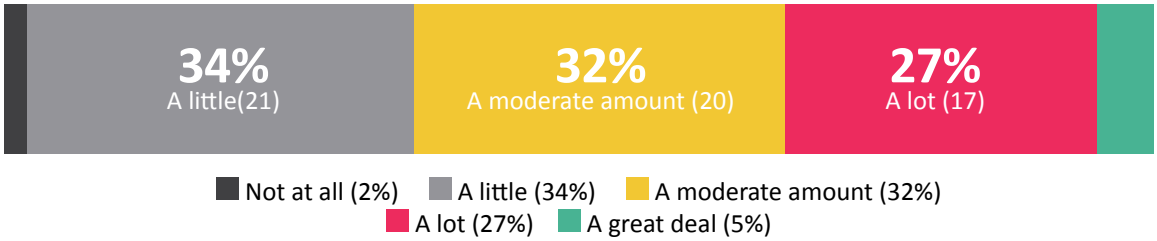


Figure 12. Level of impact on the submission of complaints

What has been affected and what has been changed?

In-person and face-to-face modalities were highly affected for most research participants. This was problematic as these modalities are often preferred by communities.

A number of research participants spoke about the trust between the organisation's staff and the communities, which is seen as crucial for well-functioning complaints system and is directly related to the organisation's physical presence in the community.

Face-to-face interactions were therefore preferred by the organisations. In this context, sensitive complaints were challenging to capture. In some contexts women in particular may not always have access to a phone or the internet. One research participant explained that there is a risk in relying on local staff for these complaints, as they might be connected to other local staff members and could circulate information amongst them. This shows that trust operates on different levels; not only between organisations and the affected people, but also between the organisations and their local partners.

Furthermore, the widely used tool of complaint and feedback boxes was also highly affected; complaint boxes were often installed at office premises that were closed, people were prevented from traveling to offices and, in some cases, the boxes and pens themselves were seen as COVID-19 contagion risks. In one pre-COVID case, an organisation appealed to children by creatively using complaint boxes in the shape of cookie monsters. When COVID prevented access to the complaint boxes, they shifted to distributing envelopes with a cookie monster design that were distributed directly to children and collected a few weeks later. This shifted their approach from a reactive to a proactive one. Research participants who were previously already working with remote modalities faced less problems; they were able to more easily switch from their in-person activities to the remote channels. But even in these cases, relying on only remote modalities were seen to affect complaint mechanisms, as in-person modalities were preferred by affected communities. Still, the impact has been largely context-dependent; with middle-income areas reporting an easier transition to using remote modalities.

In line with the face-to-face modalities being most affected, ***more emphasis was placed on remote modalities:*** *'We have already done some changes to overcome the challenges due to social distancing and risk of spreading so will try to use other existing channels such as calling, SMS messages and email facilities."*

Some organizations were actively pursuing people on the phone: *"We collected feedback through mobile calling in the past when we set up complaint boxes. But it was seen that in the complaint boxes very few people complained. So this time we collected feedback through mobile phone calling to the participants."* This can be done when phone numbers of beneficiaries are collected and known beforehand.

In another case, community leaders were called directly to ask about the programmes. Whatsapp was seen as another opportunity for submission of complaints. One research participant explained how a set of questions and answers can be pre-programmed. However, these cannot be used for sensitive complaints, which are redirected to e-mail or phone lines. An example of a semi-remote modality for rural areas without connection was to have voice recorders installed in a certain place, where people can go inside and have the privacy to record feedback and concerns. People were comfortable with this and the transmission risk was mitigated by the use of masks, washing hands and social distancing in the queue. With a staff member present, information about COVID-19 could also be shared.

However, some of these remote systems also bring additional uncertainties for the complainant; one research participant remarked that people contacted all mail accounts and submitted the same complaint through multiple channels to make sure it was received. Generally, changes were made to increase phone-based and online modalities, with physical modalities being reassessed and limited. Some participants raised awareness of these changes through

the sensitisation of community members and elders. But there are also drawbacks, such as one research participant noting that the 24h hotline would be too demanding for the staff.

