Checklist for mainstreaming protection in health sector programmes
Protection Cluster & Health and Nutrition Cluster, occupied Palestinian territory

I. Introduction

This checklist is a tool to assist in incorporating protection in health sector programmes. The questions are intended to assist organizations in identifying issues that should be factored into the design, implementation, monitoring and evaluation of their programmes.

What is protection?
Protection is defined as all activities aimed at obtaining full respect for the rights of the individual in accordance with the letter and spirit of the relevant bodies of law, namely human rights law, international humanitarian law and refugee law.

Key protection principles that must be incorporated into all programmes are:[1]

Do no harm: Avoid exposing people to further harm as a result of your actions, and ensure that:

- The environment and way in which assistance is provided do not expose people to further hazards, violence or human rights abuses or violations;
- Take all reasonable steps to ensure that the affected population is not subject to violent attack, or forced or induced into undertaking actions that may cause them harm or violate their rights;
- Manage information in a sensitive manner so that the security of informants or others who may be identifiable is not jeopardized;
- Assistance and protection measures do not undermine local capacities for self-protection. Support the efforts of the affected population and local communities to find security and restore dignity.

Non-discrimination: Ensure equitable and impartial access to assistance, without discrimination on any grounds:

- Ensure all parts of the affected population have access to humanitarian assistance;
- Challenge any deliberate attempts to exclude parts of the affected population;
- Provide support and assistance on the basis of need and guard against any form of direct or indirect discrimination.

Human rights-based approach:

- Assist and support affected people to claim their rights and access remedies from government or other sources; to obtain information on their entitlements and secure the documentation needed to demonstrate their entitlements; and to recover by providing psychosocial and community support.
- Ensure consultation with the target population at all stages, and the participation of vulnerable groups in the design and targeting of interventions.

There are three **types of protection activities** that can be carried out concurrently, and by different actors:[2]

- *Responsive* – immediate action to prevent or stop violations of human rights, or alleviate their immediate effects;
- *Remedial* – longer-term action to ensure a remedy to violations, including through access to justice and reparations, or to provide remedial assistance, including health care, psychosocial support, or livelihoods support; and
- *Environment-building* – action to create an environment conducive to respect for human rights and the rule of law, including the reduction of exposure or vulnerability to protection risks.

The right to health
Everyone has the right to the highest attainable standard of physical and mental health.[3] The four elements of *availability*, *accessibility*, *acceptability* and *quality* are essential to the enjoyment of the right to health by all.[4]

The right to health includes not only the right to equal access to timely and appropriate health care, but also to the underlying determinants of health, such as access to food, shelter, safe water and sanitation, and a sustainable livelihood.

Responding to the health needs of populations in the occupied Palestinian territory requires a multi-sectoral response that takes due account of the inter-linkages between health and protection.

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[1] Refer, for example, to the Sphere Project, *Humanitarian Charter and Minimum Standards in Humanitarian Response*.
[2] Global Protection Cluster Working Group, *Handbook for the Protection of Internally Displaced Persons*.
[3] For example, Art. 25(1) of the Universal Declaration of Human Rights; Art. 12 of the International Covenant on Economic, Social and Cultural Rights; Art. 24 of the Convention on the Rights of the Child; Arts. 16 to 23 of the Fourth Geneva Convention.
[4] See General Comment 14 (2000) of the Committee on Economic, Social and Cultural Rights on the right to the highest attainable standard of health (E/C/12/2000/4) and OHCHR/WHO, *A Human Rights-Based Approach to Health*.

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II. Checklist for Incorporating Protection into all Sector Programmes

