



**HEALTH
CLUSTER**



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Joint Operational Framework Health and Protection

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Introduction

Each humanitarian setting provides distinct opportunities and challenges for actors to coordinate and collaborate at strategic and operational levels. The Health and Protection Joint Operational Framework has been developed to ensure that the health and protection response during humanitarian emergencies can adapt to each environment and is adequately coordinated to ensure high-quality services to meet the needs of affected individuals and at-risk groups based on their situation or vulnerabilities.

The Health and Protection JOF was conceived in 2019 as a collaboration between the Global Health Cluster (GHC), the Global Protection Cluster (GPC) and its Areas of Responsibility (AoRs), the Inter-Agency Standing Committee Reference Group on Mental Health and Psychosocial Support in Emergency Settings (IASC MHPSS RG), and the Inter-Agency Working Group for Reproductive Health in Crisis (IAWG), in addition to key technical experts.

A Steering Group (SG) comprised of representatives from each of these entities guided the framework through a joint global analysis of good practices, gaps, and barriers to integrated and inter-sectoral response coordination. This included a mixed methods review of policy and practice, a survey of humanitarian experts, multiple case studies, structured stakeholder interviews, and field visits. This exercise produced a zero-draft which was then reviewed by field practitioners in three operational contexts to clarify and fully coordinate its operationally focused lens. Finally, the JOF was reviewed by the SG including via a series of consultations in early 2023 to consolidate the current framework.

The Purpose of This Framework

This framework serves as an entry point to improve strategic and operational ways of working for health and protection actors before, during and after a humanitarian or public health emergency. The JOF provides guidance and examples of good practice to remedy siloed approaches and mutually inform health and protection actors across the six core functions of cluster and cross- sectoral coordination. All areas of work should go hand-in-hand to inform each phase of the humanitarian program cycle (HPC), the Grand Bargain commitments made during the 2016 World Humanitarian Summit, e.g. on localisation, and the humanitarian-development-peace nexus (HDPN).

Who Should Use This Framework

The primary audience for the JOF includes Health and Protection cluster coordinators, coordination teams, AoRs and working groups, for example in the areas of child protection, gender-based violence, mine action, sexual and reproductive health, and mental health and psychosocial support. This framework also serves as a strategic and operational tool for cluster partners, the Inter-Cluster Coordination Group (ICCG), and the Humanitarian Country Team (HCT).

Working Toward Health and Protection Outcomes

Joint and integrated health and protection programming improves health and protection outcomes by mutually informing field operations and service delivery. It is therefore crucial to understand the basic elements of both protection and health, the importance of protection mainstreaming, how health and protection relate to one another, how their activities interact, and the distinction between joint programming and integrated programming from both perspectives.

Protection aims to promote and ensure the respect and fulfilment of human rights, including the right to health. The International Covenant on Economic, Social and Cultural Rights (ICESCR), for example, states that “Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity.”¹

The Inter-Agency Standing Committee (IASC) builds on this to define protection as “all activities aimed at obtaining full respect for the rights of the individual in accordance with the letter and the spirit of the relevant bodies of law.” This includes International Humanitarian Law (IHL), International Human Rights Law (IHRL), and International Refugee Law (IRL).² IASC has further affirmed the centrality of protection in humanitarian action by stating how protection should inform decision-making and response “as part of preparedness efforts, immediate and life-saving activities, and throughout the duration of a crisis and beyond.”³ This includes a commitment to remain accountable to populations affected by a crisis, to understand barriers faced by different at-risk groups, and to co-design and co-create with them the responses that will be required.⁴

Protection is the responsibility of the primary duty bearer, often the State, however every actor including coordination platforms should work to support an individual to claim the full spectrum of their rights. The centrality of protection emphasizes the importance of all humanitarian actors’ involvement in protection “irrespective of their sector-specific expertise.”⁵ This includes addressing protection issues that may fall within or intersect with the usual work of the cluster or organisation; to work collectively (including multisectorally) to achieve meaningful protection outcomes; to work and mobilise actors within and beyond the humanitarian system; and to evaluate how commitments are being achieved and the progress at putting protection at the center of humanitarian response.⁶ All clusters subscribe to these commitments on the centrality of protection and the obligation to mainstream protection principles⁷ and contribute to reducing or mitigating protection risks.

Protection mainstreaming is an ongoing process that ensures all actors in a humanitarian response are aware of and incorporate protection principles into their work at every level. These principles support humanitarian actors to understand the different risks that different individuals, families, and communities face, how to avoid causing harm, and promote dignity, accountability, and equal and equitable access to services, including through referral pathways. Protection mainstreaming helps to place the human rights of each and every individual at the centre of a humanitarian response.

Health should be understood in the broadest terms as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”⁸ Universal Health Coverage is

¹ Committee on Economic, Social and Cultural Rights (2000). [General Comment No. 14: The Right to the Highest Attainable Standard of Health](#).

² IASC (1999) [Policy Paper on Protection of Internally Displaced Persons](#) and IASC (2016) [Policy on Protection in Humanitarian Action](#).

³ IASC [Policy on Protection in Humanitarian Action](#) (2016) and IASC [Principals Statement, The Centrality of Protection in Humanitarian Action](#) (2013).

⁴ See for example [IASC Strengthening Accountability to Affected People](#).

⁵ IASC (2016). [IASC Policy on Protection in Humanitarian Action, 2016](#).

⁶ *Ibid*.

⁷ See Annex 1 for definition

⁸ WHO (1946). [Constitution of the World Health Organization](#), preamble. See also [WHO Fact Sheet on Human Rights](#).

paramount to fulfilling the right to health⁹ and to ‘leave no one behind’.¹⁰ The right to health care is also specified in IHL treaties such as the Geneva Conventions and the First and Second Additional Protocols where health care and health care workers are afforded special protections.¹¹ Health care and health care workers should be protected against attacks, threats, violent obstruction of their work, and any interference with obligations to provide care to the wounded and sick.

A humanitarian health response therefore involves ensuring an equitable provision of health care such that every individual regardless of their vulnerabilities can access quality health services. Quality health care is defined as “people-centered, safe, equitable, timely, integrated, effective and efficient”¹² and as such has already mainstreamed protection principles. A comprehensive health response includes services at the primary (including community), secondary, and tertiary (specialized) levels as well as during referrals and between sectoral activities. Such care can be promotive, preventive, curative, rehabilitative and palliative and includes interventions for epidemics, outbreaks, public health emergencies, and increasing health security. Throughout this continuum and across the life course, health care supports people to claim their rights.¹³

Within these rubrics, collaboration between health, protection, and cross-sectoral actors is crucial and takes many forms. What health actors refer to as ‘social determinants’¹⁴ such as food insecurity, shelter, discrimination, and violence all have a considerable impact on both health and protection outcomes. A multisectoral response and provision of humanitarian services is therefore essential.

It is vitally important, for example, to understand the full gamut of protection risks that people face during crises, including risks specific to health programming. This requires particular attention to the needs of every individual as well as at-risk groups and people with conditions that may be stigmatized. This includes for example children, women, men, LGBTIQ+ (lesbian, gay, bisexual, transgender, intersex, queer persons and persons of another gender and sexual orientation), the elderly, people with disabilities, people with mental health conditions, people with chronic illnesses such as HIV/AIDS, tuberculosis, or other non-communicable diseases, survivors of explosive ordnance accidents, and survivors of abuse or gender-based violence. Such groups may be disadvantaged in terms of power and influence or related to the control of resources, control of their bodies, participation in public life, etc. This may be due to systemic or structural inequalities, which humanitarian crises can exacerbate. Solutions must consider the different barriers that different people face, the services each requires and the modalities on how each need these services should be provided, and therefore the co-development of the humanitarian response with them as well as the primary duty bearers.

Examples of protection activities that are led by the Protection Cluster and its partners include: gender sensitive and disability inclusive case management¹⁵ and legal services, e.g. for children and adolescents due to discrimination, abuse, early unions or marriages as well as survivors of GBV, torture, and explosive ordnance accidents; mine clearance, victim assistance and risk education; the development of safe shelters, and defending rights to land, property, and natural resources. Protection actors may also help to build an environment conducive to the respect and fulfilment of

⁹ See for example [WHO Health Topics: Universal Health Coverage](#) as well as [The 2030 Agenda for Sustainable Development](#) and [SDG Target 3.8 | Achieve universal health coverage \(UHC\)](#).

¹⁰ See [UN Sustainable Development Group leave no one behind](#) as well as WHO [Leave no one behind](#)

¹¹ See for example WHO [Quality of care in fragile, conflict-affected and vulnerable settings: taking action](#) and [ICRC IHL Databases: Treaties, States Parties and Commentaries database](#).

¹² GHC (2020) [Quality of Care in Humanitarian Settings](#) and WHO (2020) [Quality of care in fragile, conflict-affected and vulnerable settings](#).

¹³ GHC (2020). [Quality of Care in Humanitarian Settings](#).

¹⁴ See for example WHO [Social Determinants of Health](#).

¹⁵ The idea of ‘case management’ may be understood differently by different actors. Please refer to the glossary in Annex 1 for definitions according to both health and protection actors.

human rights, e.g. providing training on IHL.¹⁶ Cross-sectoral work related to protection and health includes case management for anyone in need of mental health or psychosocial support. Many of these activities will be led by or in partnership with affected individuals and communities.

