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How are the health needs of internally displaced persons adressed by international actors?

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Abstract

The number of internal displacements has doubled over the last decade, as conflicts and climate related disasters have increasingly triggered movement within countries borders. Due to the lack of a legally binding framework and international agency dedicated for the protection of internally displaced persons (IDPs), the needs of IDPs are underprioritized by international actors. Evidence suggests that IDPs face worse health outcomes than any other crisis-affected population group. This leads to a policy analysis on the involvement of international actors on addressing the health needs of IDPs. The concept of humanitarianism will be utilized as the theoretical foundation and is the underlying motive of humanitarian action worldwide. As an altruistic desire to reduce suffering, humanitarianism aims to provide relief to victims of conflicts or disasters while adhering to the humanitarian principles. Assessing the humanitarian concept helps to conceptualize the role of international actors in the humanitarian assistance of IDPs. For the methodology, a description of the literature search and the selection of certain material has been provided. It also examined why documents by international organizations like the UNHCR, the OCHA, the WHO and the IASC were used for this policy analysis. The first part of the findings identified the legal protection frameworks for IDPs. International law and the Guiding Principles on Internal Displacement represent the most suitable legal tools for IDPs. Guiding concepts regarding the realization of health rights have also been developed by international organizations and national authorities. The second part of the results concentrated on the humanitarian coordination mechanisms for IDPs. Although the UNHCR does not hold an exclusive mandate for IDPs, the protection and assistance of IDPs relies mainly on the UNHCR. The humanitarian coordination mechanism applicable in internal displacement settings is the IASC Cluster approach. The Cluster approach spreads accountability of UN agencies across various sectors, including shelter, food security or health. Despite individual interventions of NGOs on the health of IDPs, the Health Cluster remains the most suitable tool for coordinating an emergency health response. Health cluster country operations have targeted the health needs of IDPs through provision of essential health care. The country cluster operations have contributed to an effective humanitarian relief coordination for IDPs. Due to the lack of an international legally binding framework, the lack of health funding for IDPs and limited accountabilities for IDPs, the issue of internal displacement will remain. Strengthening humanitarian engagement in all sectors concerning the well-being of IDPs can be achieved through a holistic approach.

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1 Introduction

1.1 Background

Humanitarian emergencies have triggered internal displacements worldwide. Due to conflicts and climate related disasters, people have lost their home and are forced to flee within their countries (IDMC a, 2022). Former UN Secretary-General Kofi Annan has already highlighted the global crisis of internal displacement and lack of recognition by international and national actors. He described in his UN report from 2005 that IDPs “are among the most vulnerable of the human family [..]” and “often fall into the cracks between different humanitarian bodies [..]” (Cohen, 2009, p. 101).

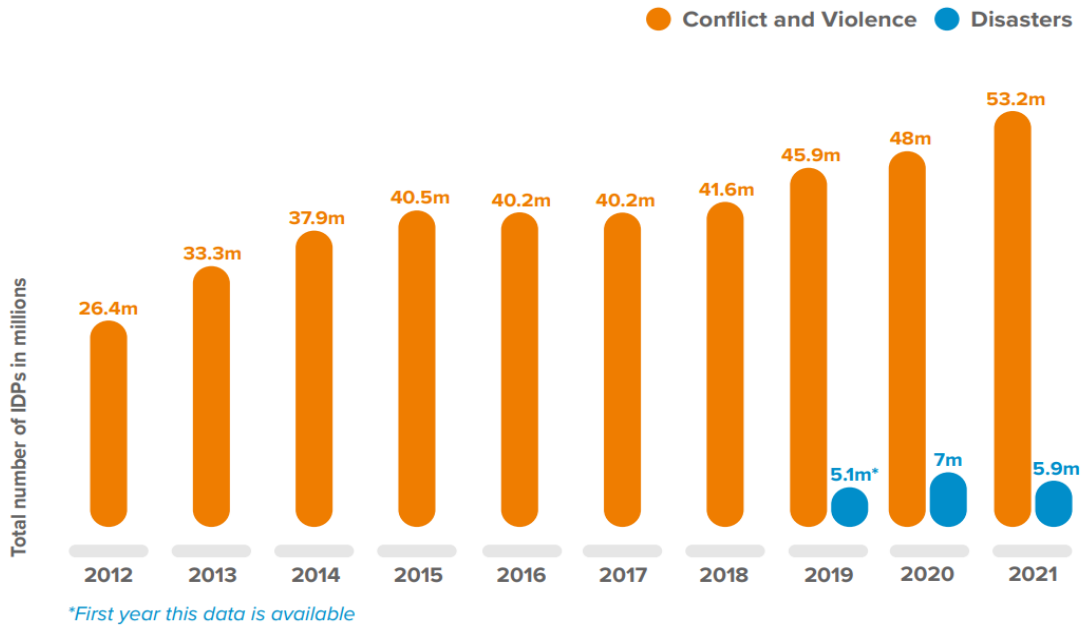
The United Nations Guiding Principles on Internal Displacement define IDPs as “persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters [...]” (OHCHR, 2022). Compared to refugees, they do not cross an internationally recognized border (Cantor et al., 2021). IDPs also do not receive the same access to international aid as they are not under an agreed international legal status unlike refugees (Roberts et al., 2022). The term “internally displaced person” is simply descriptive and describe the factual circumstance of the individual (OHCHR, 2022). There is also not a single agency or organization specifically targeted on the protection and assistance of IDPs, compared to the United Nations High Commissioner for Refugees (UNHCR). IDPs are citizens and residents of their country under the responsibility of the national authorities (Thomas &Thomas, 2004, p. 118). Another crucial element of IDPs is the involuntary character of their movement. Internal displacements can be attributed to two categories, either conflicts or natural disasters (Etikan & Babatope, 2019, p. 23).

Drawing attention to the rising scale of internal displacements, the global number of IDPs has more than doubled over the last decade (UN a, 2022). On a global scale, the Internal Displacement Monitoring Centre (IDMC) estimated 59.1 million internally displaced persons by the end of 2021. The year 2021 alone triggered 38 million displacements worldwide (IDMC a, 2022). As a result of armed conflict and violence, 53.2 million people were classified as internally displaced in 59 countries by the end of 2021. The IDMC categorized forms of conflict and violence into armed conflict, communal violence, criminal violence, political violence, and other forms of violence. Conflict related displacements occurred mostly in sub-Saharan Africa and other conflict affected countries such as Syria, Afghanistan, Columbia, or Yemen (IDMC a, 2022). The total number also includes those IDPs who have been displaced several years or even decades ago. In Nigeria for example, the Boko Haram

and other non-state armed groups have led to over 3 million displacements since 2009 (UNHCR b, 2022).

The IDMC recorded 5.9 million internal displacements due to natural disasters across 84 countries by the end of 2021. Afghanistan, China and the Philippines had the highest numbers of displacements with more than three million IDPs total. Internal displacement through disasters were mostly weather related, including storms, floods and droughts. Geophysical disasters such as earthquakes, volcanic eruptions or landslides account only for the smaller percentage of displacements. Although geophysical disasters seem smaller in numbers, they can have a significant impact on the infrastructure and repairment afterwards as seen in Haiti in August 2021 (IDMC a, 2022). The increase of 60 percent more internal displacements due to natural disasters can be linked to the global climate crisis (Cazabat & O'Connor, 2021). Human settlements appear to be more unstable due to rising sea levels and extreme weather situations (UN, 2021). The figure below illustrates the overall rise of internal displacements worldwide while drawing attention to the increase of internal displacements due to disasters since 2019.

Figure 1: Total numbers of IDPs worldwide at year end (2012-2021)



(Source: IDMC a, 2022)

IDPs are in the most vulnerable position as they face exposure to violence, poverty and poor living conditions. They experience higher rates of mortality, communicable diseases, non-communicable diseases, and mental disorders compared to other populations from conflict affected areas (Cantor et al., 2022).