When it was indicated that the submission of complaints was affected, the most important reason was **the disconnection between the organisation and the communities that was caused by the lockdowns and travel restrictions RATHER than the risk of COVID-19 itself**

A lot of project activities were suspended, and community meetings could not be held, even though these were generally used to raise complaints. Focal points and staff could not travel to the sites and many informal face-to-face complaints do not happen without field visits. This was especially prominent in countries with (sudden) total lock down, where staff were disconnected from communities and there was no time to prepare and raise awareness on other (remote) modalities. Some people were also scared to attend complaint committees due to the risk of COVID-19 and government measures.

These restrictions on movement particularly impacted the more marginalised groups, where people relied on face-to-face interactions. Especially people with low literacy, those living with a disability, groups with more cultural restrictions on contact, and where phones - if present - would be in the hands of one household member. One example highlighted the impact on women who usually do not have access to phones or risk confidentiality when their names are shown on messages or calls. Special attention needed to be paid to more vulnerable groups. Due to this limited face-to-face contact, PSEA complaints have been significantly affected.

This has been challenging for many organisations. As one research participant noted: *"More outreach to community parts [members of the community] that are less mobile, elderly etc. that may not have access to a phone, or our hotline number. Since this can't be done in person right now, and not through social media, we've not found a way to do this yet."* Another research participant mitigated this issue by conducting active outreach through calling children with a short survey and asking them their experience with the organisation and isolation. In general, there is a need to carefully consider and consult communities on how to reach these different groups.

There is also the issue of remote modalities not always being preferred by the communities; as one research participant noted after monitoring visits in the field: *"the hotline is not a practical mechanism. Communities demand that someone at field office is to be held accountable to provide them face to face response for inquiries and complaints."* While in other contexts, people did prefer the complaints phone number "as they feel more privacy instead of complaint box or mail and other option." - a research participant referring to an e-mail option that might be more confidential.

To continue with face-to-face modalities, a number of participants also underlined ***changes with regard to the protocols for face-to-face modalities*** to make these safe, but also to reach those groups that are not inline. *"In-person consultations may still be conducted but involving limited individuals only and observing minimum health protocols. Small focus group discussion among cluster/village leaders may still be implemented."* Others also limited the number of people in groups between five-10 people. However, this also requires clear communication and planning beforehand to avoid large groups gathering to observe. Another research participant gave the example of remotely managed focus groups as a solution. These would be organised locally with a direct connection by phone or internet, so people respond to questions posed by the organisation.

In terms of contact with the communities, as a few participants noted, ***the project implementation teams (who work in the project areas) became increasingly important to also play a role in CRM.*** There was an increased reliance on community volunteers and Community Based Organisations (CBOs) during project office visits and house-to-house distributions. This might transfer the risk of the organisation to the local partner; therefore, strict protocols need to be in place. Furthermore, working with incident workers, health staff, partners, community and religious leaders, access was established, and it was easier to communicate with community leaders. Field staff were also receiving calls on personal phones, indicating that communities trust them more than the helpline.

When organisations did not already have remote modalities, ***changes entailed spending resources*** on the research and implementation of these means. Whereas some organisations were prepared, by having a separate CRM budget in various activities, others relied on new funding. Here, one research participant highlighted a delay in funding and budget realignments from bilateral donors, where approvals are pending, and changes cannot yet be made to adapt the system.

In general, some mitigating factors could be identified, such as having a diversity of feedback channels. When organisations already had remote (hotline/online/SMS etc.) modalities, then they were less impacted. One example was having a phone tree in place of people of concern and organising WhatsApp groups that include a CRM focal point.

HANDLING AND RECEIVING COMPLAINTS

The handling and receiving of complaints were significantly impacted. 63% of the research participants indicated a moderate to a great level of impact.