Many activities that help to respect and fulfil human rights are also conducted by health and cross-sectoral actors or coordinated between them and protection actors. Examples include: the mapping and coordination of referral pathways between sectors; the clinical management of GBV including in contexts where the health system may be the only safe entry-point to report violence; the use of civil registries to document key events such as births and deaths (which can be essential to establishing a legal identity and to access essential services); engagement with state and non-state armed actors; negotiations that ensure equitable access to services for people in need; and advocacy in favor of humanitarian assistance as well as against human rights violations. Violent attacks on health care, for example, including health facilities, personnel, patients and health transport, limits access to care for people both physically and psychologically. It also limits the ability of health care workers to provide services as they may be the victims of attacks. Documenting such events and advocating on behalf of those affected enhances the protection of health care from all forms of violence and is important to ensure safe access.

Joint Programming and Integrated Programming

Joint programming and integrated programming support both protection and health actors to work together to improve outcomes for people in need of humanitarian services. Analysis, programme design, and implementation occur across a spectrum of joint and integrated work depending on the approach of each actor and context-specific inter-agency coordination mechanisms.

While joint programming supports actors to coordinate planning, implementation, monitoring and evaluation and maintain sector-specific objectives, integrated programming requires a more holistic response and prioritizes “collective over sector-specific” workstreams.¹⁷ For health actors, integrated programming is “a way of working whereby there is coordination and strategic collaboration across two or more clusters or sectors with the goal of achieving better health outcomes through collective action.”¹⁸ For protection actors, integrated programming “requires all humanitarian actors to commit, wherever feasible and appropriate, to protection objectives in the design of their activities.”¹⁹

Protection is fundamental to a quality health response and a quality health response contributes to the achievement of protection outcomes.

¹⁶ IASC (2016). [IASC Policy on Protection in Humanitarian Action, 2016](#).

¹⁷ The Alliance for Child Protection in Humanitarian Action. [Minimum Standards for Child Protection in Humanitarian Action](#).

¹⁸ WHO (2020). [Health Cluster Guide: A Practical Handbook](#).

¹⁹ IASC (2016). [IASC Policy on Protection in Humanitarian Action, 2016](#).

Joint Operational Framework: Areas of Work for Health and Protection

IASC has identified six core functions of cluster coordination to support clusters to focus on “strategic and operational gaps analysis, planning, assessment and results”²⁰ and ensure accountability to people in crisis. This Joint Operational Framework (JOF) is based on these six core functions common to all clusters as well as priority sectoral and cross-sectoral work areas of child protection, mine action, gender-based violence, sexual and reproductive health, and mental health and psychosocial support.

The six core functions of cluster coordination are: (i) To support service delivery; (ii) To inform the HC/HCT’s strategic decision-making; (iii) to plan and implement cluster strategies; (iv) to monitor and evaluate performance; (v) To build national capacity in preparedness and contingency planning; and (vi) To support robust advocacy. For each of these six core functions, the JOF suggests key deliverables, formulates basic considerations, and poses essential questions that cluster coordinators should ask themselves (and each other). Resources should be dedicated to this.

The six core functions, how they translate into the roles that clusters play in the humanitarian coordination system, and suggested interlinking key deliverables to improve health and protection outcomes are summarized in Table 1 and detailed below according to each core function. Dedicated resources such as an inter-sectoral task force or sectoral focal points may be needed to achieve these deliverables in a meaningful way.

Table 1: Summary of Deliverables for Core Cluster Functions

Core Cluster Functions and Roles		Deliverables
1	<p><u>To support service delivery</u></p> <ul style="list-style-type: none"> • Providing a platform that ensures service delivery is driven by the HRP and strategic priorities. • Developing mechanisms to eliminate duplication of service delivery. 	<ul style="list-style-type: none"> • Health Cluster, Protection Cluster, AoR, working group and relevant cross-sectoral group ToRs are endorsed and disseminated to partners. • Joint and harmonized tools are used, e.g. SOPs for service delivery, a harmonized inter-agency referral form, etc., notably for coordination with cross-sectoral actors. • 3W/4W/5Ws are regularly updated by partners with contextualized joint or integrated indicators as part of the reporting requirements. • Information sharing protocols are agreed. • Joint analysis and mapping of services and referral mechanisms that includes individuals in the process and can identify gaps. • Services respond to the joint analysis and are tailored to the different needs of different people. • Information on health and protection services is disseminated appropriately to affected communities. • Integrated feedback mechanisms are developed with actors in a position to hold the health and protection sectors accountable, e.g. affected communities and individuals, in case of sexual exploitation and abuse or other misconduct.
	<ul style="list-style-type: none"> • Providing a platform that ensures integrated service delivery is driven by the HRP and strategic priorities. • Developing inter-sectoral mechanisms to eliminate duplication of service delivery. 	
2	<p><u>To inform the HC/HCT’s strategic decision-making</u></p>	<ul style="list-style-type: none"> • Joint data and information collection tools for

²⁰ See the Cluster Coordination Reference Module (CCRM) at [Cluster Coordination at Country Level: IASC Sub-Working Group on the Cluster Approach and the Global Cluster Coordinators’ Group](#).

	<ul style="list-style-type: none"> • <i>Preparing needs assessments and analysis of gaps (across and within clusters, using information management tools as needed) to inform the setting of priorities.</i> • <i>Identifying and finding solutions for (emerging) gaps, obstacles, duplication and cross-cutting issues.</i> • <i>Formulating priorities on the basis of analysis.</i> 	<p>assessment and analysis are developed.</p> <ul style="list-style-type: none"> • Joint assessments and ongoing monitoring occur regularly using standardized sectoral tools, e.g. Public Health Situation Analysis (PHSA) and Protection Analysis Updates (PAU). • Data and information gaps analysis is conducted jointly. • Joint analysis including the identification of threats, barriers to access, vulnerabilities and capacities of at-risk groups and target populations takes place regularly (particularly for the development of an HCT Protection Strategy and Action Plan). • Joint briefings to HCT/ICCG occur regularly. • Joint analysis supports the development of collective outcomes (and thereby the implementation of the HDPN).
3	<p><u>To plan and implement cluster strategies</u></p> <ul style="list-style-type: none"> • <i>Developing sectoral plans, objectives and indicators that directly support realization of the overall response's strategic objectives.</i> • <i>Applying and adhering to common standards and guidelines.</i> • <i>Clarifying funding requirements, helping to set priorities, and agreeing cluster contributions to the HC's overall humanitarian funding proposals.</i> 	<ul style="list-style-type: none"> • Joint and/or integrated multi-year or annual planning (depending on the context) is developed. • Sectoral strategic plans integrate reference to each other and define a package of joint and/or integrated activities and services that respond to the barriers and needs faced by vulnerable and at-risk groups. • Strategic plans include HDPN profiles and action plans that identify entry points to strengthen collective outcomes. • Sectoral and/or joint standards are defined with reference to both protection and health, e.g. vis-à-vis referral services. • HNO, HRP, HCT Protection Strategy and Action Plan include joint health and protection analysis. • Costs for integrated activities are incorporated into the HRP, HCT Protection Strategy or Action Plan.
4	<p><u>To monitor and evaluate performance</u></p> <ul style="list-style-type: none"> • <i>Monitoring and reporting on activities and needs.</i> • <i>Measuring progress against the cluster strategy and agreed results.</i> • <i>Recommending corrective action where necessary.</i> 	<ul style="list-style-type: none"> • Monitoring of the HRP and HCT Protection Strategy occurs. • Joint monitoring and evaluation framework is established with common indicators, linked to existing frameworks such as the IASC Common Monitoring and Evaluation Framework for MHPSS Programmes in Emergency Settings, and periodically reviewed to ensure that it remains aligned with strategic priorities. • Training plans on protection mainstreaming for health actors and on health for protection actors. • Training plans on service mapping, safe reporting and referrals that have a survivor-centered approach.
5	<p><u>To build national capacity in preparedness and contingency planning</u></p>	<ul style="list-style-type: none"> • Liaise with national/local authorities and partners on joint and integrated programming. • Joint baseline assessment to support existing pathways and capacity strengthening plans. • Joint and/or inter-sectoral national and local capacity-strengthening strategies, including a monitoring and evaluation framework, are developed. • Inter-sectoral preparedness and contingency plans in link with national/local partners, including based on joint risk analysis are developed. • Trainings on joint, integrated, and inter-sectoral modalities. • Joint transition strategies with national/local authorities and partners for the deactivation of clusters.

6	<p><u>To support robust advocacy</u></p> <ul style="list-style-type: none"> • <i>Identifying concerns and contributing key information and messages to HC and HCT messaging and action.</i> • <i>Undertaking advocacy on behalf of the cluster, cluster members, and affected people.</i> 	<ul style="list-style-type: none"> • Advocacy platforms are mapped. • Shared vocabulary on key advocacy issues is developed. • Joint advocacy plans based on stakeholder mapping, power analysis, advocacy objectives, targets, tactics and actions, e.g. position papers, key messages, are shared. • Joint briefings to HCT, donors, and Member States occur regularly. • Joint communication priorities are identified in support of protection and health issues.
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Joint collaboration to support key outputs for Health

While context-specific priorities should be established according to available resources, it is vital for health actors to work in joint and integrated ways with protection and cross-sectoral partners to:

- **Ensure intersectoral referrals** such that individuals can claim their rights and access the entire minimum package of services across sectors.
- **Ensure that health risks are incorporated into protection risk analysis** and that threats that increase the likelihood of harm to a population such as injury, ill health, or death are duly addressed. This would include for example attacks on health care, housing of displaced populations in flood prone areas with a high likelihood of cholera outbreaks, and other social determinants.
- **Integrate protection analysis and information from AoRs and cross-sectoral groups with health analysis** to fully understand the different risks and barriers faced by different parts of the affected population to access health care, e.g. female access to emergency obstetric care, older people or people living with disabilities to access COVID-19 vaccination services, etc. Response to address these risks and barriers often requires a multisectoral response.