Aspects of their vulnerability can be categorized into different stages of displacements namely pre-flight, during flight and post-flight. The pre-flight phase of displacement already

encompasses the presence of vulnerable groups which are more susceptible to the effects of a humanitarian emergency. They are more likely to be displaced and are an important predictor of the upcoming health burden (Thomas &Thomas, 2004, p. 119). During the actual flight, health-related problems are very likely to occur due to lack of capacities for basic needs such as food, shelter and sanitation or lack of access to emergency health care (Thomas &Thomas, 2004, p. 120). Referring to the high vulnerability, women and girls make up more than half of the IDPs (UN, 2021). The lack of reproductive health care and the exposure to sexual and gender-based violence puts them at a high-risk position (GPC, 2010). The post-flight phase of displacement focuses on the general needs by the entire displaced population at the arrival (Thomas &Thomas, 2004, p. 120).

People affected most during the displacement process or those with preexisting health conditions require immediate action upon arrival to prevent further health difficulties. The degree of answering initial needs depends largely on the capacity of the receiving state or province (Thomas &Thomas, 2004, p. 120). Even in places where basic services are provided, the influx of IDPs in already populated areas may lead to discrimination and tension between the host community and IDPs due to the competition over resources (GANHRI, 2021). Additionally, most internal displacements occur in low- and middle-income countries with already limited resources to health (Ekezie et al., 2022). In 2020, the IDMC has reported that 99,5 percent of conflict driven displacements occurred in low- and middle-income countries (LMIC), with Syria having the highest population of 6.7 million IDPs followed by the Democratic Republic of Congo with 5.3 million IDPs (IDMC a, 2022; Roberts et al, 2022).

The health concerns of IDPs are heterogeneous and multifaceted as they vary by emergency complexity, migration flow and country of origin (Mitra, 2022). Looking at existing data on IDPs health, several studies reported that IDPs face worse health outcomes than the baseline population in their country (Owoaje et al., 2016, p. 169). This can be seen in higher crude mortality rates of IDPs in camp settings in Sudan, Democratic Republic Congo and Chad compared with the international emergency threshold (Grandesso et al., 2005, p. 1492; Depoortere et al., 2004, p. 1318; Ahoua et al., 2006). The crude mortality rate gives the average numbers of deaths per 1,000 population within specific period, while the excess mortality rate provides the number of deaths from all causes (EC, 2023; WHO, 2023). A meta-analysis of combined mortality studies even revealed a significantly higher excess mortality rate of IDPs than for refugees due to better access to humanitarian assistance (Heudtlass et al., 2016). Exposure to hazards from their new environment put IDPs at an increased risk of infectious diseases such as diarrhea, malaria or acute respiratory diseases (Cantor et al., 2021). Drivers of infectious diseases can be inadequate access to water, food insecurity, lack of sanitation facilities combined with overcrowding in IDP camps (Ajakaye &

Ibukunoluwa, 2019, p. 7). The sudden mass movement of people also disrupts the routine immunization services. This leaves IDPs at increased risk of vaccine-preventable diseases (VPD), particularly measles and respiratory infections (Cantor et al., 2021). Outbreaks of VPDs including measles, meningococcal meningitis, cholera and polio have both been reported in IDP and refugee camps across Africa (Owoaje et al., 2016, p. 169). Therefore, vaccination interventions even in insecure settings for refugees and IDPs are essential to prevent short- and long-term health-related consequences (Cantor et al. 2021). The epidemics of infectious diseases also put another strain on the healthcare system of the host country. Through social mobilization, well trained health staff and adequate vaccine delivery systems into remote areas could increase the vaccine uptake of IDPs and refugees (Lam et al., 2015, p. 2634).

The research on the prevalence of non-communicable diseases (NCD) among IDPs has been relatively scarce (Cantor et al., 2021). The provision of NCD care by humanitarian programmes have mainly focused on the big four, namely cardiovascular diseases, diabetes, chronic respiratory diseases, and cancer. Studies in Uganda, Ukraine and Georgia have noted that substance abuse due to psychological distress has been a trigger factor for cardiovascular disease, diabetes and liver diseases (Ramachandran et al., 2019, p. 1144; Roberts et al., 2011, p. 872; Roberts et al., 2014).

The body of research on mental health disorders among IDPs is broader compared with data on physical health outcomes. The lack of health workers and laboratory facilities to diagnose a physical health condition is associated with limited numbers of confirmed cases (Owoaje et al. 2016, p. 169). Commonly reported mental health disorders identified among IDPs were depression, anxiety and post-traumatic stress disorder (Cantor et al., 2021). The exposure to violence in a conflict setting, the separation of families, impoverishment, the loss of livelihoods and multiple displacements can be all predictors for mental disorders (GANHRI, 2021; Makhashvili et al., 2014, p. 514). These experiences can occur in all three phases of displacement (Thomas& Thomas, 2004, p. 125). As for instance post-migration stress adds to the experience of previous traumatic events (Silove et al. 2000, p. 604). There is a gap of mental healthcare interventions for IDPs. The education about mental disorder like anxiety and the provision of group therapy sessions is essential to help IDPs adjust into a new environment and prevent long term mental health conditions (Thomas& Thomas, 2004, p. 122)

Overall, the health concerns among IDPs not only bring an individual or community burden but also threaten public health systems in the new settlements and host areas. Ill-health among IDPs can lead to adverse socio-economic effects on individuals, as untreated physical and mental health conditions hinder IDPs to obtain a new job and integrate into a

new society (Mitra, 2022). Humanitarian crises have become more frequent and protracted. They have acute and long-term health impacts, while affecting predominantly populations in LMIC. As mentioned before, humanitarian crises affect nearly every aspect of health, such as maternal and child health, infectious diseases, or mental health. Neglecting the importance of health in fragile context can be compared with building a hospital without an emergency room (Kohrt et al., 2019). Recognizing humanitarian health as an integral part of global health is essential to prepare effective multi-agency health interventions (Thomas& Thomas, 2004, p. 125).

1.2 Research relevance and current research state

Armed conflicts and natural disasters will further threaten the livelihood of vulnerable populations and movements within borders will continue. Poor living conditions and limited access to healthcare will have prolonged consequences on IDPs physical wellbeing and mental health. In terms of international recognition, IDPs were never accounted as part of the general UNHCR mandate (UNHCR, 2022). The United Nations Guiding Principles on Internal Displacement have been introduced into the UN Commission on Human Rights in 1998. They have raised awareness on the global crisis of displacements and are an important tool for dealing with situations of internal displacement, but they are not legally binding for any states (Cohen, 2009, p. 102). With the lack of coordinated national and international assistance, the humanitarian situation of IDPs will worsen. Not only are internal displacements examples for humanitarian emergencies, but they are also directly associated with challenges of governance, humanitarian assistance and global public health. Large-scale prolonged displacement can impact the stability and development of host communities and hamper the progress of achieving the Sustainable Development Goals (SDGs) (UN, 2021).

Although the research on internal displacements has been conducted by international entities like the IDMC, IDPs remain underrepresented in academic literature due to missing epidemiolocal and demographic data (Heudtlass et al., 2016). The total reported number of IDPs remains an overall estimate due to high unofficial numbers of IDPs (Fearon, 2012, p. 66). IDPs remain hard to reach by international agencies due to the dynamics of displacements and restricted access to remote areas (Hakamies et al., 2008, p. 34). Other challenges of data collection on IDPs can be security issues due to ongoing conflicts or disease outbreaks (Baal & Ronkainen, 2017). Only a limited numbers of studies have examined the health impacts and health investments of internal displacements. The lack of research investments undermines the low recognition of this global problem (Cantor et al., 2022). Research on the health of IDPs in humanitarian settings and developing health

priorities is crucial for implementing effective strategies and approaches tailored to the needs of IDPs (Kohrt et al., 2019).

