Humanitarian principles and international humanitarian coordination mechanisms
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Abbreviations

  CHS Core Humanitarian Standard on Quality and Accountability
  FAO Food and Agriculture Organization of the United Nations
  IASC Inter-Agency Standing Committee
  IHR International Health Regulations
  NGO nongovernmental organization
  OCHA United Nations Office for the Coordination of Humanitarian Affairs
  OIE World Organisation for Animal Health
  SDG Sustainable Development Goal
  UNICEF United Nations Children’s Fund
  WHO World Health Organization
1. Humanitarian principles and international humanitarian coordination mechanisms

1.1 Introduction

This chapter provides a summary of how humanitarian action has evolved in recent decades. It includes an overview of humanitarian principles and other key global initiatives that have helped shape humanitarian coordination. For additional information, refer to the humanitarian response and Inter-Agency Standing Committee (IASC) websites.¹

1.2 Humanitarian principles

Four humanitarian principles – humanity, neutrality, impartiality and independence – provide the fundamental foundations for humanitarian action and are central to establishing and maintaining access to affected populations, whether in the context of a natural disaster, an armed conflict or a complex emergency. Table 1.1 presents the underlying concepts on which those principles are based.

Table 1.1 Humanitarian principles and their underlying concepts

<table>
<thead>
<tr>
<th>PRINCIPLE</th>
<th>CONCEPTS</th>
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<tbody>
<tr>
<td>Humanity</td>
<td>Human suffering must be addressed wherever it is found. The purpose of humanitarian action is to protect life and health and ensure respect for human beings.</td>
</tr>
<tr>
<td>Neutrality</td>
<td>Humanitarian actors must not take sides in hostilities or engage in controversies of a political, racial, religious or ideological nature.</td>
</tr>
<tr>
<td>Impartiality</td>
<td>Humanitarian action must be carried out based on need alone, giving priority to the most urgent cases of distress and making no distinctions based on nationality, race, gender, religious belief, class or political opinion.</td>
</tr>
<tr>
<td>Independence</td>
<td>Humanitarian action must be autonomous from the political, economic, military or other objectives that any actor may hold about areas where humanitarian action is being implemented.</td>
</tr>
</tbody>
</table>

Note: The first three humanitarian principles were endorsed in United Nations General Assembly resolution 46/182 of 1991, known as the “humanitarian response resolution”. The fourth principle (independence) was endorsed in 2004 under resolution 58/114.
Promoting compliance with humanitarian principles in humanitarian response is an essential element of effective humanitarian coordination. United Nations agencies are mandated to embrace all four of these principles. Commitment to the four humanitarian principles is expressed at institutional level by the majority of international humanitarian organizations. Furthermore, globally over 450 organizations are signatory to the Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGOs) in Disaster Relief, which includes a commitment to adhere to these humanitarian principles (1).

1.3 Key humanitarian issues

1.3.1 When to engage?

International humanitarian law in all types of armed conflict – whether international or non-international – imposes obligations on the warring parties to use their best efforts to collect and care for the wounded and sick (2, 3). This means either that the parties to armed conflicts perform these medical activities themselves, traditionally through their military medical corps, or, where they are unable or unwilling to do so, that they permit others, such as the local civilian administration or impartial humanitarian organizations, to assist them. In practice, the civilian administration is often unable to provide assistance in conflict settings, leaving victims – especially civilians – without access to adequate care. As a result, the World Health Organization (WHO) and humanitarian actors increasingly find themselves in a situation where, despite multiple reminders to the parties to the conflict, victims are deprived of the health care they need.

When the warring parties and civil administration cannot carry out this role, the Global Health Cluster should look to other partners to see if they are able to engage as a first step. If that is not possible, WHO can then invoke its “provider of last resort” obligations as the lead agency of the IASC Global Health Cluster to ensure that victims of the conflict can access lifesaving trauma care. WHO has developed operational guidance on the provision of trauma care in a conflict situation.

- When necessary services are not provided in a situation where the IASC cluster system is activated, it falls upon the Global Health Cluster lead agency – WHO for the health sector – to serve as the provider of last resort. This means that “Where necessary, and depending on access, security and availability of funding, the cluster lead, as provider of last resort, must be ready to ensure the provision of services required to fill critical gaps identified by the cluster” (4).
● In all other situations Article 2(d) of the WHO Constitution applies, under which WHO contributes to its objective of attainment by all peoples of the highest possible level of health by furnishing “appropriate technical assistance and, in emergencies, necessary aid upon the request or acceptance of Governments” (5).

1.3.2 Humanitarian emergencies and public health events

A humanitarian emergency is defined as a situation impacting the lives and well-being of a large number of people or a significant percentage of a population, and requiring substantial multisectoral assistance (6, 7).

A public health event is defined as any event that may have negative consequences for human health. The term includes events that have not yet led to disease in humans but have the potential to cause human disease through exposure to infected or contaminated food, water, animals, manufactured products or environments (6).

Humanitarian emergencies take many forms. They may result from natural disasters, such as flooding or earthquakes, or they may be due to conflict. They may occur very quickly (acute onset) or may evolve slowly over time (slow onset).

Humanitarian emergencies will also differ in duration; they may be limited to a finite time or continue over many years (continuing or protracted emergency). Countries may experience repeated emergencies or face combinations of different types of emergencies, for example, an acute onset emergency in a country that is already undergoing a protracted crisis.

1.3.3 Humanitarian coordination

“Humanitarian coordination involves bringing humanitarian actors together to ensure a coherent and principled response to emergencies” (8).