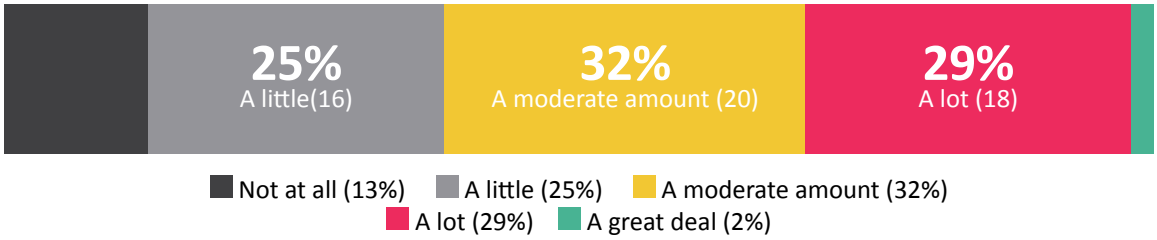


Figure 13. Level of impact on the handling and receiving of complaints

What has been affected and what has been changed?

In this modality as well, it is primarily the face-to-face contact that was been affected. This is particularly difficult in the investigation process: *"If there are any investigation, we have lost the contact in-person with the complainer. So, this is a biggest challenge that we cannot meet in person."* Many organisations have a follow-up process that requires in-person contact and movement has been restricted. Organisations cannot verify complaints in the field. Getting reports from communities, such as witnessness or survivor statements has been compromised. Some participants highlighted that the shift in home-based worked as significantly affected the processes, as there is less communication and less staff (essential staff) available for the investigation of cases. This also means that the hotline etc. is not always available 24/7.

In terms of data protection and confidentiality, responses were mixed; there are concerns about confidentiality. When remote modalities were new, the adaptation process might raise data protection issues: *"With new remote modalities, data may be collected and managed in a way teams have not done before, and so there may be different data protection concerns."* And another research participant noted: "*The confidentiality ensured by physical complaints box was not available. Telephone calls do not ensure confidentiality as numbers and data are traceable and visible."* Therefore, some research participants mitigated these risks by connecting staff to data protection and IT focal points to identify and mitigate problems. Another research participant noted: 'Measures were taken, such as changing weak passwords and revisiting SoPs. These need to be reassessed continuously'.

This problem is increased due to the unavailability of staff: "*Confidentiality is a general issue and even more during the COVID-19. Staff is busy with the challenges to handle the actual situation; limited capacities might become a problem the longer this situation will continue as it is."* Staff capacity is even more important when the nature of complaints change. One research participant noted that "more complaints arrive with a sensitive nature [involving own staff], hence more capacity is needed to address all complaints." However, in other cases, PSEA complaints have dropped or did not come in. This was believed to be due to the unavailability of dedicated staff that could handle these complaints and the confidentiality issues with remote channels. Therefore, one research participant noted that they redistributed resources within the organisation, freeing staff from other tasks, or hiring a dedicated accountability officer.

When relying on local focal points or volunteers, confidentiality is also an issue: *"Before the COVID-19 lockdown, refugees feel more comfortable to report directly to staff. Limited presence of staff at the field is expected to have a negative impact on the level of reporting despite the efforts made to enhance communication with communities. The confidentiality is affected, as in normal situation affected person may avoid reporting the case through the leaders."* When using local level CRM committee members for non-sensitive complaints and working with key people in the field (such as incident workers), it was important to equip them with necessary tools such as computers, internet and phone credit, and provide training. As one research participant noted: *"Today, our primary focus is on partners and how they interact with the local communities, but we need to do more to monitor and to make sure that information reaches the final target group."*

Still, some research participants had additional channels 'multi-layered investigations system and approach' and tools to fall back on and were less impacted. In the case of an already established online system, this also made the handling of complaints easier; "since the services were provided online, it was actually easier to trace what was said and done and investigating the complaint." Another research participant noted: *"The process continues being the same: complaints are registered in our virtual platform hosted in SharePoint, with the aim that each focal point manages, follow-up and respond to each one, having support by accountability team."* The use of online systems was encouraged, with access facilitated through online/mobile reporting systems. Additional modalities were also added, remote interviews increased, PSEA messages integrated on social media and online registry made accessible remotely.

CLOSING THE CASE

Closing the case was also highly impacted. 59% of the research participants indicated a moderate to a great level of impact.