1.3 Research objective

This research aims to conduct a policy analysis of the involvement of international actors in the humanitarian response of IDPs with a special focus on addressing the health needs of IDPs. A theoretical background will be established through the concept of humanitarianism. Humanitarianism provides an underlying rationale for action and agendas set up by United Nations agencies and non-governmental organizations (Pacitto & Fiddian-Qasmiyeh, 2013). The four principles of humanitarianism namely humanity, neutrality, impartiality and independence built the foundation to humanitarian action and are functional guidelines for humanitarian agencies to provide relief and protection (Barnett & Weiss, 2012, p. 11 f.). With the aim to deliver live-saving aid to vulnerable groups, humanitarian activities differentiate from activities with political, religious, ideological, or military intentions (EC, 2022).

Then, the theoretical background will be utilized as a foundation to explain the role of international agencies in the humanitarian assistance of IDPs. At first, examining the existing international legal framework is needed to show how the rights of IDPs are manifested in the international law, guiding international standards and national legal frameworks. The right to health for IDPs will also be part of the assessment on legal protection frameworks of IDPs. The humanitarian coordination systems for IDPs will be outlined in the findings. One of the main concepts includes the Cluster approach. It is applied by humanitarian organizations, both UN and non-UN, to coordinate an effective inter-agency response in various key sectors. The Cluster approach spreads accountability across different cluster agencies responsible for health, food security, emergency shelter and other areas (UNHCR a, 2022). It remains the most suitable humanitarian response mechanism for IDPs, while the Refugee Coordination Model by the UNHCR is applicable for refugee situations. In case refugees and IDPs are in the same setting, the coordination during mixed situations developed by the UNHCR and OCHA will be outlined as well (UNHCR b, 2019). As the research focuses on the health of IDPs, the coordination and structure within the Health Cluster will be further analyzed. For a more practical insight, examples of country operations by the Health Cluster will be given to show the scope of work with IDPs. The lack of funding experienced within the IDP assistance and the difference to other health development aid will be further discussed in the findings.

1.4 Research question

The central research question for the thesis will be as followed:

How are the health needs of internally displaced persons addressed by international actors?

The main goal of this research is to analyze how IDPs are governed on the international agenda and how the health needs are addressed among international stakeholders. The paper will examine the role of international actors in providing protection and assistance to IDPs, when the national authorities lack the capacity or are unwilling to ensure an effective response to a humanitarian crisis. The mandate of the UNHCR and their involvement within the IASC Cluster system will be elaborated, as they play a central role in the protection and assistance of IDPs.

Subtopics of this paper will focus on the health barriers and vulnerabilities faced by IDPs as well as the legal frameworks applicable to the protection of IDPs.

2 Theoretical foundation

2.1 Concept of humanitarianism

Humanitarianism is motivated by an altruistic desire with the overall aim to provide relief to victims of human-made or natural disasters (Barnett & Weiss, 2012, p. 11). The concept of humanitarianism has been an underlying rationale for humanitarian action and has shaped the agendas of humanitarian organizations. The debate over the principles, purposes and politics of humanitarianism reflects the complexity of the humanitarian identity. For many, humanitarianism is not limited to the termination of an emergency and alleviate suffering but is related to broader objectives such as peacebuilding, democracy promotion and development (Barnett & Weiss, 2012, p. 6).

Humanitarianism also shares many attributes with the moral-political concept of human rights as humanitarian interventions were rooted in protecting the human rights of innocent civilians (Wilson &Brown, 2009, p. 4 f.). Human rights and humanitarianism both promote the human dignity and human welfare. But they need to be distinguished as humanitarian assistance follows moral principles whereas human rights are grounded in pre-existing international law for the protection of individuals. For instance, victims of human rights violation can seek actively an international criminal tribunal, whereas people in need for humanitarian aid cannot easily make their claim in front of an international setting (Wilson &Brown, 2009, p. 8).

In terms of principles, the seven fundamental principles of the International Red Cross and Red Crescent Movement unify the concept of humanitarianism. These principles have been adopted in 1965 by the Twentieth International Conference of the Red Cross. They consist of humanity, impartiality, neutrality, independence, voluntary service, unity and universality (ICRC a, 2022). The first four principles define the core part of humanitarianism, while the last three are additional principles proposed by the ICRC. Humanity involves the prevention and alleviation of human suffering wherever it may be found. Impartiality presumes that that humanitarian aid must be provided solely on the basis of need, regardless of their identity. The third principle, neutrality, means that humanitarian agencies should not take sides in hostilities or being allied to one side. Theoretically, this neutrality should give them access to all vulnerable groups and prevents them from becoming targets. Independence seeks for the autonomy of humanitarian principles from any political, religious, economic or military objectives (EC, 2022). The voluntary character of humanitarian aid puts forward the non-profit effort only out of motivation to help without a desire for gain (ICRC a, 2022). The principle of unity supports the idea of a humanitarian agency acting as a unifying force, for example there can only be one Red Cross in a specific territory. Ending universal suffering

with a collective response of aid agencies is promoted by the last principle of universality (ICRC a, 2022).

The seven fundamental principles go beyond an idealistic doctrine as they have operational relevance. Maintaining independence and neutrality in situations of armed conflict and hostility reflects one of them (UNHCR d, 2022). Humanitarianism is a practical endeavor manifested in concrete humanitarian crisis, rather than an abstract idea. It involves the provision of medical care, delivering food, building shelters and protecting the rights of vulnerable groups (Barnett & Weiss, 2012, p. 7). Humanitarian actors involve intergovernmental organizations, including the World Food Programme (WFP) or the United Nations High Commissioner for Refugees as well as non-governmental organizations like World Vision International (Barnett & Weiss, 2012, p. 13 f.).

Consistent adherence to humanitarian principles differentiates humanitarian organizations from for-profit relief enterprises. For-profit firms are more bound to contracts and not to the perceived need of a population group. Although states and commercial firms provide humanitarian assistance as well, they often have underlying foreign political intentions such as building cooperation or alliances (Barnett & Weiss, 2012, p.14). The humanitarian sector has persistent gray areas because many humanitarian organizations cannot accomplish the idealized status of incorporating all seven principles. As humanitarian agencies are resource-starved, they collaborate with other organizations to have the most effective humanitarian response (Barnett & Weiss, 2012, p. 5). Humanitarian agencies like the Medicine San Frontières (MSF) advocate for improving universal access to drugs and thus even hold an influence in political and economic plans (Barnett &Weiss, 2012, p.15).

2.1.1 The taxonomy of humanitarian action

The humanitarian sector has seen an increase in terms of number of aid agencies and diversity of humanitarian action (Barnett &Weiss, 2012, p. 29). To gain more specific view on different humanitarian action, it is important to conceptualize the kinds of humanitarianism. They present different strategies by humanitarian actors that can be applied in internal displacement situations. The distinction between apolitical and political humanitarian operations is the first dimension. Apolitical actions do not aim to change the governance and political agendas that can be an underlying cause of the humanitarian crisis. Accepting the constraints and changing the constraints constitute as the second dimension of humanitarian actions. Thus, a fourfold classification of the kinds of humanitarianism is established. (Barnett & Snyder, 2012, p. 145 f.).

“A bed for a night” is the first part of the fourfold taxonomy that categorizes different strategies of humanitarian operations. Inspired by the book “A bed for a night” from David

Reiff, this strategy aims to limit humanitarian intervention only to relief. The author describes the idea of a classical approach to humanitarian action with strict compliance to the principles of neutrality, impartiality and independence. This apolitical strategy allows humanitarian aid workers to help people on all sides of a conflict. Accepting constraints is another nature of this approach as it provides short-term emergency relief and accepts the existing circumstances. Outcomes of this short-term aid can be dependency and reinforcement of economic and political inequalities. While humanitarian emergencies have become more complex, the bed-for-the-night-humanitarianism has negative side effects and limitations that need to be recognized by aid workers (Barnett& Snyder, 2012, p. 147 f.)