Humanitarian coordination underpins an effective humanitarian response. It serves to identify and meet priority needs, address gaps and reduce duplication in humanitarian response. It facilitates the development of a humanitarian strategy and ensures that assistance is delivered in a cohesive, principled and effective manner, following international standards and in line with the direction and objectives of the humanitarian strategy. Humanitarian coordination also facilitates monitoring the response, with an emphasis on ensuring adherence to humanitarian and technical quality standards.

Humanitarian coordination is not just about coordination of the emergency response. There are critical actions to be conducted prior to the onset of an
emergency in relation to disaster risk reduction, emergency preparedness and contingency planning, capacity-building, and information management. There are also critical activities to be conducted during the emergency response to ensure that structures, standards and capacities are in place to enable a sustainable transition to a post-emergency phase, as and when appropriate, in relation to continuation of residual humanitarian services and activities.

1.4 Global Health Cluster

The Global Health Cluster was established in 2005 under the leadership of WHO to promote and support collective action at global and country levels to ensure more effective, efficient and predictable humanitarian health action.

Whilst significant improvements were made following the establishment of the Global Health Cluster, nevertheless, in recognition of the need for strengthening the global capacity for humanitarian health action, the World Health Assembly, through resolution WHA65.20 of 2012, called on the WHO Director-General to (a) have in place the organizational capacity and resources to enable itself to discharge its function as the Global Health Cluster lead agency and assume a role as health cluster lead agency in the field; and (b) define the core commitment, core functions and performance standards of the Organization in humanitarian emergencies, including its role as the Global Health Cluster lead agency and as health cluster lead agency in the field.

The Emergency Response Framework (2013), developed by the WHO Global Emergency Management Team, explicitly mentions the Global Health Cluster as the mechanism to achieve the coordination function of WHO in emergencies.\(^5\)

1.4.1 WHO responsibilities as Global Health Cluster lead agency

WHO is ultimately responsible to the Emergency Relief Coordinator for ensuring the fulfilment of its lead agency role in the Global Health Cluster. At global level these responsibilities include:\(^5\)

- mainstreaming the cluster approach and the Transformative Agenda within WHO and promoting their understanding within WHO departments and offices at global, regional and country levels;

- negotiating with other United Nations agencies around cluster issues that need to be reflected in global-level documentation;
● engaging in advocacy at the highest levels of the IASC (including the Emergency Directors Group), and with donors and other concerned bodies, on the needs and position of the Global Health Cluster;

● ensuring that adequate human and financial resources and administrative structures are availed at global, regional and country levels;

● liaison and collaboration with other global clusters to enhance holistic multi-cluster humanitarian responses for improved health outcomes and improved health.7

1.4.2 Global Health Cluster vision and mission

The *vision* of the Global Health Cluster is to save lives and promote dignity in humanitarian and public health emergencies.

The *mission* of the Global Health Cluster is to collectively prepare for and respond to humanitarian and public health emergencies to improve the health outcomes of affected populations through timely, predictable, appropriate and effective coordinated health action.

1.4.3 Guiding principles of the Global Health Cluster

As a multi-agency platform, the overall approach and work of the Global Health Cluster is underpinned by five guiding principles.

● **Commitment and voluntary cooperation.** Effective coordination can only be voluntary, based on each partner’s willingness to join others in agreeing on priorities and overall response strategies and to adjust its actions to the particular humanitarian context as well as to other partners’ capacities. The cluster approach demands commitment and an openness to collaborate and adapt on the part of all agencies and individuals concerned.

● **Partnership.** Collaborative and complementary partnerships at all levels, based on transparency, mutual understanding and the tapping of comparative advantages and competencies, are essential to improving humanitarian action.

● **Community participation and accountability to affected populations.** Community-based programming is essential to successful cluster implementation and humanitarian health action. Affected populations must be involved in the actions of the country cluster, and the health cluster will actively seek ways to be accountable to the affected population.
● **Support for national authorities’ coordination efforts and priorities.** Clusters should support and complement existing national coordination mechanisms for response, preparedness and recovery. Where appropriate, national health counterparts should be actively encouraged to co-chair cluster meetings from an early stage.

● **Adherence to humanitarian principles and the right to health.** Health interventions will be based on humanitarian principles and on human rights, which state that humanitarian interventions should be provided based on needs alone, should be accessible without discrimination, and should be affordable for all. Universal access to primary health care is a fundamental element of any humanitarian health response for populations affected by crises.

### 1.5 Humanitarian reform, the Transformative Agenda and new ways of working

#### 1.5.1 Humanitarian reform

In early 2004, responding to what was perceived as a lack of an appropriate and coordinated humanitarian response to the crisis in Darfur, Sudan, the United Nations Emergency Relief Coordinator commissioned a humanitarian response review. Recommendations from the review formed the basis for a major reform of humanitarian coordination, known as the Humanitarian Reform Agenda (2005), which aimed to improve the effectiveness of humanitarian response through greater predictability, accountability and partnership (9). The key elements were:

- the cluster approach
- a strengthened humanitarian coordination system
- more timely, flexible and effective humanitarian financing
- strong partnership as an enabling element.

**The cluster approach**

Implementation of the cluster approach is the most visible aspect of the 2005 Humanitarian Reform Agenda. Eleven clusters were established at global level and lead agencies were identified for each cluster (Figure 1.1).

The cluster approach was adopted by the IASC to improve the efficiency and effectiveness of the humanitarian response in crises; to increase predictability and accountability in all the main sectors of the international humanitarian response; and to ensure that gaps in response did not go unaddressed.
Humanitarian principles and international humanitarian coordination mechanisms


Source: United Nations Office for the Coordination of Humanitarian Affairs (OCHA), humanitarian response (9).
Cluster characteristics

IASC clusters are groups of humanitarian organizations, both inside and outside the United Nations system, in each of the main sectors of humanitarian action, including health, water and logistics. The clusters are formally designated by the IASC and have clear responsibilities for coordination. Clusters are created when existing coordination mechanisms are overwhelmed or constrained in their ability to respond to identified needs in line with humanitarian principles.