KEY QUESTIONS	
DO NO HARM	
• Has the organization conducted an analysis of the protection context, including gender issues (e.g. gender based violence)?	☐
• Has the programme ensured that the humanitarian intervention will not be used to fuel further conflict, to disadvantage a particular social group or to lead to increased human rights violations?	☐
• Does the programme mitigate protection risks for beneficiaries? Have you ensured that it does not exacerbate risks or create new risks?	☐
NON-DISCRIMINATION	
• Does the programme ensure that men, women, girls and boys have equitable access to the services provided?	☐
• Does the programme ensure that all ethnic, religious and other social groups have equitable access to the services provided (e.g. Bedouins)?	☐
• Has the programme ensured that the gender/ethnic/persons with disability balance of humanitarian staff is appropriate to meet the needs of the population in oPt?	☐
• When the programme focuses on a specific group, are its targeting criteria based on evidence, clearly defined and widely disseminated within and outside the community?	☐
• Is a gender-responsive complaints mechanism set up for beneficiaries to provide feedback on concerns?	☐
PARTICIPATION – COMMUNITY CENTERED	
• Has the target population been consulted at all stages of the project cycle?	☐
• Were accessibility requirements (e.g. physical access, affordability, access to information) met to ensure the participation of the target population from design to implementation and review?	☐
• Were mechanisms set up to support and ensure the participation of vulnerable groups, including the elderly, women, children and people with disabilities, in the design and targeting of interventions?	☐
• Has the programme mapped non-formal authority and decision-making mechanisms within different minorities or population groups that might play a role?	☐
• Has the programme taken steps to increase communities' awareness of potential threats and risks, including by humanitarian workers, traffickers, child abusers and institutions?	☐
• Does the programme focus on strengthening the protective environment through consolidation of social networks and the community's existing capacities to reduce risks and address immediate protection concerns?	☐
HUMAN RIGHTS-BASED APPROACH	
• Has your organization set up an appropriate mechanism for the internal monitoring and reporting of instances of suspected abuse or trauma caused by violence (e.g. sexual and gender-based violence, torture, violence by security forces or settlers), and other violations of human rights and international humanitarian law (IHL)?	☐
• Has your organization developed a policy on how to respond to human rights abuses and IHL violations perpetrated against beneficiaries and staff? Are all staff aware of the process to refer cases to protection actors providing legal support and/or specialized assistance to victims and witnesses?	☐
• Have staff received training in international human rights and humanitarian law, and how these standards apply to their work? Have staff been trained in the human rights-based approach to programming?	☐
• Has the programme established linkages with relevant national institutions to address protection concerns? Have steps been taken to work with the responsible authorities?	☐
• Has the programme established partnerships with international and national human rights and protection actors, in particular members of the Protection Cluster Working group in oPt?	☐

United Nations Human Rights
OFFICE OF THE HIGH COMMISSIONER FOR HUMAN RIGHTS IN THE OCCUPIED PALESTINIAN TERRITORY

World Health Organization

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III. Checklist for Incorporating Protection into Health Sector Programmes

KEY QUESTIONS	
EQUITABLE ACCESS TO HEALTH FACILITIES AND SERVICES FOR ALL	
• Has the programme based its health service delivery on the needs of beneficiaries? Were selection and registration processes accessible, fair and transparent?	☐
• Has the programme been able to collect and produce data disaggregated by age, gender and disability?	☐
• Has the programme been designed to maximize physical accessibility to health services by the target population in oPt and has it conducted outreach to identify those who have major difficulties visiting clinics and/or health facilities?	☐
• Does the programme address medical referrals to health facilities outside Gaza and the West Bank (including East Jerusalem), e.g. by providing direct assistance, monitoring access or advocacy?	☐
• Have all reasonable measures been taken to maximize physical accessibility to health services by people with disabilities?	☐
• Have all humanitarian and health staff received training on disability issues, particularly surrounding communication methods, so as to promote inclusive practices across their work efforts?	☐
• Has the programme ensured that public health information is provided in accessible formats, including for people with disabilities (e.g. leaflets in Braille)?	☐
• Has the programme ensured the gender/ethnic balance of staff at health facilities is appropriate to meet the needs of the target population in oPt?	☐
• When necessary, have arrangements been made to assist members of the targeted vulnerable population who are unable to pay for health care if fees are in place?	☐
• Has the programme identified the communities or categories of persons in oPt most exposed to violence by security forces, settlers, or under threat of demolition/eviction, and identified health risks (including environmental risks) and needs within these areas?	☐
SAFETY OF BENEFICIARIES AND HEALTH PERSONNEL	
• Has the programme implementation considered potential threats of violence and coercion, safety of infrastructure, timing of distributions, long queues, threats to staff, checkpoint crossings etc?	☐
• Has the programme ensured that health facilities are strategically designed and located so that they are easily and safely accessible for target population and vulnerable groups?	☐
• Has the programme ensured that the design of health facilities reduces exposure to violence and abuse?	☐
• Has the programme taken steps to ensure the confidentiality of medical records and data, and prevent loss or leaks of personal information, especially when related to trauma caused by human rights abuses?	☐
• Has the organization developed a code of conduct applicable to all staff and made this available to the beneficiaries? Have staff been trained on that code of conduct?	☐
• Are mechanisms in place to mitigate the risk and prevent incidents of harassment and violence affecting beneficiaries in facilities run by the programme, and to respond to them appropriately?	☐
HEALTH SERVICES FOR VICTIMS/SURVIVORS OF ABUSES AND VIOLATIONS – REFERRALS	
• Has the programme ensured that safe and confidential health services are available for victims of rape, domestic violence, sexual exploitation, forced marriage, forced prostitution, trafficking and abduction?	☐
• Does the programme provide safe and confidential health services for victims of violence and violations of human rights and IHL (e.g. incidents of settler violence, use of force by security forces and armed groups, demolitions and forced evictions)?	☐
• Has the programme trained health staff members on the processes for identifying and reporting human rights abuses – in particular incidents of sexual and physical abuse among children, women, persons with mental health conditions, with disabilities, and other vulnerable groups – as well as for obtaining informed consent for the sharing of such information with relevant actors and maintaining confidentiality?	☐
• Has the organization established a mechanism to refer victims of violence, abuse and violations to other organizations or entities providing specialized support and assistance, e.g. psychosocial support, human rights monitoring and investigations, and legal assistance.	☐
RESPECT FOR RELIGIOUS AND CULTURAL PRACTICES IN HEALTH CARE	
• Has the programme ensured that health facilities are adapted to the cultural context (e.g. burials are conducted in accordance with traditions, and families are supported to carry out appropriate rites)?	☐