The do-no-harm policy in humanitarian interventions is used by many aid agencies around the world. Like the bed-for-the-night-humanitarianism, it aims to remain apolitical while providing relief to the suffering population group. Examining the outcomes of the humanitarian assistance and minimizing adverse effects of the intervention also characterizes the do-no-harm policy. This policy goes beyond the classical approach as it looks on long-term consequences of aid. Humanitarian assistance should not limit the capacity of self-protection as well as the protection should not expose people to further threats. Analyzing the outcomes of aid remains a challenge (Barnett& Snyder, 2012, p. 149; Sandvik et al., 2017, p. 323).

The third part of the taxonomy of humanitarian action involves the “comprehensive peace building”. The peace-building strategy is on many agendas of international aid organizations and states. In this approach, the humanitarian aid is part of a broader objective of removing the root causes of conflict (Barnett & Snyder, 2012, p.150). Approaching the causes of the emergency and supporting structures that promote a more stable and peaceful system avoids the relapse into conflict. The peace-building strategy accounts to the development of a new humanitarianism as it partly neglects the principle of neutrality (Weiss, 2006, p. 3-4). Cooperating with multilateral organizations for more resources of relief-oriented activities and political advocacy for a stable post-conflict setting constitute the peacebuilding agenda. This idealistic goal is hampered by several circumstances. Peace building in a setting with the lack of resources, destruction of an infrastructure and continuing interests of the local parties of conflict can be an impossible operation (Doyle& Sambanis, 2006). Transforming a crisis-prone state into a liberal democratic state cannot be accomplished within a few months as those countries lack the necessary institutional framework. The UN has been involved in over sixty-two peacekeeping operations (UN b, 2022). They are described as “multidimensional peacekeeping operations” as they range from the implementation of a peace agreement, performance of mediation to peace enforcement measures. The success of peacekeeping operations is often achieved when local authorities are exhausted by the traces of war and

international incentives for transformation are seen as essential to restore stability in the country after humanitarian emergencies (Barnett & Snyder, 2012, p.153; UN b, 2022).

“Back a decent winner” is the last component of the taxonomy of humanitarian action. It shares the same goal of the peace building strategy as it tackles the underlying cause of the suffering but remains more modest in its approach. As the name implies, the strategy aims to negotiate with a party that holds the power and is capable of rebuilding stability with the necessary resources. This approach rather accepts the constraints and follows political actions. Back-a-decent-winner strategies involve an international recognition of the leading party by the international actors. This strategy can evoke problems as “decent winners” have included controversial cooperation in the past like with warlords in the Mozambican Civil War or a communist dictator in Cambodia. Another example has been the Pakistan earthquake in 2005. International emergency aid was required and the government under the undemocratic regime of Pervez Musharraf was selected to provide relief to the victims of the natural disaster while fighting the jihadi terrorism. Transforming political, economic, and social structures in Pakistan has not been part of their humanitarian agenda (Barnett & Snyder, p. 154 f.).

There is no ideal strategy for humanitarian action, as it varies by complexity of emergency and setting. Since the end of the cold war, aid agencies have shifted from providing merely relief with the “bed-for-a-night” strategy to a do no harm and peacebuilding approach. Aid agencies have become more aware of the negative outcomes of humanitarian assistance and have started to monitor the impact of aid. Nowadays, investing in post conflict transformation and supporting comprehensive peace building plays a significant role for many aid agencies to have sustainable effect for their humanitarian activities (Barnett & Snyder, 2012, p. 157).

2.1.2 History of humanitarianism

To understand the recent developments of the humanitarian sector, it is necessary to show how humanitarianism has evolved its importance in the past.

Humanitarianism has already been encouraged by a number of world religions as a moral paradigm as well as through Enlightment ideas. The establishment of human rights manifestations, including the United States´ Declaration of Independence in 1776 or the French Declaration of the Rights of Man and of Citizen in 1789 contributed to the defense of violated rights (Wilson& Brown, 2009, p. 9). The contemporary humanitarianism has mainly emerged in the early nineteenth century (Forsythe, 2009, p. 59). As a consequence of slave trade and forces of production during the industrial revolution, the alleviation of suffering has become more important to politicians, jurists and members of the church. Thus,

humanitarian ideas have been incorporated in social and political reforms, most prominently with abolishment of the British transatlantic slave trade in 1831 (Barnett& Weiss, 2012, p. 21).

The classic humanitarian paradigm has its roots in the Dunantist humanitarianism, named after the Swiss humanitarian and entrepreneur Henry Dunant. Influenced by the shocking experience of the Battlefield of Solferino, Henry Dunant published his book “A Memory of Solferino” in 1862 to document the lack of coordinated provision of relief to wounded soldiers. He was also responsible for organizing a relief effort while recruiting parts of the local population near Solferino. Recognizing the human dignity of the wounded and enhancing relief to the suffering lays the foundation of the Dunantist paradigm (Slaughter, 2009, p. 94). As an official response, the International Committee of the Red Cross (ICRC) was founded in 1863 by five members, including Henry Dunant. The ICRC had a primarily coordinating role of military medical services with it headquarter in Switzerland (ICRC, 2016).

Another hallmark for the humanitarian movement has been the first Geneva Convention in 1864. The ICRC initiated the first Geneva Convention to establish a legal framework for international humanitarian actions (Forsythe, 2009, p. 72). The treaty was adopted by governments to recognize wounded soldiers and medical personal as neutral. The Geneva Convention also agreed on the obligation of armies to provide medical care for any wounded soldiers. It also established the unified emblem of the red cross on a white background (ICRC, 2016). Over the time, more core treaties from the Geneva Convention on international humanitarian law were introduced and adapted. After the World War II, the humanitarian system under the ICRC was shattered. In 1949, the treaties of the previous three Geneva Conventions were revised and extended to relief effort for victims of war at sea and prisoners of war. The Geneva Convention of 1949 also introduced the protection of civilians under enemy control which gives the ICRC an essential mandate in today’s increasing armed conflicts (ICRC, 2016). The ICRC led to the development of today´s 192 National Red Cross and Red Crescent Societies. According to its principles adopted in 1965, the ICRC aims to embody independent, neutral and impartial humanitarian work (Forsythe, 2009, p. 76).

Referring to the classic humanitarian paradigm by Henry Dunant, humanitarianism is entirely needs-based and is not rooted in any political motives. The classic paradigm is closely related to exceptionalism as a humanitarian crisis is of exceptional nature and differs from normality. This assumption also leads to immediate short-term relief for the victims and short-cycle funding but does not recognize long-term impact of a humanitarian crisis (Hillhorst, 2016). An additional part of the Dunanist humanitarianism has been the promotion of cosmopolitanism (Forsythe, 2009, p. 73). The term international humanitarianism stems from

the idea to relieve suffering that transcends national borders. Part of this transnational humanitarian network along the Red Cross network and nongovernmental organizations (NGO) has been the United Nations system (Forsythe, 2009, p. 59).