The cluster approach is not the only humanitarian coordination solution. In some cases, it may coexist with other forms of national or international coordination, and its application must take into account the specific needs of a country and the context.

Principles of partnership

Humanitarian reform is supported by a foundation of and commitment to strong and consistent partnership between United Nations and non-United Nations actors. The concept of partnership is based on the five principles of partnership developed by the Global Humanitarian Platform: equality, transparency, results-oriented approach, responsibility and complementarity.

Humanitarian Programme Cycle

The Humanitarian Programme Cycle is the collective response framework activated in all countries and response contexts with activated clusters and humanitarian country teams (Figure 1.2 and Box 1.1). The Humanitarian Programme Cycle consists of the humanitarian needs overview and humanitarian response plan, which both serve as a platform for all humanitarian responders to strategically work together to achieve better collective results for affected people. Starting from the 2020 humanitarian needs overview and humanitarian response plan season (commencing in mid-2019), the goals of the Humanitarian Programme Cycle are to deliver a more evidence-based, cross-sectoral humanitarian response that:

- is based on coordinated needs assessments and analyses of risk;
- facilitates more accurate prioritization of the needs of affected populations (in line with the principle of accountability to affected populations);
- is delivered as locally as possible by national and local actors in line with the Grand Bargain, which the international community has committed to in order to better serve people in need.

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Figure 1.2 Humanitarian Programme Cycle in protracted emergencies

Humanitarian Programme Cycle (HPC) in protracted emergencies
(based on the new 2020 HRP and HNO templates)

March—June
HCT starts development of a joint analytical framework that will ultimately become the HNO.

Data collection

July
Draft Analytical Framework presented to and endorsed by the HCT.
HNO IS FINALIZED

HRP preparation begins: HCT starts identifying prioritized population groups for targeting.

August
HCT to identify response options, draft HRP strategic objectives and identify monitoring indicators and HRP costing methodology. Linkages to UNDAF and/or HDP Nexus to be made.

September—October
HCT to endorse the strategic objectives and monitoring and accountability indicators.

Review strategic objectives

October—November
Sectors/clusters identify their own activities to achieve the HRP, specifying which agency/actor will implement which activities. HCT to estimate cost of the HRP. HRP IS FINALIZED

Implementation of HRP

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Implementation of HRP

HCT: humanitarian country team; HDP nexus: humanitarian-development-peace nexus; HNO: humanitarian needs overview; HRP: humanitarian response plan; UNDAF: UN Development Assistance Framework.

See also Step-by-step practical guide for humanitarian needs overviews, humanitarian response plans and updates (12). Note that this is indicative and the humanitarian country team may adapt and change the guidance depending on the nature of the crisis faced.
1.5.2 Transformative Agenda

Despite progress following the humanitarian reform in 2005, the humanitarian response to the Haiti earthquake and Pakistan floods in 2010 exposed the continuing weaknesses and inefficiencies in the international humanitarian response system. The IASC Principals therefore further reviewed the international humanitarian response system with the aim of adjusting and further improving humanitarian responses. The outcome of this process was the Transformative Agenda, which calls for a more effective response, recognizing that achieving this aim requires strengthened action and a change of attitudes in three key areas: leadership, coordination and accountability, known as the three pillars of the Transformative Agenda (13).

Underpinning these three pillars is the concept of shifting from “individual accountabilities to collective response”. This can also be expressed as stronger partnerships,13 working together better, and enhanced working relationships for a collective response. The Transformative Agenda recognizes that successful humanitarian action is dependent on this collective response. The following provides an overview of the key messages of the Transformative Agenda regarding each of the pillars.

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**Box 1.1 Humanitarian Programme Cycle**

The Humanitarian Programme Cycle is a coordinated series of actions undertaken to help prepare for, manage and deliver the humanitarian response.12 It consists of five elements coordinated in a seamless manner, with one step logically building on the previous and leading to the next. The Humanitarian Programme Cycle elements are as follows:

- needs assessment and analysis
- strategic response planning
- resource mobilization
- implementation and monitoring
- operational review and evaluation.

The Humanitarian Programme Cycle normally begins in March with the initial data collection by humanitarian country team members and concludes in October/November with the finalization and implementation of the humanitarian response plan. Coordination and information management are key enablers throughout the entire process.
Ten protocols were developed to provide guidance on the agreed mechanisms and processes required for an improved coordinated response under the Transformative Agenda (14). Whilst the impetus for the Transformative Agenda was to improve the humanitarian response in large-scale, sudden onset emergencies, most of its protocols, including the spirit of working better together for a more effective response, are applicable to all humanitarian operations (15).

In 2018, the IASC established three protocols related to the classification and management of large-scale humanitarian operations (16): Protocol 1, on definition and procedures for a humanitarian system-wide scale-up activation; Protocol 2, on “empowered leadership” in a humanitarian system-wide scale-up activation; and the Protocol for the Control of Infectious Disease Events (17–19).

IASC Protocol 1. Humanitarian system-wide scale-up activation: definition and procedures

The IASC humanitarian system-wide scale-up activation replaces the 13 April 2012 Transformative Agenda Level 3 definition and procedures. The scale-up activation is a system-wide mobilization in response to a sudden onset or rapidly deteriorating humanitarian situation in a given country, including at the subnational level, where capacity to lead, coordinate and deliver humanitarian assistance does not match the scale, complexity and urgency of the crisis. It can only be applied for a time-limited period of six months, unless one additional three-month extension is warranted. It is a short-term injection of additional capacity to meet urgent humanitarian needs.