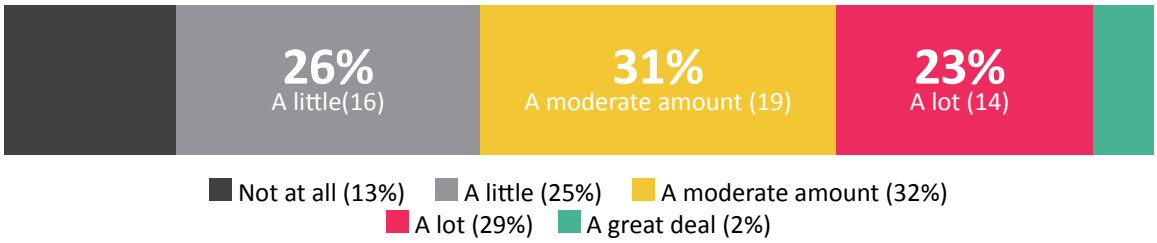


Figure 14. Level of impact on closing the case

What has been affected and what has been changed?

The main constraint that was faced, again, related to the restricted access to the communities, as most organisations relied largely on face-to-face modalities, either in person or through community leaders and focal persons who needed to go directly to the people who had filed a complaint. Travel restrictions prevented access to the communities, no home visits could be done even though some types of complaints needed face-to-face meetings, such as verifying details etc. Therefore, the loop could often not be closed; only if a phone number was given. In places where phone and online access is weak, this presents difficulties. Most respondents therefore increased the use of remote modalities to communicate responses to complaints, also when reaching community leaders. One research participant mentioned online meetings were held if necessary, and another referenced providing feedback on the spot when applicable. But often, the contact with the complainant had been lost, and closing the loop was difficult.

For some, the remote modalities are seen as an opportunity as there was direct contact and it was easier and quicker to respond with feedback and decisions: "a complaint box that was emptied once a month and mostly anonymous is difficult to close the case, but if it's by phone, it's easier." Others saw them as limiting; one research participant noted that *"psycho-social counsellors reported that it was challenging to move onto online counselling instead of having face-to-face sessions."* Limitations present themselves when there is limited access to phone/online means or when the complaints warrant in-person response. In places where there are no support services and restrictions on movement, it is challenging. One research participant identified a grave risk; to lose the connection and relationship with the communities:

> "By referring callers to another hotline put them in a difficult situation. They think we are ignoring them."

Remote modalities were, at times, causing dissatisfaction. In addition, these options also come with a cost: *"keeping people updated on their complaint status will be more costly and challenging."*

To close the case, local CSOs were engaged in the complaints process; a research participant explained that when delivering items, they provide the phone number of the hotline. This again indicates an increased reliance on focal points close to the beneficiaries. As another research participant noted; these focal points would contact the communities. But it was important to have consent prior to delegating this responsibility.

Another problem was a decreased attention to referrals. The complete attention of local government authorities and humanitarian actors is currently diverted to COVID-19. While complaints were not always seen to be heavily impacted, for the assistance requests, more follow up is needed.

To overcome these difficulties, research participants asked to share knowledge through webinars, share best practices, providing a list of focal points and skilled staff, establishing an online forum for experts, panel discussions on common challenges and solutions, consultation with wider humanitarian communities. *"To develop a new strategy taking into account the eventual epidemic or pandemic situation; CHS Alliance could publish a document stating the challenges faced by several organisations during COVID-19 and to publish thereafter a guideline on how to respond to beneficiaries' needs and complaints in time of pandemic. To propose alternative and solutions accordingly."*