The integration of Mental Health and Psychosocial Support Coordination in Health and Protection

Mental Health and Psychosocial Support (MHPSS) is a cross-sectoral area of the humanitarian response with a natural strong integration with both Health and Protection as well as other sectors.

Because of its cross-sectoral nature, MHPSS must be emphasized within sectors while also ensuring its coordination across them. This can be particularly difficult because each sector may have its own technical approach to MHPSS. Having multiple disconnected coordination groups focused on MHPSS leads to miscommunication, duplication, inefficient use of resources, and gaps. In line with IASC MHPSS Guidelines, MHPSS Technical Working Groups (TWG) are ideal forums to address this challenge and work together to unite approaches. A single MHPSS TWG at country level that supports the coordination of MHPSS partners across sectors, e.g. health, protection, education, and others, should be established early in any emergency response to facilitate the humanitarian response.

Wherever possible, it is recommended that national authorities, and potentially one or more national organization(s) or actor(s) knowledgeable in MHPSS, co-chair the MHPSS TWG and are supported by international organizations, if necessary.

The MHPSS TWGs and the Inter-Agency Standing Committee Reference Group on Mental Health and Psychosocial Support (IASC MHPSS RG) at global level are well placed to support health and protection actors to integrate MHPSS considerations throughout the core functions described in this framework.

Core Function 1: To support service delivery

Clusters and AoRs support service delivery by providing a platform to coordinate sectoral and multi-sectoral approaches and eliminate duplication. This helps fulfill the right to health, uphold protection principles, and promote access to health and protection services. Common approaches or areas of convergence between health and protection objectives and activities should be identified during preparedness and in the early stages of a crisis. Once the differentiated needs of vulnerable and at-risk groups within the affected population are jointly defined, minimum and available services can be identified, mapped, and supported to ensure that joint areas of the health and protection response are coordinated in a way to optimize service delivery.

Cluster coordinators should also routinely share information between sectors on service provision gaps while ensuring that service locations and types are well-communicated to affected populations. Gaps should be addressed through inter-sectoral collaboration. This should be done on a routine basis so that a collaborative approach to the inter-sectoral information sharing processes may take shape. Health and protection actors should be continually informed of each other's work.

Critical activities for service delivery include:

[Multisectoral Presence and Response Tracking](#). An overview of Who is doing What, Where (3W), When (4W), and for Whom (5W) are key steps in the coordination of agencies and between clusters. These tools should depict the presence of cluster partners, both local and international, in each location, the types of activities being run, and key reporting indicators such as the number of people targeted or for whom services have been provided. Note that 3W/4W/5W may be sectoral or inter-sectoral and used as reporting tools, e.g. for monitoring the HRP.

[Service Mapping](#). Once the needs of the affected population including those at risk have been identified, a cluster plan and standard package of services that mainstreams protection should be jointly agreed upon and mapped. Mapping for referrals, joint services, and gap analysis should occur at the onset of a crisis and be updated throughout all stages of the response (including as emergencies transition to cluster deactivation). Service mapping needs to include the granular details of services provided, the contact information of service Focal Points, hotline numbers, eligibility criteria and conditions of access to services. Service mapping is a critical inter-sectoral tool and key to support convergence and complementarity.

[Information Sharing Protocols](#). One of the most significant constraints to the improvement of health and protection outcomes is linked to data, as agencies and sectors hesitate to share data for many reasons. For example: there may be legitimate concerns that sensitive data will not be handled appropriately or to protect sources, including related to the safety of an individual, the service, or an organisation; misunderstanding of professional data sharing standards or uncertainty about how information will be used; perceptions that controlling information can improve funding; concerns that some information could reflect negatively on an organisation, e.g. as an indicator of poor performance or an inability to generate an evidence base for decision-making; etc. Overcoming this culture of mistrust while ensuring safety and security requires dedicated and consistent efforts to change behaviour, both individual and organizational, as well as protocols that engender systems-wide buy-in. Context-specific information sharing protocols and platforms can help mitigate such concerns and ensure that data is shared safely and appropriately, in a manner that does not burden partners but promotes their engagement.

[Minimum Service Package](#). As part of the humanitarian commitment to remain accountable, clusters and working groups should jointly and in link with people affected by a crisis define the standard package of services that will be provided as part of the humanitarian response. This is critical to ensure a person can claim their wider rights and access the full spectrum of services to which they are entitled.²¹

[Referral Pathways](#). Referral pathways define how service delivery is linked across sectors to provide holistic care for every individual and ensure a person can claim their wider rights and access the full standard package of services to which they are entitled. Cluster coordinators should jointly agree on referral pathways as well as a universal or inter-agency referral form.²² Note that inter-agency referral processes should remain flexible enough to account for sensitive issues, e.g. anonymity of certain cases or the location of safe spaces. Cluster coordinators should establish processes for updating, sharing, and orienting partners on referral pathway tools and services. In some contexts, defined referral pathways may support the development of Standard Operating Procedures (SOPs) or serve as a reference tool for actors at the local level.²³

[Standard Operating Procedures \(SOPs\)](#). It is critical to jointly define what services should be provided, roles and responsibilities across sectors (and actors) by jointly developing Standard Operating Procedures (SOPs). This allows actors across sectors to harmonize and standardize services and approaches to ensure the multi-sectoral needs of an affected individual are fully identified and addressed.²⁴ SOPs commonly describe guiding principles, reporting and referral mechanisms, services to be provided by different actors and sectors, mechanisms to engage communities, how to ensure data protection, and coordination at all levels.

Key Considerations

- Multi-sectoral referral pathways used by actors delivering services at the operational level should be based on pre-identified service delivery points and activity mapping.
- Multi-sectoral 4W/5W mapping should be conducted and shared across all sectors to ensure an understanding of the services available, gaps, and to avoid duplication.
- Information sharing protocols between the Health Cluster and Protection Cluster should be developed around data protection, compliance, and accountability.
- Training should be developed for all stakeholders on joint and harmonized tools. For example, front-line service providers who are working across sectors such as community health workers should receive training at regular intervals that complement their backgrounds, including on protection mainstreaming, basic psychosocial skills such as psychological first aid, how to identify people for a variety of risks, and referral of those in need of further support. Other sector specific trainings should also be proposed.
- Inter-sectoral programming at the service provision level can improve access where sectoral programming may be challenged; e.g. explosive ordnance risk education (EORE) could be

²¹ See for example [IASC Minimum Service Package Mental Health and Psychosocial Support](#) and [Minimum Initial Service Package \(MISP\) for SRH in Crisis Situations](#).

²² See Annex 2.

²³ GBV AoR (2019). [Handbook for Coordinating Gender-based Violence Interventions in Emergencies](#).

²⁴ The Alliance for Child Protection in Humanitarian Action (2019). [Minimum Standards for Child Protection in Humanitarian Action](#).

conducted by accredited community health care workers where EORE activities are otherwise not possible due to access issues.

- Safety and security assessments by relevant actors should be conducted and shared across sectors and measures put in place to ensure safe and secure access by service providers, especially for those most marginalized among the affected population

Essential Questions

- Has an integrated analysis identified the needs of the affected population including at-risk and vulnerable groups? Has a package for each sector as well as integrated services, been defined to address these needs? Has inter-sectoral coordination around these activities occurred?
- Have girls, boys, women, men, and other groups from the affected population been consulted regarding their service seeking intentions and/or preferences? Has the appropriateness and accessibility of services been addressed in the package of sectoral and integrated services?
- Have local and national partners and service providers been consulted and have they participated in the service mapping? Has the mapping been communicated and approved by service providers? Are community-based organizations aware of the different services available at the local level?
- Are humanitarian protection and health actors aware of local or national institutions that are licensed to provide services in cases where rights have been violated?
- Have common terms been defined across sectors to ensure all actors are referring to the same action and is this reflected in multi-sectoral mapping, referral pathways, and SOPs?
- How will protection risks be minimized during an individual's referral to service providers? Are health workers trained and compliant with humanitarian principles, medical ethics, and commitments to prevent sexual exploitation and abuse (SEA)? How will different service providers access an individual's information and ensure that the data is protected? Have risks inherent to social media been accounted for?
- Are the respective roles of the Health Cluster, Protection Cluster, AoR, working groups and relevant cross-sectoral groups understood by all stakeholders and reflected in agreed upon SOPs and referral pathways?
- Is proper due diligence conducted for land rights in complex environments before the construction of health infrastructure, e.g. hospitals, clinics, burial sites, etc.?
- Are there linkages between the mental health and psychosocial support services provided through Protection Cluster partners and Health Cluster partners?

Promising Practice

In the Syrian Arab Republic, the Mine Action sub-sector in close collaboration with the Physical Rehabilitation and Disability Working Group and Child Protection AoR has established a Victim Assistance Working Group to coordinate actors working in protection, health, livelihoods, and education and improve access to services and social protection for survivors and indirect victims of explosive ordnance. The group has identified over 250 services in thirteen governorates to develop a service mapping dashboard that includes information on relevant service providers, their contact details and the types of service provided. Providers are categorized as psychosocial and socio-economic services (social support for persons with disabilities, inclusive education for children with disabilities, in-kind assistance, vocational training) and disability specialized services (needs assessment, physical rehabilitation, assistive devices for hearing or visual impairment, psychiatric, prosthesis, occupational therapy, speech therapy). The data is searchable by geographical region, governorates, districts, implementing partner, sector, and donor. This mapping complements the Protection Resource Matrix and other sectoral mapping such as GBV and Child Protection services. It currently represents the main source of information at cluster level on disability inclusive services available across all sectors. Through this work, the Victim Assistance Working Group aims to increase access to services for persons with disabilities, including explosive ordnance survivors.