Transition away from a scale-up activation to a less urgent degree of response activation does not necessarily mean a crisis is over, rather that the response is deemed sufficiently comprehensive to deliver results in a sudden onset crisis or significant deterioration in a humanitarian situation. If there are factors affecting the response that the scale-up activation cannot address, transition from scale-up may occur.

A scale-up activation may be initiated in any type of humanitarian emergency when the Emergency Relief Coordinator and the IASC Principals determine that the capacity to lead, coordinate and deliver humanitarian assistance and protection on the ground does not match the scale, complexity and urgency of the crisis. The decision will be based on an analysis of five key criteria: scale, complexity, urgency, capacity, and risk of failure to deliver effectively and at scale to affected populations, in relation to assessed needs and severity. Table 1.2 shows the main elements considered under each of these criteria.
Table 1.2 Criteria considered for initiating a scale-up activation

<table>
<thead>
<tr>
<th>CRITERION</th>
<th>ELEMENTS</th>
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| **Scale** | • Number of affected or potentially affected populations, including in proportion to total country population  
• Size of affected areas |
| **Complexity** | • Multilayered emergency  
• Presence of a multitude of actors  
• High risk of politicization  
• Lack of humanitarian access  
• High security risks to humanitarian actors |
| **Urgency** | • Number of people displaced  
• Crude mortality rates  
• Minimal or no access to lifesaving support  
• Critical protection risks |
| **Capacity** | • Low levels of local or international response capacities, including lack of required specialized or technical expertise  
• Needs outweigh the capacity to respond  
• Inadequate humanitarian leadership |
| **Risk of failure to deliver effectively and at scale to affected populations** | • Violations of human rights and international humanitarian law  
• Exacerbation of food insecurity  
• Deterioration of civil unrest |

Details regarding the division of responsibilities, the activation and deactivation procedure, and steps for decision-making and monitoring are presented in the protocol.

National authorities must always be informed of a scale-up activation. The scale-up activation is not contingent on an assessment of national capacity, nor is it a measure of the severity of the crisis, so it should not result in an exacerbation of any inequities in funding between crises.

A scale-up activation triggers the following to be completed within 72 hours:

- establishment of the humanitarian country team;
- deployment of coordination capacity, including a humanitarian coordinator, qualified cluster coordinators and information managers;
- activation of priority sector clusters;
- issuance of a statement of key strategic priorities by the resident coordinator or humanitarian coordinator;
• announcement of funding from the Central Emergency Response Fund (and country-based pooled fund if available), with allocations issued by the Emergency Relief Coordinator (or humanitarian coordinator for pooled funds), supporting the priorities in the strategic statement.

The head of the WHO country office will undertake certain responsibilities in the scale-up process, as defined and agreed.

Within a short period, there should be:

• a situation analysis from a rapid assessment, followed by a multisectoral assessment and report (within the first two weeks);
• a flash appeal (by day 5);
• activation of the “empowered leadership” model, as set out in the IASC concept paper;
• an operational peer review (no more than five months later);
• an inter-agency humanitarian evaluation (within 9–12 months).

IASC Protocol 2. “Empowered leadership” in a humanitarian system-wide scale-up activation

During a humanitarian crisis, it is possible that the roles and responsibilities of the humanitarian coordinator could be revised for an initial limited period of six months. These revised roles and responsibilities are outlined in the protocol on empowered leadership. They apply only for the period of scale-up activation and so may only be extended if the scale-up activation is extended.

The humanitarian coordinator is empowered to be the primary responsible agent for setting priorities, ensuring effective planning, taking the lead in cluster coordination, ensuring advocacy, and establishing and maintaining relationships with national authorities and donors. The humanitarian coordinator also has responsibility for monitoring and assessing the response and establishing mechanisms for monitoring and accountability.

Key aspects of these revised roles and responsibilities include the following.

• If a situation arises where it becomes urgent to have a decision by the humanitarian country team regarding essential actions required for affected communities, the humanitarian coordinator is authorized to make relevant decisions if no consensus can be achieved in a timely and expedient manner.

• To ensure effective analysis of a situation and priority needs and appropriate coordination by the humanitarian country team, the humanitarian coordinator
must have access to and be able to share all information regarding needs and necessary responses.

The humanitarian coordinator will be responsible for establishing agreements with humanitarian country team members as a basis for accountability in measuring agreed results and performances during the response period. The humanitarian coordinator works with the humanitarian country team to ensure accountability to affected populations.

**Humanitarian system-wide scale-up activation: Protocol for the Control of Infectious Disease Events**

Under the International Health Regulations (IHR) (2005), WHO assesses the risks associated with infectious disease events on an ongoing basis, consulting as necessary with the relevant governments, country offices, United Nations Children’s Fund (UNICEF), the Global Outbreak Alert and Response Network and partner agencies, including the Food and Agriculture Organization of the United Nations (FAO) and the World Organisation for Animal Health (OIE). The WHO Director-General informs the United Nations Secretary-General and the Emergency Relief Coordinator of all public health events assessed as high or very high risk at regional or global levels, or when WHO declares an internal Grade 3 emergency (20).16

As stated in the Protocol for the Control of Infectious Disease Events (19):

The designation of a Scale-Up response to an infectious disease event will be issued by the Emergency Relief Coordinator (ERC), in close collaboration with the Director-General of WHO, and in consultation with IASC Principals and, potentially, Principals of other relevant entities. For infectious disease events, the designation of a Scale-Up activation should be based on both an analysis of the IASC’s five criteria [scale, urgency, complexity, capacity and risk of failure to deliver effectively and at scale to affected population] adapted to meet International Health Regulations (2005) (IHR) criteria … and WHO’s formal risk assessment of the event.