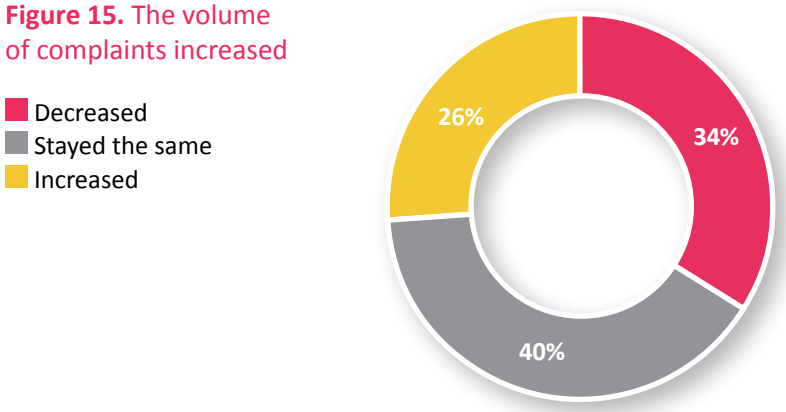
From the limited answers to this question in the survey, an observation by one of the research participants could be confirmed:

"I see a huge focus on maintaining channels open/changing channels modalities for receiving feedback to ensure beneficiaries continue to be able to communicate with us and not enough thought given on how we are going to close the loop. This is a concern as delays and relaxation of standards for closing the feedback loop will affect trust and feedback in the future."

VOLUME AND TYPES OF COMPLAINTS

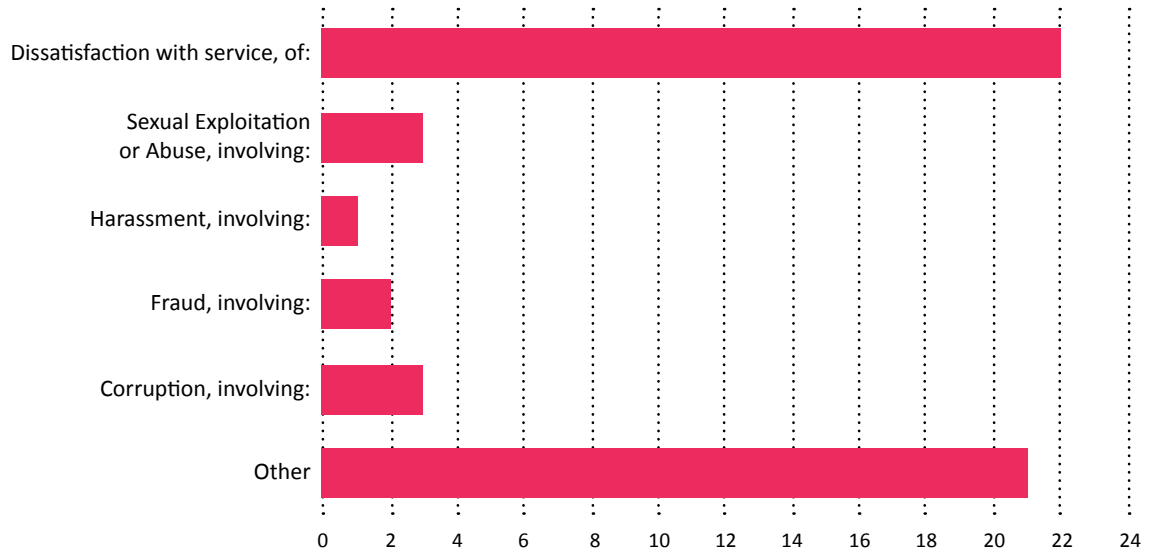
Overall, the COVID-19 crisis has impacted the volume of complaints. But not in a predictable way. 40% of the research participants noted the volume stayed the same, 34% indicated a decrease and 26% an increase in complaints.

Figure 15. The volume of complaints increased



Of the complaints that increased, most were related to a dissatisfaction with services or requests for more (financial) assistance and information (other). Needs have increased, which explains the rise in requests for support. One research participant noted the increase in health and socio-economic complaints. But also, one research participant explained that people are being rights sensitive and they want to share their rights.

When research participants noted that complaints stay the same or decrease, these concerned all categories. Some communities raise complaints related to COVID-19 directly to their Ministry of Health. But it should be noted that the type of complaints might change the longer the crisis prevails.



CONCLUSION AND DISCUSSION: WHAT CAN WE LEARN FROM THE COVID-19 CRISIS?

What have we learned from the COVID-19 crisis? The challenges that research participants had faced during the first wave of the pandemic were a combination of 'new' obstacles and a number of 'old' obstacles that were intensified.