In Ukraine, the Protection Cluster is in dialogue with the Trauma & Rehabilitation Working Group and the MHPSS Working Group (both within the Health Cluster) on how to develop a joint referral network for specific vulnerable groups such as children and adults with disabilities, including mental health conditions, survivors of GBV, and those with chronic disease or injuries.

In Colombia, the Protection and Health Clusters work closely on the Prevention of Sexual Exploitation and Abuse (PSEA). The GBV AoR and the Sexual and Reproductive Health sub-group have an integrated space to generate and mainstream awareness on this issue. This is shared with other clusters via the Inter-Cluster Coordination Group.

Additional Resources

- IOM (2022). [Manual on Community-based Mental Health and Psychosocial Support in Emergencies and Displacement - Second Edition.](#)
- IRC (2022). [Integrated Health and Protection Outbreak Response Toolkit.](#)
- IASC (2021). [IASC Operational Guidance on Data Responsibility in Humanitarian Action.](#)
- CP AoR (2021). [Working with other sectors to enhance outcomes of MHPSS elements of child protection: An introductory guide for child protection practitioners.](#)
- IASC (2021). [The Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings: with means of verification.](#)
- WHO (2020). [Violence Prevention through Multisectoral Collaboration.](#)
- GPC and MHPSS RG (2020). [MHPSS and protection outcomes.](#)
- GHC (2020). [Quality of Care in Humanitarian Settings.](#)
- GHC (2020). [Essential Health Services: A Guidance Note.](#)
- The Alliance for Child Protection in Humanitarian Action (2019). [Minimum Standards for Child Protection in Humanitarian Action.](#)
- IASC (2019). [IASC Guidelines, Inclusion of Persons with Disabilities in Humanitarian Action.](#)
- GBV AoR (2019). [Handbook for Coordinating Gender-based Violence Interventions in Emergencies.](#)
- GBV AoR (2019). [The Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming.](#)
- IASC (2018) [The Gender Handbook for Humanitarian Action.](#)
- Protection Information Management (2018). [Framework for Data Sharing in Practice](#)

- IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings (2017). Inter-Agency Referral Form and Guidance Note.
- WHO (2016). Policy statement on data sharing by WHO in the context of public health emergencies.
- UNFPA (2015). Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies.
- IASC (2012). Who is Where, When, doing What (4Ws) in Mental Health and Psychosocial Support: Manual with Activity Codes.
- GBV AoR (2010). GBV SOP Workshop Manual for the Gender-based Violence Standard Operating Procedures Guide.
- Global Health Cluster (2009). Health Resource Availability Mapping System (HeRAMS).
- IASC (2008). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings: Checklist for Field Use.

Core Function 2: To inform the HC/HCT's strategic decision-making

Working to improve protection and health outcomes requires continuous, context-specific analysis of risks that affected individuals are facing, as well as strategic thinking about what can be achieved in the short, medium, and long term (with defined intermediary steps and benchmarks to reach these goals). Cluster coordinators and agencies need to assess the capacity and willingness of the primary duty bearers to address health and protection concerns as well as understand the threats, vulnerabilities and capacities of affected individuals and the health and protection issues they face.

Assessments might be performed by individual sectors or jointly via inter-sectoral coordination mechanisms at the onset of a crisis and throughout the HPC. Analysis should be performed jointly and be supported by a range of health and protection actors. Joint analysis allows for a more integrated understanding of the inter-relationships between needs, their underlying causes, and vulnerabilities, resulting in a more targeted response. To conduct joint analysis, streamlined and cohesive criteria on threats, vulnerability, and needs must be clearly defined. Criteria should take into account the national information landscape and include indicators of vulnerability collected through primary and secondary data sources and disaggregated by age, gender, physical ability as well as related to discrimination, marginalization and exclusion. Protection and health outcomes may be expressed at the individual, household, community or population sub-group level with vulnerabilities and existing capacities described in relation to a certain threat.

Joint analysis will allow for joint identification of risks, prioritization of geographical areas, affected population groups, activities, response strategies, and advocacy. This will be reflected in the Humanitarian Needs Overview (HNO), Humanitarian Response Plan (HRP), and other Humanitarian Country Team (HCT) products as well as Protection Analysis Updates (PAUs), Public Health Situation Analysis (PHSA), and cluster strategies.

Important activities that help to inform the HC/HCT's decision-making include:

[Data and Information Collection](#). The different needs and capacities of different affected and at-risk populations within a given context can be identified through a variety of mechanisms including: context analysis; assessments conducted by individual clusters, sub clusters and working groups; joint assessments between the Health and Protection clusters; protection risk analysis conducted by the Health Cluster, supported by the Protection Cluster; Public Health Situation Analysis (PHSA); multi-sectoral needs assessments; Health and GBV Safety Audits; Protection Monitoring Initiatives and Protection Analysis Updates (PAUs) led by the Protection Cluster with input from all clusters; GBV risk analysis; gender analysis; surveillance of attacks on health care, led by the WHO; tools from cross-sectoral areas of work such as the MHPSS, and assessments conducted by individual actors within their sector of expertise. Data should be disaggregated by sex, age, disability, and, where appropriate, ethnicity or other indicators. Tools should be aligned with IASC endorsed guidance on intersectoral needs assessment.²⁵

[Data Analysis and Validation](#). Relevant, reliable quantitative and qualitative data is key to informing a health and protection response, however information management is sometimes conducted in isolation due to the absence of joint analytical approaches or routine sharing of information across sectors to inform joint areas of work. Analysis of data collected through joint needs assessment should (i) identify and prioritize who requires

²⁵ OCHA (2021). [Joint Intersectional Analysis Framework 1.1](#). NB: This document (JIAF 1.1) is currently under review and an updated version JIAF 2.0 is expected. IASC (2012). [Operational Guidance for Coordinated Assessments in Humanitarian Crises](#).

assistance, where and when, and what is needed based on timely information and analysis and (ii) inform strategic planning based on an analysis of the relevance, effectiveness and efficiency of the humanitarian response.²⁶ The humanitarian coordination architecture is important only insofar as it delivers services to meet such holistic needs.

[Protection Analysis](#). Protection analysis is important to all core functions. It is typically led by the Protection Cluster and supported by other clusters to identify the main protection risks and underlying factors, with the aim of informing strategies and responses. Protection analysis details the threats, vulnerabilities, and capacities that are available to an affected population to cope with a threat or to resist or mitigate the impact of a threat and is used to formulate response priorities. This feeds into the evidence base for joint analysis in the development of the HNO, HRP, HCT Protection Strategy, and PAUs.²⁷ Protection analysis, including for the health sector, should be conducted regularly to ensure proper mitigation measures can be incorporated into the joint response.

[Public Health Situational Analysis \(PHSA\)](#). Led by the Health Cluster, this risk assessment of potential health threats that populations affected by humanitarian crisis may face over time includes an understanding of current health status and the likelihood and potential impact of major health threats. PHSA incorporates contextual factors that may increase health risks such as attacks on health care, insecurity, displacement, environmental conditions such as WASH and shelter conditions, and movement restrictions. PHSA also includes analysis of local capacities to address these risks from both health system and humanitarian angles.

Key Considerations

- Involve the Health Cluster in protection analyses, e.g. conducted by the Protection Cluster, via a structured approach to identify, assess, and mitigate risks for individuals and related to program settings.
- Involve the Protection Cluster and protection analysis in Health Cluster risk analysis, e.g. PHSA, to help identify the different risks faced by different groups as well as the barriers they face in meaningfully accessing health care.
- The Protection Cluster should support the Health Cluster by assigning focal points for training, capacity building, support to risk analysis, protection mainstreaming and different approaches to integration. This should include inputs or focal points from the AoR as needed, e.g. Health Cluster focal points in the GBV service directory.
- Information management specialists in the Protection Cluster and Health Cluster are generally the technical and methodological leads of the analysis process to ensure that secondary and primary data are used following the sectoral and inter-sectoral methodologies.²⁸ They also ensure that information sources are reliable, easily accessible and build on local data systems.
- Health and Protection information management specialists together with cluster coordinators should define the purpose of the assessment and analysis, develop the planning, geographic coverage, and data collection modalities, and agree on indicators and sources of information.

²⁶ IASC (2019). [Advancing Coordinated Needs Assessment and Analysis Through the Grand Bargain](#).

²⁷ GPC (2021). [Protection Analytical Framework](#). GPC (2016). [Humanitarian Country Team Protection Strategy: Provisional-Guidance Note](#).

²⁸ See for example: [Protection Analysis and HPC guidance and tools](#) and the [Joint Intersectoral Analysis Framework](#).

- According to the operational environment, agree on a set of indicators between Health and Protection clusters and make use of them to harmonize assessments, monitor and evaluate joint programming. The use of both quantitative and qualitative indicators is vital in all phases of an assessment, as is data disaggregation by age, sex, disability and, where appropriate, ethnicity or other relevant indicators.
- An integrated HNO joint analysis framework should reflect sector-specific community needs at the national and sub-national level.
- Health and Protection clusters should coordinate with the MHPSS Technical Working Group to integrate MHPSS information relevant to joint sectoral analyses.
- Joint sectoral analysis results should be communicated incrementally to decision-makers, community authorities, sectoral partners and others to whom clusters are accountable when relevant information becomes available. Results should be shared promptly in an agreed upon manner and must highlight the identified health and protection data gaps and/or limitations.
- Monitoring of attacks on civilians and civilian infrastructure (including healthcare, health care providers and other protected groups) should be conducted jointly by Health and Protection clusters with the support of OCHA, WHO, and the HCT. This will provide an evidence base to identify global and context-specific trends and patterns of violence, inform risk reduction and resilience measures, and for advocacy to stop such attacks and reduce the impact of violence.