Once a public health event is detected and WHO has verified it, WHO may decide to undertake a rapid risk assessment. The WHO formal rapid risk assessment is an internal document that will:

- impartially and independently assess the risk posed by an infectious disease event;
- provide transparency and reproducibility regarding the WHO decision-making process, through application of a standardized methodology and reporting template;
- document and summarize all relevant public health, operational and contextual information on the event;
- inform and support WHO, United Nations, and IASC decision-making on how to respond to the public health event.

When WHO indicates the need to discuss IASC scale-up activation, within 24 hours of having informed the United Nations Secretary-General about the event, WHO will provide to the United Nations Secretary-General and to the Emergency Relief Coordinator a draft statement of public health strategic priorities, proposed response structure, and the major activities required to control the infectious event.

The Emergency Relief Coordinator will make a final decision on the system-wide scale-up activation based on the recommendations of the Director-General of WHO and the IASC Emergency Directors Group, in consultation with the IASC Principals, and invited Principals of relevant non-IASC entities.
The initial duration of the scale-up activation will be defined by the Principals during their first meeting but should not exceed six months. That could be exceptionally extended by three additional months, as the primary purpose is to support the surge necessary for an effective response.

The activation commits IASC member organizations to ensure that they put in place the most appropriate systems and dedicate the required capacities and resources in a timely manner to contribute to the effectiveness of the response as per their mandated areas, cluster lead agency responsibilities, and commitments made in the statement of key strategic priorities.\textsuperscript{17}

During the period of assessment and decision-making by the IASC Principals regarding scale-up activation, the response at country level is already under way.

### 1.5.3 The “triple nexus” of humanitarian, development and peacebuilding actors

Against the backdrop of the Sustainable Development Goals (SDGs) – with the promise of leaving no one behind – reducing risks and vulnerabilities for all people is now a shared commitment within the United Nations and the IASC\textsuperscript{(21)}.\textsuperscript{18}

Reducing the impact of protracted crises on affected populations requires both meeting immediate needs and investing in the medium to long term to reduce chronic vulnerabilities and risks affecting communities. It requires boosting resilience and building self-reliance by strengthening formal and informal institutions and the capacities of communities, improving livelihoods, and increasing access to services that can enhance people’s ability to cope with current disasters and withstand future crises, while addressing the root causes of crises and vulnerabilities. In practice, this requires providing short-, medium- and longer-term assistance concurrently to vulnerable people, while prioritizing “reaching those furthest behind first”.

The notions of “collective outcomes” and a “whole-of-society” approach have emerged as elements of a strategic pathway to cut across traditional sectors and intervention time frames. Collective outcomes can capitalize on the comparative advantages and mandates of individual agencies. This entails defining a collective vision based on a joint analysis of context and risks, and setting out clear strategies, roles and responsibilities for relevant actors to deliver those outcomes.

A collective outcome consists of an objective that envisions a sustained positive change, for example through reduction of vulnerability and risk. In most cases achievement of this sort of objective will require multi-year action and include the following components.

- Action must be needs based and target those furthest behind.
- It must also be quantifiable, with clear lines of accountability.
- Involvement must “do no harm” and be consistent with the norms of accountability to affected populations.
• Civil society and local communities should be involved in planning and implementation.

• Action should take into account comparative advantage, including that of local actors.

This approach acknowledges that in protracted situations humanitarian, development and peacebuilding actors need to work together and collaborate. Context-specific analysis will need to take place to underpin the development of such collective outcomes and implement activities in the context of the “triple nexus”. The IASC and the United Nations system established a process flow to facilitate the definition of engagement opportunities by humanitarian actors in that process, and guidance will be produced early in 2020 to support country teams in the definition and implementation of collective outcomes. It is highly recommended that health clusters actively engage at country level in the definition and implementation of collective outcomes. Health humanitarian interventions are directly lifesaving, and functioning health systems are an essential foundation for both development and peace. It is recommended that health clusters support the development of collective outcomes that clearly lead to identifiable and measurable progress in the most critical health issues affecting the country, and oppose convenient but vague formulations bringing together different sectors (for example, formulations such as “better access to [unspecified] essential services” are too vague and unspecific to be operationally useful).

1.6 Centrality of protection in humanitarian action

In December 2013, IASC Principals endorsed a statement on the centrality of protection in humanitarian action (22). This statement affirms the commitment of the IASC Principals to ensuring the centrality of protection in humanitarian action and the role of humanitarian coordinators, humanitarian country teams and clusters in implementing this commitment in all aspects of humanitarian action. This was reinforced by the IASC Policy on Protection in Humanitarian Action, 2016, which defines the centrality of protection in humanitarian action as well as the process for its implementation at country level (23).

1.6.1 What is protection mainstreaming?

Protection mainstreaming is the process of incorporating protection principles and promoting meaningful access, safety and dignity in humanitarian aid. The following elements must be considered in all humanitarian activities (24, 25).
Humanitarian principles and international humanitarian coordination mechanisms

- Prioritize safety and dignity, and avoid causing harm: prevent and minimize as much as possible any unintended negative effects of your intervention that can increase people’s vulnerability to both physical and psychosocial risks.

- Meaningful access: arrange for people’s access to assistance and services in proportion to need and without any barriers (such as discrimination). Pay special attention to individuals and groups who may be particularly vulnerable or have difficulty accessing assistance and services.

- Accountability: set up appropriate mechanisms through which affected populations can measure the adequacy of interventions, and address concerns and complaints.