The first new challenge that research participants had faced concerned the **access** to communities and vulnerable groups; not only in terms of physical access but also regarding **confidentiality** where physical visits are needed and the number of focal points that risk data confidentiality. Second, the **technology constraints** were felt, mostly regarding the access of communities to technology, poor infrastructure and illiteracy. Third, **additional resources** were needed to adapt to these new challenges; through internal prioritisation, funding, increasing staff to process complaints and the availability of technical support, which would also support safety in reporting and safeguarding sensitive data.

From this research, an important learning is the potential for **hybrid mechanisms** that combine both remote and in-person modalities. Here, organisations might be able to draw on the experiences of other types of crises, because research participants from organisations that normally work in conflict affected areas were less impacted by the COVID-19 crisis. Mostly because they already faced issues of access before and created systems that incorporated remote modalities more systematically. This is an opportunity that could be further explored.

The COVID-19 pandemic further **intensified a number of challenges** that were already at the core of the accountability debates; namely, ensuring the **access for more vulnerable and marginalised groups**, collaboratively choosing the **channels that are more appropriate for the needs** of the affected communities, and the **inclusion of local actors**.

Research participants noted that COVID-19 disproportionally impacted the access to complaints mechanisms of those social groups that are already more vulnerable or marginalised. One example illustrated the importance of flexibility and proactivity when it concerned lowering these barriers:

> In Nepal, an education programme targeted married, out of school, teenage girls. When the community classes needed to be halted due to the lockdown, there was no access anymore to the group. So, the programme shifted to classes over the phone. This way, the local team was able to continue, and space was given for complaints to come in. However, the girls themselves did not have access to these phones on their own. The programme worked by bringing in family members to the call and having the classes on speaker phone. Although this limits the types of complaints that could be voiced, it still ensured there was continued connection with the group.

Multiple channels are not stand-alone solutions. As a briefing note by HPG/ODI[3] on communication and community engagement during COVID-19 states, **reactive and proactive approaches are required for an inclusive approach**. This *"involves multiple, integrated feedback channels: Over-emphasis on a single feedback mechanism – especially hotlines – is likely to exclude people who cannot access it. Similarly, reactive channels focused on complaints handling are likely to produce biased data unless complemented by proactive attempts to reach out to affected people and understand their concerns."* (HPN/ODI, 2020, p. 8). Furthermore, these reactive and proactive approaches are context dependent.

[3] https://www.odi.org/sites/odi.org.uk/files/resource-documents/covid-19_cce_briefing_note_web.pdf

This underlines the importance of having multiple channels for feedback and complaints. Organisations that were able to have face-to-face, remote and hybrid solutions were better equipped to adapt, but these also needed to be used proactively. Furthermore, the example shows that it is not only about the type of channel that is available, but also **how you can lower the barrier for certain groups to access this channel**. People are often not individual islands but are connected and part of social groups. Therefore, including certain gatekeepers might increase the access of more marginalised groups, even though there might still be other limitations.

The research showed an increased reliance on **local representatives** to continue to have access to the communities. On the one hand, this involvement of local actors provides opportunities to localise accountability mechanisms and increase the access to complaint mechanisms for certain population groups, also in the long term. On the other hand, when it concerns sensitive matters, people do not always prefer to share their complaints with someone who is based in the community due to privacy reasons. And we need to be careful not to just transfer the health risk to local partners.

This requires capacity strengthening and training: to identify and train focal persons in place for direct feedback and the hotline, providing them with a phone and credit. Research participants encouraged **active participation of community leaders** to gather complaints/feedback, establishing CRM committees to review complaints and respond with dedicated staff, or complaint forms for remote communities with submission through focal persons. But for any channel, it is crucial to get community input on the most appropriate one. Therefore, **reflecting on community communication and participation** has become even more central. It is imperative to establish different possibilities for preferred channels before a crisis happens. This needs to be done with the community members. Main channels and back-up channels, and a hybrid approach to modalities to be established and re-evaluated over time.