The foundation of the UNHCR as part of the UN system in 1950 was a first attempt for organized disaster response. The UNHCR was first designed to act as a protection agency for the legal representation of refugees (Forsythe, 2009, p. 62). It was primarily created in light of the aftermath of World War II to assist around one million European civilians that had to resettle (UNHCR c, 2022). The Israeli-Palestinian war over the territory of British Palestine in 1948 led to the establishment of the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA). The UNRWA has been the first relief agency created by the UN and is the only UN agency dedicated to one specific group (Forsythe, 2009, p. 62). The work of the UNHCR increased over the next decades due to decolonization in African countries that led to hundreds of thousands of refugees or the flight of 10 million Bengalis to India in 1971 (UNHCR c, 2022). Until 1970, other UN specialized agencies including the World Health Organization (WHO) had not yet incorporated humanitarian disasters response in their agendas. The lack of coordination by the UN during the well-publicized Nigerian-Biafra War from 1967 until 1970 led to a higher recognition of complex humanitarian emergencies (Goetz, 2001). It triggered the creation of a United Nations Relief Office in 1971, which was changed in 1991 into the United Nations Office for the Coordinator of Humanitarian Affairs (OCHA) (Forsythe, 2009, p. 63). The Nigerian-Biafra War has also risen the debate over humanitarian assistance for IDPs as well as among the international humanitarian community and the repatriation of unaccompanied children (Goetz, 2001). Since the 1980s there has been a growth of international and regional organizations for coordinating humanitarian assistance for instance the European Community Humanitarian Aid Office (Barnett& Weiss, 2012, p. 32). UN specialized agencies like UNICEF or the UN World Food Program started to include refugees and IDPs in their mandate for humanitarian affairs. The UNHCR and the UNRWA transformed over time from a merely legal protection agency to a relief agency (Forsythe, 2009, p. 63).

Overall, the humanitarian sector has been largely shaped by actions and agendas of Northern agents and institutions, specifically the International Committee of the Red Cross (Pacitto & Fiddian-Qasmiyeh, 2013). Its humanitarian principles are centered on United Nations agencies and NGOs.

2.1.3 International humanitarian system in change

Over time, the concept of humanitarianism has been reshaped and changed due to global developments (Munslow, 2019, p. 358).

Recent developments have shown that the classic approach of the Dunantist humanitarianism has been paralleled or replaced by a resilience paradigm (Hillhorst, 2018). As natural disasters have rapidly grown due to climate change and national actors have started to adapt their resources, a new discourse of resilience has evolved. The classic paradigm differentiates between a crisis and normality, whereas the resilience humanitarianism adapts to the protraction and reoccurrence of a crisis. The new way of resilience thinking promotes the engagement of national and local authorities in the humanitarian response. It takes into account the larger control of national players in the service provision and capacity building. Recognizing the role of other aid providers, specifically the private sector and local responders, is part of the resilience humanitarianism. It allows to decentralize the state's power and allows a cooperation with other actors for an efficient response. The resilience paradigm also shifts away from aid recipients seen as victims to survivors or active respondents in a humanitarian crisis (Hillhorst, 2018). This different perception of crisis-affected populations can be seen in the annual World Disaster Report of the International Federation of the Red Cross in 2013. They defined aid recipients as "a significant force of first responders" (IFRA, 2013). Crisis-affected people become visible as they are primarily responsible for their survival while mobilizing resources provided by aid agencies. They adapt to new realities in a crisis and are engaged in the resilience building on the long-term. A suitable illustration of the continuity of a crisis is the refugee camp setting as refugees stay in camps for a longer period while adapting to the available resources. One major concern of the resilience humanitarianism are the thin boundaries of support of the local institutions and the real risk of abandonment often seen in refugee camps (Hillhorst, 2018).

The resilience paradigm views the humanitarian system as an ecosystem with different actors involved and not just primarily international humanitarian agencies (Hillhorst, 2018). The new realities in a crisis evoked a change of the current models of delivery (Munslow, 2019, p. 358). Another main critique has been the change from humanitarian aid to development aid. Development aid implies the cooperation with governments, which often have their own political agenda and might be one party in a conflict. Due to resource constraints, humanitarian agencies partner with the private sector or governments (Barnett & Weiss, 2012, p. 5). This tendency interferes with the classic humanitarian assumption of impartial and neutral aid. It also makes humanitarianism more of a development issue with the consequence of weaking the immediate humanitarian health care response. The instrumentalization of humanitarianism by governments and non-state actors has been discussed increasingly by the international community over the years (Munslow, 2019, p. 359). Promoting an early engagement of development and humanitarian actors for a shared

strategic vision has been a proposed solutions developed by the Red Cross EU Office and the ICRC in 2018 (Red Cross EU Office& ICRC, 2018).

Other significant developments have transformed the picture of humanitarianism. After the end of the cold war, there has been a global expansion of the humanitarian sector. Since the 1990s governments have developed humanitarian units in their foreign offices. The number of NGOs also increased and the professionalization within their system. These developments also led to a higher mobilization of humanitarian actors, which can be seen in the global response to the tsunami in 2004 as NGOs were providing medical support within hours and states followed with giving their military humanitarian assignments (Barnett, 2005, p. 723).

But not all developments have had a positive impact on the humanitarian sector. Nowadays, several factors pose a threat to the humanitarian sector. Attacks on humanitarian personnel or on health facilities have seen a rise over the past decade (Munslow, 2019, p. 358). The Office for the Coordination of Humanitarian Assistance (OCHA) reported that from 2014 until 2017 660 attacks on more than 1,200 aid workers were recorded. There has also been a tendency to more violent attacks as in 2017 44 percent of attacked aid workers were killed (OCHA, 2019). The Geneva Convention of 2019 recognized this as an attack on the humanitarian principles (Munslow, 2019, p. 358). The rising climate emergency is another threat to the humanitarian sector, as it also affects social and environmental determinants of health. Having a combination of a conflict-driven and climate emergencies create high numbers of displacements and the need coordinated humanitarian action (Red Cross EU Office& ICRC, 2018).

The politicized purpose of humanitarian aid has been another concern along with the instrumentalization of the humanitarian sector. Since the 1990s more humanitarian agencies have become concerned with tackling the root causes of the conflict. Humanitarian agencies began to acknowledge the contribution of the state to transform local structures and have started to work alongside governments (Barnett& Snyder, 2012, p. 152). Politicization has been the outcome of this development while undermining the humanitarian principles of independence and neutrality. The complete neglect of humanitarian principles was seen in countries of conflict like Kosovo or Afghanistan. Humanitarian agencies were funded by governments responsible for the crisis. The concern of politized humanitarianism and corruption through the influence of private and state actors remains present (Barnett, 2005, p. 724). Another significant change has been the decline of direct field work by large aid agencies. Most UN agencies are confronted with non-operational activities like coordination of local staff and reporting to partners which implies also longer chains of intermediaries. The WFP is one of the only remaining UN agencies with real operational capacities on the field along with other international agencies like the MSF and the ICRC (Kent et al., 2016).

Taken together, these developments challenge the humanitarian sector. According to the recommendation of the Red Cross EU Office and the ICRC, humanitarian aid and development activities should coexist with independent and separated budget. Cooperation between these two sectors is needed as humanitarian emergencies have become multifaceted and protracted, but this should compromise the humanitarian principles. Investing in the resilience of crisis-affected people and communities while strengthening the local resources will have a long-lasting positive impact (Red Cross EU Office& ICRC, 2018).

Now more than ever, humanitarianism is on the global agenda and has expanded features like human rights, democracy building and economic development (Barnett & Weiss, 2012, p. 6). These developments within the humanitarian architecture help to conceptualize the role of international actors in the humanitarian assistance of IDPs.

3 Methodology

This chapter describes the literature search and why certain material is used for the policy analysis on the health of IDPs.

The problem of poor health outcomes among IDPs has been identified in the introductory part of the paper through scientific research on the health of IDPs from databases like PubMed. A policy analysis on the legal frameworks applicable for the protection of IDPs, involved stakeholders and humanitarian coordination mechanism follows through reviewing existing literature. To start with, a major source of information has been credential websites of international organizations like the UNHCR, the OCHA, the WHO and the IASC. Through these websites, key terminologies, such as “Cluster approach” were specified and important stakeholders for IDPs like the UNHCR were identified. Databases like Refworld managed by the UNHCR serve as a leading source of information to gather documents about refugees and IDPs. The database Reliefweb, managed by the OCHA, is a humanitarian information source where reports such as the yearly Humanitarian Response Plan are published. Both databases have been used with the key terminologies to find IDP related documents.