- Participation and empowerment: support the development of self-protection and capacities and assist people to claim their rights, including the rights to shelter, food, water and sanitation, health, and education.

**1.6.2 Health: tips for protection mainstreaming**

1. **Prioritize safety and dignity, and avoid doing harm**

Prevent and minimize, to the extent possible, any unintended negative effects of an intervention that can increase people’s vulnerability to physical and psychosocial risks.

- Ensure that the location of health facilities and routes to them are away from actual or potential threats such as violence, especially the risk or threat of gender-based violence, and attacks from armed groups.

- Make infrastructure adaptations such as ramps and railings to health facilities and latrines so that all individuals and groups can access and use them in safety and with dignity. Use direct observation and discussion groups with persons with disabilities in the community to identify the type of adaptations that are needed. Health facilities need latrines. Design must preserve the safety and dignity of users.

- Ensure that the health services are respectful and inclusive of cultural and religious practice.

- Ensure that confidentiality and privacy is respected in any form of consultation, counselling or personal information sharing.
Do not share identifiable information unless consent has been given by the beneficiary (including names, addresses, or traits and characteristics that can lead to identification).

If setting up health facilities for displaced communities, consult them as well as host communities about health needs so as to avoid community tensions. Make sure that there is no tension or inequality that could lead to violence and harassment of one group by another.

Employ female health staff members with skills and experience of working with women and children.

Put in place guidelines and mechanisms for monitoring and reporting instances of abuse and exploitation (26).

2. Meaningful access

Arrange for people’s access to assistance and services, in proportion to need and without any barriers (such as discrimination). Pay special attention to individuals and groups who may be particularly vulnerable or have difficulty accessing assistance and services.

Ensure that the health facilities are accessible to all.

Ensure that services can be accessed by persons with reduced mobility (for example, persons with physical disabilities, the elderly, bedridden individuals).

Ensure that services can be accessed by persons with non-mobility-related disabilities (such as those with sight, hearing or intellectual disabilities).

Ensure that health staff are representative of gender and ethnic differences.

Ensure that health staff know how to respond to the specific needs of victims of grave human rights violations, including rape and physical abuse.

Ensure that beneficiaries know their right to health care, and where and how to obtain it.

Monitor access and discrimination, and whether any services are being diverted.
✓ Identify what are the power dynamics within the intervention area. Who has access to health care?

3. Accountability, participation and empowerment

Set up appropriate mechanisms through which affected populations can measure the adequacy of interventions, and address concerns and complaints.

✓ Identify local authorities and civil society groups specialized in working with persons with low mobility or disabilities. Strengthen and support their roles, and learn from their experience on how to improve service delivery.

✓ Ensure that health staff and committees are representative of all layers of society (by gender, age, ethnicity, socioeconomic group or ability).

✓ Before leaving an area, make sure that responsible actors and systems for health care are in place.

✓ Report and share protection concerns with the protection cluster, including the gender-based violence and child protection subclusters. Other actors may be able to provide assistance.

✓ Make sure that all layers of society are consulted when identifying and responding to health needs.

✓ Ensure that health committees are representative of all layers of society and that all members are trained on protection mainstreaming principles.

✓ Find out what the coping strategies are. Where do people go when they get sick? What kind of treatments can they expect? Are they placing their safety and dignity at risk? Does one group have access over others? Are women allowed to access formal health care? Do they need to be accompanied by male members of their families? Risks must be recognized as soon as possible and interventions undertaken to help people avoid resorting to negative coping strategies.

✓ Set up accessible, well understood mechanisms for suggestions and complaints.
1.7 Protection from sexual exploitation and abuse

Sexual exploitation and abuse of affected community members by anyone associated with the provision of aid is a protection issue (26). It is also one of the most serious breaches of humanitarian accountability. Such exploitation may occur where the essential needs of those most at risk in communities are not adequately met. Issues of impunity and lack of accountability in relation to sexual exploitation and abuse are derived from existing asymmetries in the balance of power, and erode the confidence and trust of affected communities and other stakeholders (host States, donors, media and the public) in all those providing assistance. Therefore, protection from sexual exploitation and abuse is an essential issue of accountability.

The IASC six core principles relating to sexual exploitation and abuse are as follows (27).

1. Sexual exploitation and abuse by humanitarian workers constitute acts of gross misconduct and are therefore grounds for termination of employment.

2. Sexual activity with children (persons under the age of 18) is prohibited regardless of the age of majority or age of consent locally. Mistaken belief regarding the age of a child is not a defence.

3. Exchange of money, employment, goods, or services for sex, including sexual favours or other forms of humiliating, degrading or exploitative behaviour, is prohibited. This includes exchange of assistance that is due to beneficiaries.

4. Any sexual relationship between those providing humanitarian assistance and protection and a person benefiting from such humanitarian assistance and protection that involves improper use of rank or position is prohibited. Such relationships undermine the credibility and integrity of humanitarian aid work.

5. Where a humanitarian worker develops concerns or suspicions regarding sexual abuse or exploitation by a fellow worker, whether in the same agency or not, he or she must report such concerns via established agency reporting mechanisms.

6. Humanitarian workers are obliged to create and maintain an environment that prevents sexual exploitation and abuse and promotes the implementation of their code of conduct. Managers at all levels have particular responsibilities to support and develop systems that maintain this environment.

Upholding and promoting policies on sexual exploitation and abuse is critical in all WHO operations in all countries (28).
The Global Health Cluster has a key role to play to:

- identify risks and integrate protection from sexual exploitation and abuse strategies into cluster workplans;
- encourage all cluster members to put in place appropriate mechanisms to deal with any issues of sexual exploitation and abuse;
- ensure that issues are brought to the attention of the appropriate stakeholders for action, such as the humanitarian coordinator.