Essential Questions

- How is data collected and shared between sectors? How, when, and where is this information shared? Does this information feed into risk assessments such as PAUs and PHSA as well as strategic processes like the HNO/HRP? Is this information routinely shared to inform the operational response in a timely manner?
- Does data and information sharing inform the prioritization and operationalization of protection and health activities to respond to the different needs of different groups?
- Are the most appropriate actors collecting, analysing, and sharing useable data? Is data collected, stored, and shared in line with the protection information management principles, including do no harm, informed consent, confidentiality, and data protection?
- Where possible, does information sharing go beyond sex, age, and disability disaggregation to inform common approaches when relevant. Do information sharing protocols conform with the principles of do no harm?
- Is the Health Cluster involved in the design of the protection monitoring mechanisms and the protection risk analyses led by the Protection Cluster (and vice versa)? Does the Health Cluster take part in the prioritization of protection risks for overall collective action, e.g. linked to the HCT Protection Strategy or Action Plan?
- Is the Protection Cluster involved in the PHSA led by the Health Cluster to help identify threats, vulnerabilities and capacities that may negatively affect health outcomes?

- Has the HCT undertaken an analysis of data gaps across the clusters in terms of sex and age-disaggregated data (SADD) on disability and/or gender to inform the development of the HNO/HRP? Have the Health Cluster and Protection Cluster reflected these findings accordingly in their specific and joint areas of work?
- Have the Health Cluster, Protection Cluster, AoRs, working group and cross-sectoral group coordinators shared synthesized data with each other to ensure harmonization on data and to foster joint analysis initiatives?
- Has analysis been validated by local actors who are partners of the respective clusters, for example through their participation in joint analysis sessions? How are local communities engaged in the interpretation of the data, identification of problems and solutions? Has this work been shared with community members to ensure it correctly interprets information and appropriately feeds into the evidence-base of decision-making? Has the information been used to have discussions with different parts of the community to collaboratively design programmes across sectors to address needs? Does this inform early warning mechanisms and timely adjustments to programming?

Promising Practice

In Nigeria, health and protection sectors worked together to better understand the drivers and impact of violence against health staff, patients, and infrastructure in the northeast of the country. Based on the priorities set by frontline health care workers, health and protection sector partners worked with government officials to jointly identify the best forms of prevention and response to such violent incidents. An integrated protection/health data collection tool was developed based on the WHO definition of an attack on health care and the results were analysed according to a tailored version of the Protection Analytical Framework (PAF) during dedicated joint analysis sessions. The findings were jointly published as Joint Health Staff Survey: Protection of Health Care in Northeast Nigeria.

Additional Resources

- Insecurity Insight, et al. (2023). Toolkit: Evidence That Protects Health Care.
- IASC MHPSS RG (2022). Handbook for Mental Health and Psychosocial Support (MHPSS) Coordination.
- IASC MHPSS RG (2022). The Mental Health and Psychosocial Support Minimum Service Package.
- IASC MHPSS RG (2022). Guidance Note: Addressing Suicide in Humanitarian Settings.
- IAWG on Reproductive Health in Crises (2022). Minimum Initial Service Package for Sexual and Reproductive Health in Crisis Situations (MISP).
- WHO (2022). INSPIRE: seven strategies for ending violence against children: uptake between 2016 and 2021.
- Global Protection Cluster (2021). GPC and AoRs HPC Guidance.
- Global Protection Cluster (2021). Protection Analytical Framework.
- WHO (2019). Surveillance System for Attacks on Health Care (SSA).
- WHO and GHC (2018). Public Health Situational Analysis Standard Operating Procedures.
- Child Protection AoR (2018). Needs Identification and Analysis Framework (NIAF).
- WHO and UNHCR (2015). mhGAP Humanitarian Intervention Guide: Clinical Management of Mental, Neurological and Substance Use Conditions in Humanitarian Emergencies.
- IASC MHPSS RG (2013). Mental Health and Psychosocial Support Assessment Guide.
- IASC (2012). Operational Guidance for Coordinated Assessments in Humanitarian Crises.

Core Function 3: To plan and implement cluster strategies

Protection underpins all humanitarian action. HCTs are responsible for ensuring that protection is central to all humanitarian work, including by informing access to and provision of quality health care.

Important products that help to plan and implement cluster strategies include:

[Humanitarian Needs Overview \(HNO\)](#). The HNO provides an evidence base and analysis of the magnitude and severity of the crisis and most pressing humanitarian needs (including related to health and protection).²⁹

[Humanitarian Response Plan \(HRP\)](#). The needs defined in the HNO inform the development of the HRP. The HRP describes both the overall HCT strategy as well as cluster plans. The country strategy and strategic objectives (including indicators) capture protection priorities and often mirror health priorities.³⁰ Each cluster develops response plans that contribute to the strategic objectives outlined in the HRP.³¹ As such, the Protection Cluster strategy within the HRP establishes the objectives, activities, and capacity needed to address key protection issues within the scope of the Protection Cluster, i.e., for protection actors.³² Likewise, the Health Cluster strategy within the HRP also defines objectives, activities and capacities needed to achieve HRP objectives that can be addressed by health actors. Joint or integrated planning and programming that responds to the strategic objectives of the HRP may also be reflected in cluster or multisectoral strategies.

[HCT Protection Strategy](#). The main purpose of an HCT Protection Strategy is to mobilize a systems-wide multi-sector effort to prevent or respond to the most serious protection risks facing affected populations as well as to prevent and stop recurrences of violations. The development of an HCT Protection Strategy provides an opportunity for health and protection actors to jointly develop key messages and joint indicators at the strategic level. It supports an HCT to focus its attention and to act on protection priorities that may go beyond the scope of an HRP and/or the strategy of the Protection Cluster. The HCT Protection Strategy is not strictly tied to the HPC yet it can inform, and be informed by, HPC deliverables, e.g. the HRP and cluster strategies.³³

Key Considerations

- Cluster Lead Agencies should support the participation of relevant health and protection stakeholders in the development of the HCT Protection Strategy and in the implementation of the strategy's action plan. The development of an HCT Protection Strategy provides an opportunity to integrate key messages around health and protection.
- The Protection Cluster should ensure that protection mainstreaming principles are integrated into all planning processes, including at the cluster and working group level.
- Provide information in local languages and at the sub-national level through appropriate channels to remove barriers for organizations and local authorities to participate and take

²⁹ See for example [Strategic response planning: Overview](#).

³⁰ Ibid.

³¹ Ibid.

³² GPC (2016). [Humanitarian Country Team Protection Strategy: Provisional-Guidance Note](#).

³³ Ibid.

ownership of coordination structures and the development and implementation of a joint health and protection response.

- Integrated health and protection indicators should include quantitative and qualitative measurements to assess the impact of integrated and intersectoral programming.
- Health and protection actors should coordinate with cross-sectoral areas of work, e.g. MHPSS via the MHPSS Technical Working Group, to integrate data and indicators into the HRP that are relevant to the cross-sectoral workstream within each cluster.

Essential Questions

- Has the Health Cluster been consulted in the development of the HCT Protection Strategy and for AoR strategies, e.g. related to GBV? Inversely, is the Health Cluster strategy and its activities informed by a collective protection analysis or HCT Protection Strategy?
- Are joint and/or integrated areas of work reflected in the HCT Protection Strategy to facilitate advocacy on health and protection outcomes?
- Has the Health Cluster used multisectoral data including protection analysis produced by the Protection Cluster, AoR or cross-sectoral working groups to ensure service delivery is appropriate and relevant to address the different needs of different groups affected by crisis?
- Has the Health Cluster undertaken a protection risk analysis in line with their protection mainstreaming commitment when designing and delivering programs, for example to ensure they do no harm? Has the Health Cluster consulted with the Protection Cluster to support this analysis?
- Have the Health and Protection clusters including sub clusters and working groups planned joint areas of work to establish common priorities to guide planning and implementation?
- Does at least one strategic objective in the HRP reflect convergent approaches between the Health Cluster and Protection Cluster (including AoRs and working groups)? Are there common or sector-specific indicators that reflect cross-sectoral areas of work? How will these activities and indicators be monitored?

Promising Practice

In Iraq during the COVID-19 period of movement restrictions enforced by the government, GBV service providers were required to have government approval to do their work. These requirements resulted in an inability to identify new cases, delays in referrals, and delays in the distribution of dignity kits. Prompted by this apparent reduction in services, the Iraq GBV AoR conducted an online survey to examine GBV service utilization. A total of 36 GBV partners including 23 national NGOs and 13 INGOs shared information on 109 GBV service provision points. Sixty-five percent of these service provision points reported an increase in reported cases of GBV. Among those reporting, 94% observed an increase in disclosures of intimate partner and family member violence. Respondents also indicated that female-headed households, adolescent girls, under-age mothers, and families perceived to be affiliated with extremist groups were the groups most at risk of experiencing GBV. The Health and Protection clusters in collaboration with service providers therefore adapted their strategic approach and moved to channel resources into remote case management, psychosocial support, dignity kit distribution, prevention, addressing social stigma, and training on the [Handbook](#)

for Coordinating Gender-based Violence Interventions in Emergencies. National NGOs were also supported to integrate GBV services into their mental health and psychosocial support programs and health facilities developed information materials for GBV survivors seeking psychosocial support and other services. A GBV counselling flowchart was developed for primary healthcare workers that clarified management methods and referral pathways. WHO Iraq further trained frontline staff from the Ministry of Interior and Ministry of Defence on GBV and psychological first aid as these were the ministries responsible to enforce movement restrictions and therefore often survivors' first point of contact and a key source of GBV referrals.³⁴

Additional Resources

- IASC (2023). Humanitarian Needs Overview and Humanitarian Response Plan templates.
- Global Protection Cluster (2020). Protection in a Climate of Change: Strategic Framework 2020-2024.
- UN Mine Action (2018). The United Nations Mine Action Strategy 2019 – 2023.
- Global Protection Cluster (2017). Protection Mainstreaming Toolkit.
- Global Protection Cluster (2016). Provisional Guidance Note: Humanitarian Country Team Protection Strategy.
- Global Protection Cluster (2014). Protection Mainstreaming Training Package.