In addition, important documents and reports have been utilized from the website of the UNHCR, OCHA or the Health Cluster itself. These documents involved the Policy on UNHCR's Engagement in Situations of Internal Displacement, the UNHCR Global Appeal, or the Joint UNHCR-OCHA Note on Mixed Situations. The UNHCR Emergency Handbook gives clarification on the humanitarian coordination mechanisms, namely the Cluster approach for IDPs and the Refugee Coordination Model for a refugee situation. The WHO has also released a Health Cluster guide in form of a handbook which has been examined in the result chapter. Referring to the legal frameworks, the Handbook for the Protection of Internally Displaced Persons published by the Global Protection Cluster clarifies the rights of IDPs manifested in international and national law. The Guiding Principles of Internal Displacement published by the OCHA were also assessed as the main legal guidance for IDPs.

A literature review on the health financing of IDPs has been conducted through scientific research on PubMed. Key terminologies for the advanced search on PubMed comprised “health financing”, “IDPs”, “internally displaced persons” and “health overseas development aid”. To extend the systematic research, Boolean operators such as “AND” have been used. The search history on the health financing for IDPs has been added to the appendix. The study by Robert et al. on the health overseas development aid for IDPs has been identified as the only one on its field.

Information on health cluster operations were given on PubMed through a study by Bile et al. analyzing the health cluster operation in Pakistan 2007 and through the Humanitarian Response Plan of Iraq. The Health Cluster Bulletin published under the WHO gives country specific Emergency Situational Updates, while including information about IDP numbers and involved stakeholder in the health response.

4 Results

4.1 Legal protection frameworks for IDPs

Internally displaced persons are entitled to enjoy the same rights and freedoms on an equal basis like any other person in the same country without discrimination under international and domestic law. The protection of IDPs is primarily manifested in national law as states are responsible to grant individual rights for their citizens or habitual residents without differentiating in the status of their displacement. Although national law forms the primary legal framework for IDPs, international law should be incorporated in the state's legal obligation to ensure the rights of IDPs (GANHRI 2021; GPC, 2010).

Examining the existing international and national legal frameworks is essential to understand how humanitarian assistance for IDPs is grounded in protection of their basic rights. This chapter also covers the right to health for IDPs.

4.1.1 International law

Despite the lack of a legally binding global treaty targeted for the protection of IDPs such as the 1951 Refugee Convention, they are still protected through various bodies which includes national law and international law (ICRC, 2002). International law derives from international treaties as agreements between states and from customary international law as "a general practice accepted as law" (ICRC, 2010). The protection of IDPs by international law can be divided into three sub-branches of law which are applicable for all situations of internal displacement, including situations of armed conflict (Ghráinne, 2021, p. 367). The three bodies of law consist of international human rights law, international humanitarian law and international criminal law (GPC, 2010).

International human rights law applies to both times of war and peace and obliges states to guarantee human rights to all residents (GANHRI, 2021). Human rights are part of the international customary law which includes norms like the right to life, prohibition of torture, freedom from discrimination based on gender and race, or the right to peaceful enjoyment of property (GPC, 2010). Many of these rights are particularly relevant for IDPs during all stages of their displacement. The rights to food, shelter, education and access to healthcare as well as the right to personal safety are part of the rights ensured by international human rights law (ICRC, 2002). A number of international human rights instruments have been implemented and accepted by states in the past decades. The Universal Declaration of Human Rights in 1948 or Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in 1984 are part of these human rights instruments (GPC, 2010).

Regarding the legal protection of IDPs, a global advocate position has been established in 2010 with the “Special Rapporteur on the human rights of internally displaced persons by the Human Rights Council” (GPC, 2010). The mandate was created to engage in the advocacy and dialogue with governments and international actors for protecting the human rights of IDPs. Reporting to the United Nations Human Rights Council and the United Nations General Assembly is also among the task of the mandate. The Special Rapporteur also works towards strengthening the international response to the crisis of internal displacement. The position demands also undertaking country visits as well as funding research related to internal displacement (GPC, 2010; OHCHR b, 2022).

International humanitarian law also provides a legal body involved in the protection of IDPs rights as it applies in situations of armed conflicts (GANHRI, 2021). IDPs are protected as citizens of their country under international humanitarian law as long they do not take part in hostilities (ICRC, 2018). International humanitarian law (IHL) is legally binding to all parties of an armed conflict. IHL applies human right principles in a situation of armed conflicts, which involves also the right to freedom of movement. Prohibiting forced displacement as well as attacks on the civilian population is among the core values of international humanitarian law. The use of civilians for military objectives or the starvation of civilians as a method of warfare is also always prohibited. Displacement can only be allowed in special circumstances on a temporary basis when the security of civilians or military imperatives absolutely requires it. This also implies safe and humane conditions during the displacement and the right to voluntary return in safety to their homes or habitual residence (ICRC b, 2022). Families are also protected under IHL as parties of the armed conflict have to ensure that families are not separated and measures to facilitate a reunification should be taken (GPC, 2010). Access to essential medical services for the wounded and sick should be established by the parties to the conflict (ICRC b, 2022).

Key instruments of IHL have been implemented which include the four Geneva Conventions from 1949, particular the Fourth Geneva Convention on the protection of civilians and two Additional Protocols. The rules of customary international humanitarian law are also law binding to all parties of a conflict and to the work of international humanitarian organizations (Henckaerts & Doswald-Beck, 2009). The resolution of the United Nations Security Council from 2000 puts a special focus on the peacekeeping missions for the protection of civilians as victims of conflict, most prominently affecting IDPs (GPC, 2010).

International criminal law provides another body of law protecting IDPs from violations of international human rights and humanitarian law (GPC, 2010). National authorities are obliged to criminalize international crimes such as war crimes, crimes against humanity or genocide in their national legalization as well as the prosecutions in national courts

(GANHRI, 2021). The International Criminal Court is a judicial body that only exercise jurisdiction when national courts have failed to prosecute and punish those crimes (Encyclopedia Britannica, 2022)

4.1.2 The Guiding Principles on Internal Displacement

Although there is no legally binding instrument, such as a treaty dedicated to IDPs, the Guiding Principles of Internal Displacement represent a practical guideline for governments, intergovernmental organizations and NGOs involved in the work with IDPs (OCHA, 2004). Initiated in 1998 by the first Representative of the Secretary-General on the human rights of internally displaced persons, they consist of thirty principles (GANHRI, 2022). The Guiding Principles of Internal Displacement are based on legally binding standards of international law applied to the situation of IDPs (GPC, 2010). They circle around protecting and addressing the needs of IDPs at all stages of displacement (IDMC b, 2022).

After defining IDPs and explaining the purpose of the principles, the first four principles address the responsibility of national authorities to protect and assist IDPs as well as the entitlement to the same rights and freedoms without discrimination. The fourth principle takes into account the special needs of the most vulnerable people, primarily unaccompanied minors, expectant mothers or disabled people (OCHA, 2004). Principles five to nine deal with the protection from arbitrary displacement (IDMC b, 2022). In this section, the unlawfully displacement of IDPs is even further elaborated compared to international law as it prohibits displacement due to ethnic or racial reasons, a collective punishment or as result of armed conflict unless evacuation is needed. The protection during displacement is covered from principle ten to twenty-three as they restate the civil, social, economic, and political rights of IDPs (OCHA, 2004). This section targets different rights including the right to safe access to essential food, potable water, basic shelter, medical services and sanitation, the right to education and training without discriminating based on gender and the right to freedom of movement, in and out of IDP camps (GANHRI, 2022). The fourth section encompasses principles relating to humanitarian assistance (OCHA, 2004). It allows international organization to provide services to IDPs when national authorities are unable to do so, as long these services do not interfere with states internal affairs (OCHA, 2004). This again relates to the principles of impartiality and humanity as humanitarian assistance should focus on rapid relief of suffering without taking political sides (GANHRI, 2022). The last section is concerned with the return, resettlement, and reintegration of IDPs. Safely returning to their homes or voluntarily resettling in another region of the country as well as reintegrating into society through the right of participation in public affairs are all part of the durable solutions to displacement (GPC, 2010).