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IV. Incorporating protection in the project cycle

KEY QUESTIONS	
ASSESSMENTS	
• Has your organization included protection risks in the context analysis, and conducted an assessment of the protection risks and threats that will impact upon the delivery of health services to the target population?	☐
• Have staff taking part in assessments received adequate training on the protection implications and risks, as well as the protection potential, of humanitarian assistance?	☐
DESIGN	
• Have the protection risks identified in the assessment been factored into the design of the programme or project, including planning for the necessary staff and resources?	☐
IMPLEMENTATION & MONITORING	
• Are the identified protection risks and concerns being taken into consideration during all phases of the project cycle, including implementation and monitoring (e.g. integrating lessons learned, and tailoring implementation to better address protection concerns affecting the delivery of health services)?	☐
• Have relevant indicators been incorporated into monitoring frameworks (including logical frameworks) and used as a basis for monitoring the extent to which programmes and projects are mainstreaming protection?	☐
EVALUATION	
• Do programme or project evaluations measure the protection impact of activities, in particular the extent to which they have enhanced access to health services for all, and promoted the enjoyment of the right to the highest attainable standard of physical and mental health?	☐
ADVOCACY	
• Are mechanisms in place to ensure advocacy responses to protection concerns impacting upon the delivery of health services, including direct advocacy with duty bearers and joint advocacy with relevant partners (e.g. protection actors)?	☐

V. Key reference documents

1. OHCHR & WHO, *A Human Rights-Based Approach to Health* http://www.ohchr.org/Documents/Publications/Factsheet31.pdf
2. OHCHR & WHO, *Fact Sheet on the Right to Health* http://www.ohchr.org/EN/PublicationsResources/Pages/FactSheets.aspx
3. Caritas Australia, Care, Oxfam Australia, World Vision, *Minimum Agency Standards for Incorporating Protection into Humanitarian Response (Field Testing Version)* http://www.globalhumanitarianplatform.org/doc00002448.pdf
4. Hugo Slim & Andrew Bonwick, *Protection: An ALNAP guide for humanitarian agencies* http://www.hdcentre.org/files/alnap_protection_guide.pdf
5. Global Protection Cluster Working Group, *Handbook for the Protection of Internally Displaced Persons* http://oneresponse.info/GlobalClusters/Protection/Documents/IDP%20Handbook_FINAL%20All%20document_NEW.pdf
6. Child Protection Mainstreaming Checklist