³⁴ Barriers to Gender Based Violence (GBV) health services in humanitarian settings during COVID-19: A desk review from Cox's Bazar (Bangladesh), Iraq, & Northeast Nigeria.

Core Function 4: To monitor and evaluate performance

The purpose of joint monitoring and evaluation (M&E) is to ensure that integrated programs are efficient, effective, and equitably meet the different needs and priorities of different groups within affected populations identified through joint sectoral and inter-sectoral needs assessments. Systematic approaches to M&E gather evidence on integrated programming through joint frameworks, ensuring that Health and Protection clusters remain accountable. A set of joint health and protection indicators can measure collective outcomes and specifically assess healthcare quality and access as well as the protection risks and vulnerabilities of individuals in each context. Joint monitoring tracks the outcomes of integrated activities and measures progress toward the HRP strategic objectives while ensuring that converging areas of work are implemented in a timely manner. Evaluations identify areas for current and future programming to improve and measure the extent to which results have been achieved and joint areas of work remain appropriate, effective, and accountable to an affected population.

Key Considerations

- Health and protection indicators should move beyond quantitative indicators benchmarking success via minimum targets, e.g. for HRP process, to include qualitative indicators to assess scope, type, access and quality of services. Resources must be allocated for this.
- Cluster, AoR, working group and cross-sectoral coordinators should conduct joint monitoring missions to ensure regular assessment of integrated and inter-sectoral activities.
- Harmonized indicators should include harmonized reporting requirements. Findings should be used for advocacy initiatives to the Inter-Cluster Coordination Group (ICCG), HCT, and other platforms when possible.
- M&E frameworks should include information-sharing protocols and people-centred feedback mechanisms to ensure accountability to crisis-affected individuals.
- Existing M&E frameworks should be consulted for cross-sectoral areas of implementation via country level coordination mechanism, e.g. MHPSS Technical Working Groups, to integrate validated common indicators and means of verification.
- Sectoral monitoring and reporting capacities should be strengthened to capture data that has been disaggregated by sex, age, and characteristics that have been jointly agreed upon to understand protection risks relevant to the context, e.g. race, ethnicity, migratory status, disability, geographic location, sexual orientation, stigmatized income conditions, gender identity and expression, etc.
- The capacities of international, national, and local actors to identify risk factors at an early stage in planning should be strengthened. Risk mitigation procedures should be developed throughout the stages of the HPC and shared across sectors. Where access is difficult, the relevant sectors could engage each other and cluster partners for integrated activities.
- Monitoring and evaluating HRPs should be informed by the participation and feedback of crisis affected populations (including evidence of cluster participation).
- Output performance metrics should be included in the HNO, HRP and HRP monitoring reports.

- The perceptions of affected populations should be qualitatively collected and independently analysed by third party monitoring to limit institutional bias.

Essential Questions

- Have Health and Protection cluster, AoR, working group and cross-sectoral partners jointly agreed upon monitoring indicators that reflect integrated programming?
- Do Health and Protection cluster, AoR, working group and cross-sectoral coordinators regularly inform other coordinators of monitoring outcomes including related to the provision of data, analysis, changes to 4W/5W activity, and service mapping that affects integrated programming?
- Are specific inter-sectoral indicators used in multi-sectoral assessments for monitoring at the household, community, and institutional levels? Are these reflected in the HRP?
- Have health actors been routinely trained on protection mainstreaming and risk identification to ensure knowledge transfer and institutional learning? Is this reflected in M&E plans for common health and protection approaches?
- Is situational evidence routinely collected by the Health and Protection clusters to monitor health and protection risks and the affected population's capacity to respond to these risks?
- Is reliable data routinely collected and are integrated activities updated to reflect identified changes in programming?
- Are health and protection data being shared with national data management systems that are used to inform national health strategies and policies?
- Are joint M&E processes performed throughout all stages of the HPC including with AoR, working groups and cross-sectoral areas and is this work reflected in the mid-year review of the HRP?

Promising Practice

For the HRP in oPt, there is robust collaboration between Health and Protection clusters whereby a protection focal point reviews the health projects to ensure appropriate protection mainstreaming.

Additional Resources

- IASC (2021). IASC Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings: With means of verification (Version 2.0).
- IASC (2018). Inter-Agency Humanitarian Evaluations – Process Guidelines.
- OCHA (2015). Humanitarian Response Monitoring Guidance.
- WHO (2011). The Humanitarian Emergency Settings Perceived Needs Scale (HESPER).

Core Function 5: To build national capacity in preparedness and contingency planning

Strengthening the capacities of governments as the primary duty-bearer and civil society involved in health and protection builds long-term resources to respond to humanitarian, health, and protection emergencies. Capacity building for cluster coordinators on preparedness and response is also critical to effectively and efficiently improve health and protection outcomes: coordinators who have the capacity to mainstream protection principles will strengthen the capacity of partners and individuals involved in response activities.

Key Considerations

- A capacity strengthening strategy or plan should identify and respond to the needs of national institutions, communities, cluster coordinators and partners across all aspects of the HPC to support long-term development of inter-sectoral response. Clusters, AoRs, and working groups should conduct internal skills assessments to ensure that national and sub-national coordinators are trained on protection mainstreaming.
- Long-term approaches to capacity development can strengthen institutional knowledge and mitigate loss of capacity due to staff turnover (while also strengthening both technical and operational capacities of cluster partners).
- Cluster coordinators, co-coordinators and partners would benefit from inter-sectoral training and guidance on: indicators; reporting; advocacy; the roles and responsibilities of the HCT, clusters, AoRs and working groups; ToRs of cluster coordinators and co-leads, including related to integrated programming; introduction to sector-specific core thematic issues in emergencies, e.g. minimum services, minimum standards; the expectations and limitations of each sector; sector-specific activities, e.g. an introduction to basic implementation tools; international humanitarian and international human rights law, including the use of rights-based language; information management systems used by the Health Cluster, Protection Cluster and AoRs, e.g. the Public Health Information Services, the Child Protection Information Management System (CPIMS), Gender-Based Violence Information Management System (GBVIMS); M&E frameworks.
- Beyond training, a joint and harmonized protocol for collecting socio-demographic data, e.g. to define at-risk and vulnerable groups, is useful for governments as well as international and national humanitarian actors and should include reference to protection principles.
- Where applicable, health and protection data should be coordinated with national data management systems to inform national health policies.

Essential Questions

- Is there inter-ministerial coordination between cross-sectoral areas of work, e.g. MHPSS? Do cluster and/or working group coordinators liaise with such a platform or is support needed to facilitate it?
- Do Health, Protection, sub cluster and working group coordinators consult with each other vis-à-vis their respective government counterparts, e.g. for legal and policy challenges?

- Do Health and Protection cluster coordinators understand the roles and responsibilities of other sectors and working groups vis-à-vis their sectoral responsibilities, e.g. how MHPSS is a cross-cutting area of work in all preparedness and response activities?
- Have the training needs of cluster coordinators and partners at the national and sub-national level been identified and developed to ensure coordinated approaches to the health and protection response?
- Have inter-sectoral training materials and plans been shared with cluster partners to ensure long-term knowledge transfer?

Promising Practice

In Bangladesh during the height of the COVID-19 pandemic in 2020, access restrictions limited movement and the provision of services for many actors. This led the Health Sector to strengthen cooperation and coordination between the SRH Working Group and the GBV sub-sector to ensure the continuity of GBV services including case management and psychosocial support. Despite funding cuts, providers were able to continue to work remotely thanks to multi-pronged support to national and local actors: training was provided to community volunteers to fill key gaps; training on gender and protection mainstreaming was provided for frontline health workers and program managers; engagement was enhanced with women community leaders, LGBTIQ+ rights organizations and working groups, and informal networks to reach GBV survivors; referral pathways were updated according to the newly restricted environment; and the guideline on Clinical Management of Rape and Intimate Partner Violence Survivors (CMRIPV) was translated into Bangla for frontline providers.³⁵

In the Democratic Republic of Congo (DRC), health and protection actors have coordinated to develop joint contingency plans and identified locations at high-risk of displacement due to conflict-related violence. In these locations, training to health professionals has been provided and post-exposure prophylactic (PEP) kits have been pre-positioned. This has allowed for a rapid response to the health consequences of GBV in these areas as the conflict evolves.

Additional Resources

- GPC (2017). Protection Mainstreaming Toolkit.
- WHO and UNHCR (2012). Assessing mental health and psychosocial needs and resources: toolkit for humanitarian settings.
- IOM (2010). Psychosocial Needs Assessment in Emergency Displacement, Early Recovery, and Return.

³⁵ Barriers to Gender Based Violence (GBV) health services in humanitarian settings during COVID-19: A desk review from Cox's Bazar (Bangladesh), Iraq, & Northeast Nigeria.

Core Function 6: To support robust advocacy

Advocacy is fundamental to achieve common outcomes on critical protection and health issues and is a key responsibility for Health and Protection Cluster Coordinators. Advocacy may be directed to a variety of stakeholders including community, national, non-state, international or global level actors. This requires coordinated advocacy strategies, shared messaging, resources, and platforms. Advocacy activities should also include efforts to remove existing operational barriers to joint and integrated programming, e.g. siloed reporting requirements and funding opportunities.