The Guiding Principles may seem rather informative, but they allow to monitor to which extent the rights of IDPs are guaranteed in the country as well as advocating for the needs and rights of IDPs in national legal frameworks (GPC, 2010). On a global scale, the Guiding Principles on Internal Displacement have been recognized by national authorities as a significant tool for the response to IDPs. They have achieved considerable authority as the principles are reflected in national law of several countries. In the legal framework of Angola, the rights of resettlements of IDPs have been strengthened or in Peru the material compensation for IDPs has been covered in new laws (Cohen, 2004, p. 470). UN agencies and NGOs have translated the Guiding Principles into over forty languages (GPC, 2010). But there remains a lack of legal protection obligation of IDPs which echoes the need for improving the institutional framework for IDPs (Cohen, 2009, p. 104).

The UN Principles on Housing and Property Restitution for Refugees and Displaced Persons, also called Pinheiro Principles, built another international legal framework for both IDPs and refugees (GANHRI, 2022). Adopted in 2005 by the Sub-Commission on the Promotion and Protection of Human Rights, they address the housing, land and property rights issues of displaced populations. As properties and homes of refugees and IDPs are unprotected during their flight, the Pinheiro Principles provide practical guidance on the post-conflict restitution of property for refugees and IDPs (Anderson, 2011, p. 305).

4.1.3 National legal frameworks

The responsibility of protecting IDPs relies primarily on national authorities. Some countries and regions have established national legal frameworks concerning IDPs in line with the Guiding Principles of Internal Displacement (GPC, 2010).

The African Union Convention has been the first to develop a legally binding regional framework on internal displacement (GANHRI, 2022). It is based on the Pact on Security, Stability and Development in the Great Lakes Region that has been implemented by the members of the Great Lakes Region member states (Beyani, 2007, p. 173). Two out of the ten protocols are specifically important to internal displacement: “The Protocol on the Protection and Assistance to Internally Displaced Persons” and “The Protocol on the Property Rights of Returning Persons” (GANHRI, 2022). The first mentioned protocol obligated governments to integrate the Guiding Principles into their national legislation. The Africa Union Convention for the Protection and Assistance to Internally Displaced Persons, also called Kampala Convention, has been developed in 2009. The Kampala Convention has become effective in 2012 and since then thirty members of the African Union have become part of it. As it enhances compliance to the IDP protection, the Kampala Convention targets

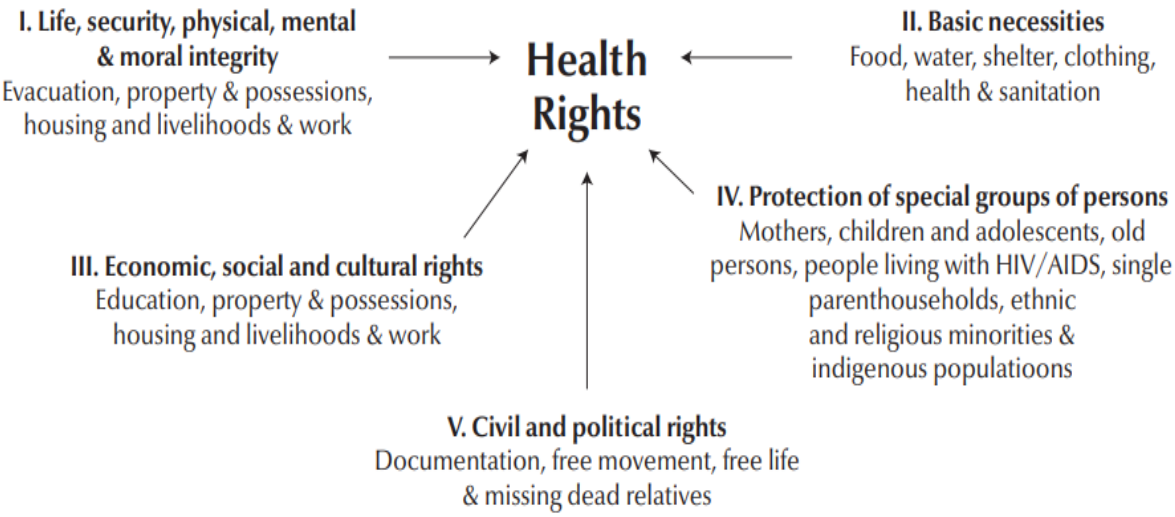
different responses practices during all stages of displacement and to the displacement setting in Africa (GANHRI, 2022).

Despite the emphasis of other regional organizations like the Council of Europe to apply the Guiding Principles to their national policies, the Kampala Convention remains the only legally binding regional framework on internal displacement (ICRC, 2020; GANHRI, 2022).

4.1.4 The right to health for IDPs

In order to examine the health rights of IDPs, it is necessary to define what are health rights. According to the WHO, health is not merely the absence of a diseases, but a state of complete physical, mental and social well-being. As a fundamental human right, health is an inclusive right. The right to health is linked to other determinants for enjoying the highest standard of health including access to safe water, food, shelter and sanitation (Bermudez, 2022). Other determinants such as the right to education, especially health literacy, and housing also impact the level of well-being. to The UN Committee on Economic, Social and Cultural Rights (CESCR) has formulated in the General Comment No. 14 various aspects of the right to health. It also encompasses the right to health facilities, goods and services based on an equal treatment without discrimination (CESCR, 2000). The figure below illustrates different sectors that are connected with the protection of the health rights of IDPs (Bile et al., 2011, p. 983).

Figure 2: Protection of specific human rights during disasters



(Source: Bile et al., 2011, p. 983)

Regarding the health rights of displaced population, the Refugee Convention from 1951 already emphasizes the right to the same access to medical services for displaced populations compared with the host population (Bermudez, 2022). The Guiding Principle 19

specifically addresses the right to healthcare for IDPs, which is continuous through all phases of internal displacement. The health needs of women such as access to reproductive healthcare and mental support for victims of sexual abuse are also mentioned in Principle 19. Special attention is given to the prevention of infectious diseases like HIV among IDPs (OCHA, 2004). The Guiding Principle reflect the right to healthcare and the right to healthy environment for IDPs as they support the combination of clinical and preventive perspectives (Kaelin et al., 2010). Referring to psychological services, the Inter Agency Standing Committee (IASC) has passed the Guidelines on Mental Health and Psychosocial Support in Emergency Settings. They put forward the idea of psychological care as an integrated cross-sectoral approach between host and displaced communities. The IASC Guidelines also highlight the psychological impacts of emergency settings and the need for long-term mental healthcare of the affected population (IASC, 2007). In 2021, the UN Secretary's High-Level Panel on Internal Displacement highlighted in its final report the urgency of psychological support for the recovery of traumatic experiences of IDPs (Bermudez, 2022). The Inter Agency Field Manual for Reproductive Health in Emergencies has been revised in 2018 and presents another global standard used response to reproductive health service during humanitarian emergencies (Foster et al. 2017, p. 18 f.).

The Sphere Humanitarian Charter and Minimum Standards in Disaster Response gives an insight on how people affected by disasters should have access at least to a minimum standard of healthcare (Sphere Association, 2018). Prioritizing health interventions that reduce main causes of excess mortality and morbidity is among the minimum standards. A disease surveillance system is essential to prepare for displacement-related health emergencies and to document and monitor the emergence of infectious and non-communicable diseases (Sphere Association, 2018). The support of a standardized health information system in humanitarian emergencies is also needed for health agencies to collect relevant data on demographics, morbidity and mortality. Other minimum standards formulated in the Sphere handbook include the establishment of a health infrastructure and the eligibility of displaced populations to primary health care and clinical services. The handbook is a leading guideline for humanitarian agencies to supply displaced populations with basic services such as water, sanitation and shelter (Kaelin et al., 2010).