### 1.8 Accountability to affected populations

Accountability to affected populations requires that humanitarian agencies develop a system-wide culture of accountability and collectively provide effective and quality programming that considers the needs and capacities of different groups in the community. It encompasses taking account of, giving account to, and being held to account by the affected population.

The IASC Commitments on Accountability to Affected Populations articulate commitments that leaders of humanitarian agencies undertake in relation to (a) leadership, (b) participation and partnership, (c) information, feedback and action, and (d) results (29).

#### 1.8.1 What is accountability to affected populations?

In summary, accountability to affected populations is an active commitment by aid workers and organizations to use the power and resources entrusted to them ethically and responsibly; to work to develop a system-wide culture of accountability to affected populations; and collectively to provide effective and quality programming that recognizes the community’s dignity, capacity and rights to participate in decisions that affect them. It encompasses taking account, giving account, and being held to account.

- **Taking account** involves giving affected populations influence over decision-making at all phases of the Humanitarian Programme Cycle, in a way that takes account of the diversity of communities and allows the views of the most vulnerable to be equally considered.

- **Giving account** refers to transparency and effective sharing of information to affected communities through all phases of the Humanitarian Programme Cycle.
● **Being held to account** means being accountable for commitments, actions and decisions made, and for proper use of resources. It involves self-regulation and compliance verification and entails giving others the opportunity to assess and, if appropriate, sanction the actions of individuals and organizations.

When the IASC Principals endorsed the five Commitments on Accountability to Affected Populations they agreed to incorporate them into the policies and operational guidelines of their respective organizations and to promote them with operational partners, within humanitarian country teams and among cluster members.

The Commitments on Accountability to Affected Populations and the Core Humanitarian Standard on Quality and Accountability (CHS) are mutually supportive and reinforcing. Combined, they provide a solid base for building accountability to affected populations into humanitarian programming (30).

The CHS was developed in 2014 as a result of extensive consultation with humanitarian agencies (31, 32).20 The CHS outlines what good humanitarian action looks like for communities and people affected by crisis, and for the staff and organizations involved in a response. Its purpose is to help organizations design, implement, assess and improve the quality of assistance while at the same time being accountable to communities and people affected by crisis.21

**1.8.2 Incorporating accountability to affected populations into the health cluster response at country level**

Many health cluster partners, including WHO, already have policies and practices in place that promote accountability to affected populations within their programmes. However, health clusters are key to ensuring that accountability to affected populations is addressed in a harmonized and cohesive manner.

• It will be important to build a shared vision within the health cluster on what it means to provide an emergency health response that ensures safe and equal access to quality health services and ensures accountability to affected populations (including taking account, giving account, and being held to account).

• Health cluster coordinators should utilize the available skills and expertise of specialized agencies and relevant focal points in a country on such accountability-related matters as age, diversity, gender and protection, and should help build understanding on these issues within the health cluster through
briefings, orientation and training, and adaptation of generic tools for use by the health cluster.

- It is the responsibility of the health cluster coordinator to improve accountability by placing affected populations at the centre of decision-making and at the centre of action to promote meaningful access, safety and dignity with a desire to meet humanitarian needs, to systematically reduce those needs, and to increase resilience. The Global Health Cluster Operational Guidance on Accountability to Affected Populations, August 2017, outlines actions, responsible actors and indicators to incorporate accountability to affected populations into coordination processes and each of the phases of the Humanitarian Programme Cycle for the health response (30).

1.8.3 What is the link between accountability to affected populations and protection?

Accountability and protection complement and mutually support each other. Without one, the other is not complete. Both are rooted in a rights-based approach. Accountability is not only about improving humanitarian programme effectiveness but also about ensuring that affected people can exercise their right to access services.

Protection mainstreaming involves incorporating protection principles and promoting meaningful access, safety and dignity in all aspects of humanitarian aid, and is a crucial pillar of programme quality in all sectors. The following protection-related issues must be considered in all humanitarian activities.

The health cluster has the responsibility of identifying risks and ensuring that protection strategies are appropriately incorporated into all phases of the Humanitarian Programme Cycle for the emergency health response (22).

Box 1.2 provides information on gender-based violence, an important aspect of protection.
**Box 1.2 Gender-based violence**

Gender-based violence is a protection issue and as such WHO and the health cluster have responsibility to ensure that appropriate interventions to prevent and respond to gender-based violence are incorporated into all phases of the Humanitarian Programme Cycle for the emergency health response.

Gender-based violence prevention and response interventions should not be delayed due to lack of solid information or reporting on incidents of violence. Evidence shows that gender-based violence will usually be present in humanitarian situations, and hence the minimum set of prevention and response interventions should be established right at the beginning of an emergency.

### 1.8.4 Mainstreaming a comprehensive people-centred approach in the health response

It is the responsibility of the health cluster coordinator to ensure that a people-centred approach is incorporated into all phases of the Humanitarian Programme Cycle for the health response – preparedness, needs assessment and analysis, strategic response planning, response implementation, monitoring and evaluation, and learning. The Global Health Cluster Operational Guidance on Accountability to Affected Populations provides examples of key activities in mainstreaming a people-centred approach in the health sector (32).
References


Key reference materials

Websites
Inter-Agency Standing Committee: https://www.interagencystandingcommittee.org
Humanitarian Response: https://www.humanitarianresponse.info/
Agenda for Humanity: https://www.agendaforhumanity.org
United Nations Office for the Coordination of Humanitarian Affairs: https://www.unocha.org
Health Cluster: https://www.who.int/health-cluster