Key forums to support robust advocacy include:

[Advocacy Working Group \(AWG\)](#). Beyond information sharing and joint analysis of data, AWGs coordinate the development of joint advocacy strategies and actions, e.g. identifying advocacy priorities, framing advocacy common messages, developing related advocacy products, engaging and influencing key target audiences, and providing support to communication with communities.

[Inter-Cluster Coordination Group \(ICCG\)](#). The ICCG is well positioned in the humanitarian coordination architecture to advocate for integrated health and protection programming to be factored into strategic processes such as the HRP and HCT Protection Strategy.

[Humanitarian Country Team \(HCT\)](#). The WHO and UNHCR, as Cluster Lead Agencies (CLAs) for health and protection, respectively, represent the Health and Protection clusters in the HCT. Representatives of the CLAs should be informed of joint health and protection needs and apprised of joint initiatives, assessment findings, and targeted advocacy messaging.

Key Considerations

- Joint stakeholder analysis should further identify key advocacy targets at local, national, and global levels to inform an advocacy strategy. This stakeholder analysis should furthermore support the work of all the core functions.
- Cluster coordinators should attend coordination meetings of other sectors at least quarterly and have a standing agenda item monthly to ensure regular communication and updates with other sectors, especially in contexts where shared advocacy mechanisms do not exist.
- In contexts where advocacy is channelled from the AoRs to the Protection Cluster and then from the Protection Cluster to the Health Cluster, consider multi-lateral meetings between all coordinators to share information in a timely way and ensure clarity in messaging.
- Key messages on shared advocacy priorities should be developed jointly and disseminated across relevant products, e.g. related to common protection and health priority issues such as attacks on healthcare, increased health risks for populations living in inadequate environmental conditions, the impact of violence and conflict on mental health and wellbeing, the lack of integrated services or resources dedicated to providing care to GBV survivors or survivors of explosive ordnance accidents, bureaucratic and administrative impediments to the provision care, etc.
- Monitoring of attacks on civilians and civilian infrastructure (including healthcare, health care providers and other protected groups) and advocacy to stop attacks on civilians and civilian infrastructure and reduce the impact of such violence towards all concerned actors

to ensure the full respect of international humanitarian and human rights law should be conducted jointly by Health and Protection clusters with the support of OCHA, WHO, and the HCT.

- Terminology should be clear and all actors from all sectors should understand it. While health actors should be able to understand and apply protection terminology, protection actors should have a grasp of health-related terminology, e.g. related to clinical mental health conditions across sectors to avoid over- or under- referrals for care. Terms and indicators may need to be developed jointly for priority issues that require the mobilization of special resources or for specific advocacy channels.
- Health and Protection actors should capitalize on the AWG to share strategic priorities and messaging toward the HCT. The absence of an AWG however should not deter the elevation of strategic health and protection advocacy priorities to the HCT for action. Seek the active engagement and final endorsement of the HC/HCT for actions and messaging. Messaging can be monitored through an HCT Protection Strategy and work plan.

Essential Questions

- Are advocacy platforms, mechanisms and groups mapped at national and sub-national levels?
- Are existing protection monitoring and surveillance systems for attacks on health care used for evidence-based advocacy?
- Have joint advocacy priorities between health, protection actors, and cross-sectoral actors been identified?
- Have joint advocacy plans based on objectives, stakeholder mapping, power analysis, targets, tactics and actions been developed?
- Has joint messaging between health and protection actors been developed and taken forward with targeted audiences at the national and/or global level?
- Is sector-specific advocacy informed by data from other sectors, drawing on an overall trends analysis to craft sector-specific as well as joint messaging?
- Do joint briefings to the HCT, donors and Member States occur regularly?
- Are joint communication channels identified in support of protection and health issues?
- Do affected individuals participate in advocacy mechanisms? Do clusters, AoRs and working groups engage with affected communities to ensure their needs and priorities are represented in messaging? Is this requirement included in accountability mechanisms?
- Are advocacy efforts monitored to assess and track their contribution to change and impact? Does such monitoring inform future advocacy initiatives?

Promising Practice

In Colombia, the Protection Cluster uses the Protection Analysis Update (PAU) both at the national and sub-national level as a strategic tool to strengthen advocacy efforts with a different range of actors. This includes the integration of health messages that the AoRs present in the country provide with an emphasis on the barriers people face in terms of access to the health system, which are exacerbated in the regions of the country most affected by recurring emergencies.

Additional Resources

- IASC MHPSS Reference Group (2022). [Handbook for Mental Health and Psychosocial Support \(MHPSS\) Coordination](#).
- IASC MHPSS Reference Group (2022). [The Mental Health and Psychosocial Support Minimum Service Package](#).
- WHO (2021). [The Surveillance System for Attacks on Health Care \(SSA\) Mobile App](#).
- Global Health Cluster (2020). [Health Cluster Guide: A Practical Handbook](#).
- IASC (2020). [IASC Key Protection Advocacy Messages – COVID-19](#).
- Gender-Based Violence AoR (2019). [Handbook for Coordinating Gender-based Violence Interventions in Emergencies](#).
- The Mental Health and Psychosocial Support Network (2019). [MHPSS Emergency Toolkit](#).
- Child Protection AoR (2016). [Child Protection in Emergencies – Coordination Handbook](#).
- IASC MHPSS Reference Group (2011). [Advocacy Package: IASC Guidelines on mental health and psychosocial support in emergency settings](#). IASC MHPSS Reference Group.

Annex 1: Glossary

At risk individual, group, population	Persons who might be subject to protection violations and abuse; taking into account the specific vulnerabilities that underlie these risks, including those experienced by men, women, girls and boys, and groups such as internally displaced persons, older persons, persons with disabilities, and persons belonging to sexual and other minorities. ³⁶
Capacity	“The resources and capabilities that are available to individuals, households, and communities to cope with a threat or to resist or mitigate the impact of a threat. Resources can be material or can be found in the way a community is organised. Capabilities can include specific skill sets or the ability to access certain services or move freely to a safer place.” ³⁷
Case management	<p>For protection actors, case management is defined as “a structured method for providing help to a survivor. It involves one organization, usually a psychosocial support or social services actor, taking responsibility for making sure that survivors are informed of all the options available to them and that issues and problems facing a survivor and her/his family are identified and followed up in a coordinated way.”³⁸ The survivor should be provided with emotional support throughout the process</p> <p>For health actors, multiple definitions of ‘case management’ exist, all of which involve the management of a person with a confirmed or suspected health condition. Case management may be “a targeted, proactive approach to care that involves case-finding, assessment, care planning and care coordination to integrate services around the needs of people with long-term conditions.”³⁹ It can also be integrated community case management (iCCM) to end preventable child deaths involving community health workers diagnosing and treating children with diarrhea, malaria and other preventable diseases.⁴⁰ Certain diseases may have specific case management guidelines, for example for people suspected or confirmed to have COVID-19.⁴¹</p>
Health	“Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” ⁴²
Health outcome	“A change in the health status of an individual, group or population that is attributable to a planned intervention or series of interventions, regardless of whether such an intervention was intended to change health status.” ⁴³
Risk	“The likelihood of the occurrence and the likely magnitude of the consequences of an adverse event during a specified period.” ⁴⁴

³⁶ GPC (2017). [Protection Mainstreaming Toolkit – Field Testing Version](#).

³⁷ GPC (2021). [Protection Analytical Framework: An Introduction](#).

³⁸ See UNFPA (2017). [Interagency Gender-Based Violence Case Management Guidelines: Providing Care and Case Management Services to Gender-Based Violence Survivors in Humanitarian Settings](#), p8.

³⁹ World Health Organization. (2015). [WHO global strategy on people-centred and integrated health services: interim report](#).

⁴⁰ See WHO and UNICEF (2020). [Institutionalizing integrated community case management \(iCCM\) to end preventable child deaths](#).

⁴¹ See for example WHO (2020). [Coronavirus disease \(COVID-19\) technical guidance: Patient management](#).

⁴² WHO (1946). [Constitution of the World Health Organization](#), preamble.

⁴³ WHO (2021). [Health promotion glossary of terms 2021](#).

⁴⁴ WHO (2012). [Rapid Risk Assessment of Acute Public Health Events](#).

Risk assessment	“A systematic process for gathering, assessing and documenting information to assign a level of risk. Risk assessment includes three components — hazard assessment, exposure assessment and context assessment.” ⁴⁵
Protection	“The concept of protection encompasses all activities aimed at obtaining full respect for the rights of the individual in accordance with the letter and the spirit of the relevant bodies of law.” ⁴⁶
Protection mainstreaming	<p>“The process of incorporating protection principles and promoting meaningful access, safety and dignity in humanitarian aid. The following elements must be taken into account in all humanitarian activities:</p> <ol style="list-style-type: none"> 1. Prioritise safety and dignity, and avoid causing harm: prevent and minimise as much as possible any unintended negative effects of your intervention which can increase people’s vulnerability to both physical and psychosocial risks 2. Meaningful Access: arrange for people’s access to assistance and services - in proportion to need and without any barriers (e.g. discrimination). Pay special attention to individuals and groups who may be particularly vulnerable or have difficulty accessing assistance and services. 3. Accountability: set-up appropriate mechanisms through which affected populations can measure the adequacy of interventions, and address concerns and complaints 4. Participation and Empowerment: support the development of self protection capacities and assist people to claim their rights, including - not exclusively - the rights to shelter, food, water and sanitation, health, and education.”⁴⁷
Protection outcome	“A response or activity is considered to have a protection outcome when the risk to affected persons is reduced. The reduction of risks, meanwhile, occurs when threats and vulnerability are minimized and, at the same time, the capacity of affected persons is enhanced. Protection outcomes are the result of changes in behaviour, attitudes, policies, knowledge and practices on the part of relevant stakeholders.” ⁴⁸
Protection principles	<p>“Four Protection Principles apply to all humanitarian action and all humanitarian actors.</p> <ol style="list-style-type: none"> 1. Enhance the safety, dignity and rights of people, and avoid exposing them to harm. 2. Ensure people’s access to assistance according to need and without discrimination. 3. Assist people to recover from the physical and psychological effects of threatened or actual violence, coercion or deliberate deprivation. 4. Help people claim their rights.”⁴⁹
Protection risk	“Actual or potential exposure of the affected population to violence, coercion, or deliberate deprivation.” ⁵⁰

⁴⁵ Ibid.