Although the centrality of local actors is important for the humanitarian localisation commitments, it is also important to understand how actions affect relationships and tensions. Many organizations stated in the research that they **rely on pre-existing structures**. Whether they are authority structures within the community, community-based organisations or stakeholders, or local (partner) staff, local actors (like any other actor) are often representative of certain groups, but not others. In some contexts, local leaders may control certain community members' complaints and mistrust between the communities and authorities can become a restraining factor. This directly relates to power relations, as information could be a way to control people and resources or exclude groups from decision-making processes. Especially in conflict settings, existing power inequalities can be reproduced, or the authority's voice legitimised. This again underlines **the importance of different communication channels, continuous learning regarding power relations, and the inclusion of different social groups in deciding on the type and manner of feedback modalities**. Oxfam advises a risk assessment and mapping of preferred communication and information chains.[4] As one of the research participants noted, *"a poorly implemented CRM can be worse than no CRM at all. It can result in distrust and further disempowering the communities. And therefore, we need to make sure we take time to plan and prepare for CRM."*

Through research and assessments, an understanding of these limitations can generate ideas to overcome them. This might require **a culture of change within the organisations** to ensure senior leadership enforces the prioritisation of accountability in their operations; to understand that it is to improve quality, not to make staff look bad or to control them. Furthermore, this might require **more, or more flexible, resources, donor requirements, and/or a better integration with the everyday activities** of the programme.

[4] https://oxfam.app.box.com/s/n796gxjzig76ho900wwjh35kxxs7nf8w

Finally, a note for further reflection. It may be argued that these complaint mechanisms and accountability practices are especially important due to the current aid systems that retains a top-down approach. But we might also ask ourselves: **how would complaint mechanisms and accountability look like when the programmes themselves are created and implemented from the bottom up?** When we start from this intention and give space to the affected communities to co-design and shape the programs, with continuous moments of reflexivity and flexibility to adapt to changing contexts, it might allow the most appropriate complaint mechanisms and accountability practices (vertical and horizontal) to emerge and evolve and might achieve more meaningful two-way communication and community participation in decision-making processes.

What recommendations can support the continued functioning of complaint mechanisms, even in times of crisis?

RECOMMENDATIONS FOR FURTHER LEARNING AND/OR RESOURCE DEVELOPMENT BY CHS ALLIANCE AND THE SECTOR

Those parts of the research that we were not able to learn as much as we expected or that deserve follow-up.

- **Inclusion:** Limitation of access to complaint mechanisms was exacerbated during the COVID-19 crisis. This particularly affects persons with disabilities as well as potentially vulnerable or marginalized groups. More research is needed on good practice for ensuring inclusivity during times of crisis.
- **Types of Complaints:** The findings did not conclusively reveal either a decrease or increase in specific types of complaints. More research is needed on what types of complaints increased or decreased under what conditions.
- **Learning & Peer 2 Peer Exchange:** Several research participants desired more forums to continue learning and exchange good practice. Despite several existing opportunities, including the CHS Alliance Communities of Practices, webinars and exchanges, and events organised by organisations like Sphere and PHAP, many research participants either don't know about or how to access these forums.
- **Technical support:** Research participants desired to have technical support from the CHS Alliance on the contextualisation of the CHS. Training is requested on; 1) how to receive and manage complaints remotely and digitally with data safety and security following EU laws, 2) on how to establish remote modalities in contexts with low phone access and limited physical access, 3) trainings for partners/CSOs/ community focal points on how to conduct investigations.
- **Minimum Service Delivery:** Discussions during the finalisation of the report brought to light the importance of "closing the loop" of complaints. COVID-19 has stopped or delayed certain processes, but what should be the minimum level of response that humanitarian development actors should provide to complainants. The answer to this question might depend on the context, type of complainant, or type of complaint. For example, if dealing with a sensitive complaint like sexual assault, how can the concerned organisation ensure a minimum level of in-person assistance and what kind of protection services should be provided? While there appears to be agreement on the principle of a "minimum service", more research is needed to define what this is.
- **Crisis Guidelines:** While some guidance exists, it needs to be better contextualized and requires more specifics on crisis situations. In the first place, this could be a responsibility of the organisation itself; to contextualize the tools and methods for their own situation. However, especially in terms of a crisis, a crisis manual could be created. Here, different scenarios can be described, and different suggestions made to improve the complaint mechanism under such conditions. For example, a 'lockdown' could be a scenario, or a 'health crisis' could be another. Even different scenarios of marginalisation could be created. But also, different types of disasters or conflicts. These require specific approaches to complaint mechanisms.