Further recommended reading
• Reference Module for Cluster Coordination at Country Level, IASC, July 2015
• Humanitarian Programme Cycle, IASC, revised July 2015
• Operational Framework for Accountability to Affected People, IASC, 2013
• Common Framework for Preparedness, IASC, October 2013
• Emergency Response Preparedness, Draft for field testing, IASC, July 2015
• Multisector Initial Rapid Assessment Guidance, IASC, Revision July 2015
• Commitment to Principles of Partnership – Global Humanitarian Platform 2007
• Commitment to Action – World Humanitarian Summit, Istanbul, May 2016
• Too important to fail—addressing the humanitarian financing gap: High-Level Panel on Humanitarian Financing – Report to the Secretary-General, January 2016
• The Grand Bargain – A shared commitment to better serve people in need, Istanbul, May 2016
• The Grand Bargain, https://interagencystandingcommittee.org/grand-bargain
• IASC Post WHS commitments – statement from IASC Principals Endorsed June 2016
Endnotes


2. A list of signatories is found at https://media.ifrc.org/ifrc/who-we-are/the-movement/code-of-conduct/. Note that the Red Cross/NGO Code of Conduct includes principles beyond the four core principles endorsed by the General Assembly. However, for United Nations humanitarian agencies, these principles are considered to be the essential ones. Conceptually, many other principles can be linked back to the four endorsed by the General Assembly.

3. See, for instance, common article 3 to the 1949 Geneva Conventions; articles 12 and 15, First Geneva Convention; articles 16 and 17, Fourth Geneva Convention; article 10, Additional Protocol I of 1977; articles 7 and 8, Additional Protocol II of 1977; International Committee of the Red Cross study of customary international humanitarian law, rules 109 and 110 (2, 3).


5. During its special session on Ebola, the 136th session of the WHO Executive Board (2015) called on Member States and relevant actors in humanitarian situations with health consequences to support WHO in fulfilling its role as lead agency of the Global Health Cluster within its mandate.


8. The foundations of the current international humanitarian coordination system were set by General Assembly resolution 46/182 of December 1991.

9. The Global Humanitarian Platform was established in 2006, bringing together leaders from the United Nations and related international organizations, NGOs and the International Red Cross and Red Crescent Movement to discuss how to improve partnership between very diverse humanitarian organizations. It was founded on the premise that the international humanitarian community was made up of three equal families – United Nations agencies, the International Red Cross and Red Crescent Movement, and NGOs – and with the underlying belief that no single humanitarian agency could cover all humanitarian needs. Collaboration was, therefore, not an option but a necessity. The principles of partnership were endorsed at a Global Humanitarian Platform meeting in 2007, where leaders of partner organizations agreed to implement the principles within their own organizational policies.

10. See subsection 2.3.3 of Chapter 2 for more details on the principles of partnership.

11. Grand Bargain: as part of the preparations for the World Humanitarian Summit in 2016, the High-Level Panel on Humanitarian Financing sought solutions to close the humanitarian financing gap. The outcome was the Grand Bargain: an agreement between some of the largest donors and humanitarian organizations that aims to get more means into the hands of people in need and to improve the effectiveness and efficiency of humanitarian action.


13. This refers to partnerships between all actors involved in humanitarian action, including governments, United Nations agencies, NGOs and civil society.

14. Eight protocols were developed in 2013 and a further two were developed in 2015.

15. An IASC Principals letter of 4 January 2013 stated that while the focus of the Transformative Agenda had been on massive Level 3 (L3) emergencies, most of the
Transformative Agenda – apart from some of the elements related to system-wide activation and empowered leadership – would generally apply in non-L3 situations (15).

16. Grading is an internal activation procedure that triggers WHO emergency procedures and activities for the management of the response. The grading assigned to an acute emergency indicates the level of operational response required by WHO for that emergency. In the WHO Emergency Response Framework, second edition, Grade 3 is defined as follows: “A single country or multiple country emergency, requiring a major/maximal WHO response. Organizational and/or external support required by the WCO [WHO country office] is major and requires the mobilization of Organization-wide assets. The provision of support to the WCO is coordinated by an Emergency coordinator in the Regional Office(s). An Emergency Officer is also appointed at headquarters, to assist with the coordination of Organization-wide inputs. On occasion, the WHO Executive Director and the Regional Director may agree to have the Emergency coordinator based in headquarters. For events or emergencies involving multiple regions, an Incident Management Support Team at headquarters will coordinate the response across the regions” (6).

17. Among the actions triggered by the scale-up activation, the Protocol for the Control of Infectious Disease Events lists the following: “Development of a ‘Statement of Key Strategic Priorities’ (SSP) by the humanitarian coordinator/humanitarian country team within four days of the Scale-Up activation, with the technical direction of WHO and in accordance with the IASC template. The SSP will lay out priorities and a common strategic approach for controlling the infectious disease event, including community engagement strategies to build trust with affected communities, managing humanitarian consequences and, where appropriate, implementing preparedness measures. It will serve as a basis for the Flash Appeal and for the performance monitoring benchmarks” (19). See also Annex 2 of the protocol: Timelines for IASC infectious events protocol.

18. In 2016, at the World Humanitarian Summit, partners agreed on a commitment to action that would transcend the humanitarian–development divide. To this end, the Summit urged the international aid system, including the United Nations, NGOs and bilateral donors, to commit to working in a new paradigm marked by three fundamental shifts: (a) reinforce, do not replace, national and local systems; (b) anticipate, do not wait for, crises; and (c) transcend the humanitarian–development divide by working towards collective outcomes, based on comparative advantage and over multi-year time frames.


20. The CHS consultation was facilitated by HAP International, People In Aid and the Sphere Project, and drew upon a number of sources.

21. See Chapter 5 on promoting standards for a quality cluster response.