⁴⁶ IASC (1999). [IASC Policy Paper on Protection of Internally Displaced Persons](#).

⁴⁷ GPC (2014). [Protection Mainstreaming Training Package](#).

⁴⁸ IASC (2016). [Policy on Protection in Humanitarian Action](#).

⁴⁹ Sphere Association (2018). [The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response](#).

Threats	<p>For protection actors, threats consist of “A human activity or a product of human activity that results in a form of violence, coercion, or deliberate deprivation. Threats can be the perpetrator (agent of the threat) or a policy or an ethnicity norm (source of threat) that is causing harm.”⁵¹</p> <p>For health actors, although there is no agreed definition, threats relate to any factor that can result in increased chance of ill health. The Public Health Situational Analysis (PHSA) will analyse health threats to understand their potential impact on people affected by humanitarian crisis⁵²</p>
Vulnerability	<p>“Certain characteristics or circumstances of an individual or group, or their surrounding physical environment, which diminish ability to anticipate, cope with, resist, or recover from the impact of a threat. People differ in their exposure to a threat depending on their social group, gender, ethnicity, age, and other factors. Vulnerability is not a fixed or static criterion attached to specific categories of people, and no one is born vulnerable.”⁵³</p>

⁵⁰ GPC (2021). Protection Analytical Framework: An Introduction.

⁵¹ Ibid.

⁵² GHC Public Health Information Services Toolkit and Public Health Situational Analysis

⁵³ GPC (2021). Protection Analytical Framework: An Introduction.

Annex 2: Inter-agency referral form (Example)⁵⁴

Receiving agency copy Routine Urgent Date of Referral (DD/MM/YY):

Referring Agency	
Agency / Org:	Contact:
Phone:	E-mail:
Location:	

Receiving Agency	
Agency / Org:	Contact (if known):
Phone:	E-mail:
Location:	

Client Information	
Name:	Phone:
Address:	Age:
Sex:	Nationality:
Language:	ID Number:
If Client Is a Minor (under 18 years)	
Name of primary caregiver:	Relationship to child:
Contact information for caregiver:	Is child separated or unaccompanied? <input type="checkbox"/> Yes <input type="checkbox"/> No
Caregiver is informed of referral? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, explain)	

Background Information/Reason for Referral: (problem description, duration, frequency, etc.) and Services Already Provided	
Has the client been informed of the referral? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, explain below)	Has the client been referred to any other organizations? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, explain below)

Services Requested		
<input type="checkbox"/> Mental Health Services	<input type="checkbox"/> Protection Support/ Services	<input type="checkbox"/> Shelter
<input type="checkbox"/> Psychological Interventions	<input type="checkbox"/> Community Centre/ Social Services	<input type="checkbox"/> Material Assistance
<input type="checkbox"/> Physical Health Care	<input type="checkbox"/> Family Tracing Services	<input type="checkbox"/> Nutrition
<input type="checkbox"/> Physical Rehabilitation	<input type="checkbox"/> Legal Assistance	<input type="checkbox"/> Financial Assistance
<input type="checkbox"/> Psychosocial Activities	<input type="checkbox"/> Education	
Please explain any requested services:		

Consent to Release Information (Read with client/ caregiver and answer any questions before s/he signs below)
I, _____ (client name), understand that the purpose of the referral and of disclosing this information to _____ (receiving agency) is to ensure the safety and continuity of care among service providers seeking to serve the client. The service provider, _____ (referring agency), has clearly explained the procedure of the referral to me and has listed the exact information that is to be disclosed. By signing this form, I authorize this exchange of information.
Signature of Responsible Party:
(Client or Caregiver if a minor). Date (DD/MM/YY):

Details of Referral
Any contact or other restrictions? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, explain below)
Referral delivered via: <input type="checkbox"/> Phone (emergency only) <input type="checkbox"/> E-mail <input type="checkbox"/> Electronically (e.g., App or database) <input type="checkbox"/> In Person
Follow-up expected via: <input type="checkbox"/> Phone <input type="checkbox"/> E-mail <input type="checkbox"/> In Person. By date (DD/MM/YY):
Information agencies agree to exchange in follow up:

Name and signature of recipient: _____ Date received (DD/MM/YY): _____

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⁵⁴ IASC MHPSS RG (2017). [Inter-Agency Referral Form and Guidance Note](#).

Annex 3: Protection Mainstreaming in Health (Example)¹⁰⁷

Why do we need to think about protection in health programming?

Surely by providing health care we are protecting people? Well yes and no. Yes, the provision of health care is in itself meeting people's needs, but specific steps need to be taken to ensure that everyone gets equal access to health care and that it is provided in the way that can best protect each individual. For example, if there is no provision for a blind person to read the information then the service may not be accessible to him/her or if a victim of sexual abuse is not afforded privacy then you may cause her greater harm even if the medical provision is good. We need to ensure that health is truly accessible to all persons.

Does your programme ensure that the availability of health care meets everyone's needs?

- With the massive caseload in Gaza it is clear not everyone can be reached at once, so identify and find ways to support those with greatest needs first.
- If providing **health care for collective centres** also ensure there are services for the local/host community.
- Is health care available in **all geographic locations**? Can people who live in the ARA access health care? What about people who live in an area where the health facility was destroyed in the recent conflict?
- Is the service provision suitable for the most vulnerable persons – elderly, persons with a disability, pregnant women, children.
- During and after conflict ensure that facilities are available for **reproductive health**; whilst response to conflict related injuries have a priority, reproductive health cannot be marginalized.
- Ensure that health staff know how to respond to the specific needs of **victims of serious human rights** violations, including sexual violence and physical abuse.
- Essential to **have female staff available**.
- Health care services should include access to treatment for STIs and post exposure prophylaxis for HIV (PEP).
- Staff should be trained in providing **psychosocial support** to reduce

Is the health service you provide accessible to all persons?

- Ensure staff are **aware of protection concerns**, such as the need to ensure access for all beneficiaries including vulnerable groups?
- **Health in collective centres**: Ensure people know how and where to obtain health care particularly for new arrivals at the centres.
- There are significant numbers of **newly disabled people** after the conflict – are they fully informed and able to access services.
- Ensure that provision is in place to refer patients to **services outside of Gaza** – this includes providing direct assistance, monitoring access and where required advocacy.
- Ensure that services can be **accessed by persons with reduced mobility** (e.g. persons with physical disabilities, the elderly, bed-ridden individuals, victims of GBV who may have limited mobility due to fear/stigma).
- Consider different physical disabilities. Artificial limbs may make even relatively short distances difficult. **Talk to persons with disabilities** about what solutions would best fit their needs.
- Ensure that staff are trained to work with **individuals with intellectual disabilities**.
- Make special arrangements for people who have difficulty accessing services (e.g. **mobile health teams, home visits**).

¹⁰⁷ [Health Programmes: Quick guide on how to address protection](#). To be read in conjunction with [Protection & Prioritizing Vulnerable Persons in the Gaza Humanitarian Response](#).

Would the way the service is provided be acceptable to all persons?

- | |
|--|
| <ul style="list-style-type: none"> - Identify areas in and around health facilities that could be potentially unsafe like dark alleys, and mount lights or place security around them - Provide separate waiting areas for men and women - A code of conduct applicable to all staff should be developed and staff orientated to this - To avoid trauma and reduce the chance of being singled out in the health center, victims of serious human rights violations should be prioritized. - Staff should ensure the confidentiality of victims/survivors ; respect the wishes about the care provided, and obtain consent prior to sharing information. - Ensure that an information sharing agreement is established, for referrals, so that a survivor of abuse will not need to repeat their story - Ensure examination rooms are well separated from public spaces or the waiting area - If female doctors/nurses are not available, consider advocating with the authorities to organize a female doctor rotation between locations. |
| <ul style="list-style-type: none"> - Consult with the local community; ensure that men and women, boys and girls, elderly and persons with disabilities are consulted - Make sure that data storage is secure - Evaluation mechanisms must measure the protection impact and in particular the extent to which they have enhanced access for health services - Do you have a complaints mechanism? Do not assume an “open door” policy is enough. Make sure that there are other possibilities for submitting complaints that do not require the person exposing themselves to staff. - RESPOND to complaints, regardless of whether corrective measures can/need to be put in place. - Complaints mechanisms should be in line with Protection from Sexual Exploitation and Abusive systems. |

Check list – make sure you can answer yes to these five questions

Have you consulted with the community about what different groups need and want?	1.
Are you prioritising the most vulnerable? <i>E.g. In the geographic area you work, who are most in need?</i>	2.
Is your planned response appropriate <i>to local culture</i>	3.
Does your response address security and accessibility concerns? <i>Have you considered if there might be unintended consequences?</i>	4.
Are services accessible to all persons? [e.g. persons with disabilities, chronically sick, elderly]	5.

What should I do if I have protection concerns?

If you are aware of someone in need of protection support [child who may be abused/ an adult with a disability/ elderly person who is at risk) contact the UNRWA Protection section for refugees and the Protection Cluster lead/OHCHR for non-refugees who can advise of relevant partner organisations to follow up.



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