RECOMMENDATIONS FOR OPERATIONAL ACTORS

Those recommendations and good practice that came out from the research that we believe operational actors (i.e. CHS Alliance members) should adopt.

- **Contingency Planning and Preparedness:** Organisations must have in place contingency plans for emergencies that explicitly account for how complaints will be received, handled, and responded to, as well as what will continue to exist as a "Minimum Service" (see above). These must account for health emergencies and address the need for continued accountability mechanisms that reach even the most marginalised affected people. Organisations should consider different modalities for proactive and reactive community engagement, whether remote, in-person, or hybrid approaches
- **Prioritise Accountability Mechanisms:** Organisations should continue to prioritise accountability, even in times of crisis, including the reception and handling/closing of complaints.
- **CRM Focal Points:** Organisations should identify and train CRM focal points in the communities to continue to receive complaints and convey up to date information about any delays or changes regarding the process for handling complaints.
- **Availability of Investigators:** Organisations should train investigators of complaints on distance case management and have them available as part of a pool of investigators who can be called on to support investigations when limitations and restrictions are place on human resources. This pool is preferably set up through an inter-agency approach.
- **Joint Approaches:** Organisations should seek to develop joint codes of conduct, complaint mechanisms, and investigation procedures. This will help alleviate resource restrictions in time of crisis. This can be achieved bilaterally or as part of an inter-agency approach. A global incident reporting system and handling system could be made accessible to all focal points, and a two-way referral to other agencies to fast-track case resolution linked to joint accountability mechanisms.
- **Community Engagement:** Organisations should establish different modalities for community engagement that allow for both face-to-face and remote communication. This can include free hotlines, establishing community contact lists with phone numbers. But these have to be co-created together with the affected population and organisations should continue to inform affected populations on how these complaint mechanisms work or if they need to be adjusted. Co-creation of the complaint modalities must go beyond consultation of different options, as the community may suggest solutions that the organisation has perhaps not considered. At this stage it is especially important to consult different population groups separately so as to ensure modalities can meet all needs (i.e.- children, elderly, persons with disabilities, vulnerable or marginalised groups).
- **Face-to-Face Communication:** Organisations should continue to conduct face-to-face engagement when this is possible while respecting good practice to avoid contamination. One reaction to COVID-19 has been this perception that everything needs to become remote. However, the research shows that face-to-face interaction is critical to establishing a relationship of trust with the complaint mechanism and the concerned organisations. Organisations should embrace more hybrid approaches that allow for face-to-face interaction. Be mindful of confidentiality issues (i.e.- announcing that only PSEAH complaints will be handled face-to-face could expose and stigmatise complainants).
- **Dedicated Funding:** Organisations should have an earmarked budget to strengthen accountability to affected people systems. This budget should be flexible to change modalities depending on the circumstances.
- **Advocacy:** Organisations should advocate with local authorities to ensure adequate communications and information dissemination about lockdowns before and during the lockdown, to allow sufficient time for changes in the complaint mechanisms.

RECOMMENDATIONS FOR DONORS

Those recommendations that cannot be implemented by operational actors and/or require donor support.

- **Monitoring Accountability Mechanisms:** Request funding recipients to prioritise accountability and complaint mechanisms and monitor whether this is being applied (i.e.- CHS Verification, Direct Spot Checks)
- **Funding:** Donors should provide flexible funding that allows organisations to adapt complaint mechanisms modalities in times of crisis. A follow through on funding from bilateral donors for COVID-19 was requested and donor budget allocation and improving technology with protection measures. Besides the mechanisms, this funding would also be needed to distribute personal protective equipment to communities, for counselling and information services in different languages, and to increase access to phones, chargers, internet etc.


CHSAlliance
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