Referring to health in humanitarian settings, a resolution by the 58th World Health Assembly in 2005 on health interventions during times of crisis has been passed to ensure that member states provide access to essential health care for all affected populations, including IDPs. Similar to the Sphere Handbook, it prioritizes on the health needs of those most endangered and pays attention to maternal and newborn health (Kaelin et al, 2010). Three years later, the 61st World Health Assembly passed another resolution on the health of migrants, asylum seekers and refugees (Bermudez, 2022). IDPs are implied in this resolution

as migrants who do not cross borders. The resolution urges member states to implement migrant-sensitive health policies (WHO, 2010).

An example country having implemented a national law for the right to equitable access to health services for IDPs has been Colombia. The government passed a law in 1997 that guaranteed registered IDPs access to public primary health services. However, the law was limited in 2003 by a government decree that proposes unlimited access to health services only to IDPs with health insurance but lacking the financial means. The decree decentralized the accountability for IDP health services on local authorities. This illustrates barriers to healthcare due to lack of documentation or health insurance and thus leaves IDPs only eligible for emergency medical services (Kaelin et al., 2010; Bermudez, 2022)

Overall, guiding concepts for health in humanitarian settings have been developed and revised over time by international organizations ensuring equal access to essential health care for IDPs. Through international humanitarian law, IDPs and their well-being remain also protected in times of armed conflict (Bermudez, 2022).

4.2 Humanitarian Coordination Systems for IDPs

4.2.1 UNHCR mandate for IDPs

Refugees, returnees and non-refugee stateless person fall under the core mandate of the UNHCR (UNHCR e, 2022). The UNHCR does not hold an exclusive or general mandate for coordinating the assistance of IDPs but remains the lead agency in the protection for people affected by forced displacement, including IDPs (UNHCR, 2009; UNHCR e. 2022). According to the Global Focus, UNHCRs operational reporting webpage, the UNHCR is engaged in 33 operations concerning the response to internal displacement (UNHCR d, 2022). In the Global Appeal, the UNHCR has also estimated among the 117.2 million forcibly displaced or stateless people that 61.2 million people will be considered as IDPs under their mandate in 2023 (UNHCR f, 2022).

A legal basis for UNHCRs engagement with IDPs offers the UN General Assembly Resolution 48/116 from 1994 It reaffirms the support through humanitarian assistance and protection for IDPs by the UNHCR. The Resolution recognizes the need for engaging with other UN agencies like the Department of Humanitarian Affairs, later renamed OCHA, and international organizations like the ICRC (UNHCR b, 2019). The UNHCR has released a number of documents on their guidance and policies with IDPs. Those involve the Policy on UNHCR's Engagement in Situations of Internal Displacement and the Guidance Package for UNHCR's Engagement in Situations of Internal Displacement, both revised in 2019 (UNHCR a, 2019; UNHCR b, 2019). The UNHCRs Initiative on Internal displacement 2020–2021 provides information on the nine target country operations namely: Afghanistan, Burkina Faso, Colombia, the Democratic Republic of the Congo, Ethiopia, Iraq, South Sudan, Sudan and Ukraine (UNHCR g, 2022). The report also demonstrates the main cornerstones of UNHCRs work with IDPs as they involve delivering technical capacities, emergency preparedness and coordinated leadership (UNHCR, 2021).

In the next part of the paper, humanitarian coordination systems applied in situations of internal displacement will be outlined. The involvement of the UNHCR in the humanitarian response for IDPs and the Health Cluster approach targeting the health needs for IDPs will be analyzed as well.

4.2.2 Cluster approach

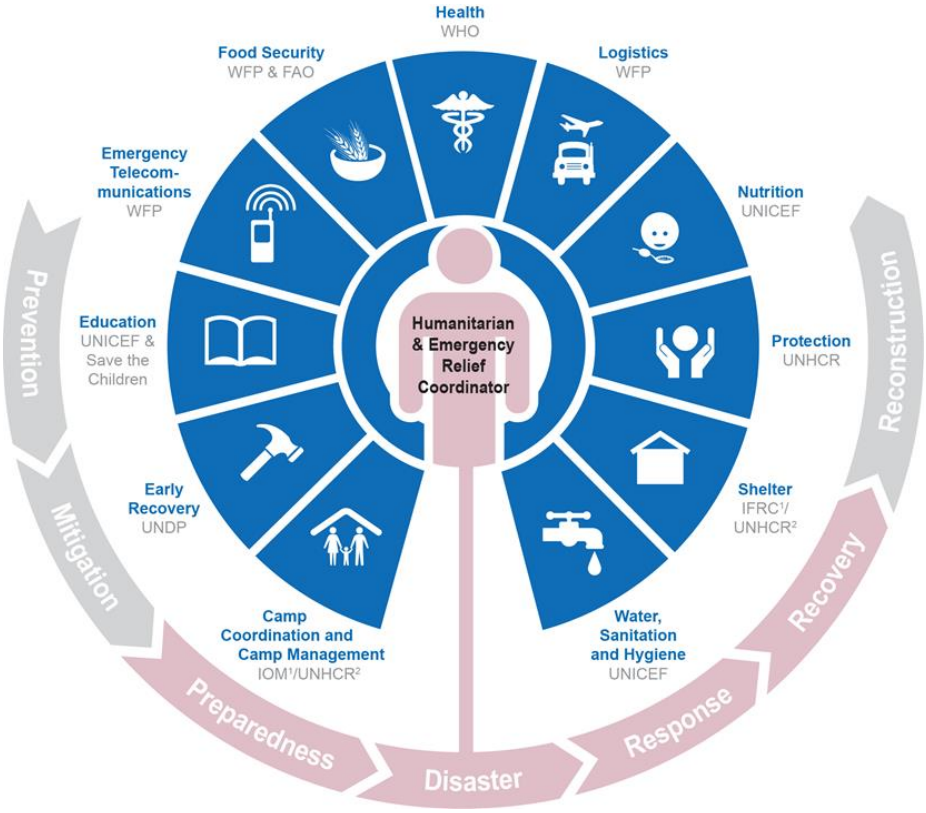
One of the main concepts of humanitarian coordination systems includes the Cluster approach. It is applied by humanitarian organizations to coordinate an effective inter-agency response in various key sectors (UNHCR a, 2022). Initiated within the UN Humanitarian Reform Agenda in 2005, the Inter Agency Standing Committee formed a “cluster leadership approach” (OCHA, 2020). The UN Humanitarian Reform was designed to create higher levels of predictability and strengthened leadership in the humanitarian response for IDPs. After the lessons learnt from two natural disasters in Haiti and Pakistan during 2010, the Transformative Agenda by the IASC was developed to create quicker response to a sudden-onset humanitarian crisis, also called Level 3 emergency. The Cluster approach spreads accountability across different cluster agencies responsible for health, food security, emergency shelter and other areas. At the global level, each cluster is headed by an international organization with a specific expertise in a sector, called the “Cluster Lead Agency” (UNHCR a, 2022).

The Cluster approach can be applied at country level when cluster lead agencies, such as the WHO for health, work together with governments and NGOs. In this case, the responsibility for coordinating and delivering the international humanitarian response within the country relies on the Humanitarian Coordinator (HC). Enhancing the activation of the cluster-based response in alliance with the host government is among the tasks of the HC. The HC leads the Humanitarian Country Team which consists of representatives of responsible UN agencies, NGOs and local authorities. The Humanitarian Country Team (HCT) is involved in the strategic decision-making in the crisis country, which is based on needs assessment and gap analysis. The cluster strategy is not only applicable in phases of disaster response but can also be applied through an Early Recovery cluster. Additional members or observers of the HCT can include the ICRC or MSF. Both cluster lead agency and the HC are accountable to the Emergency Relief Coordinator (ERC). As Under-Secretary-General for Humanitarian Affairs and head of the IASC, the ERC holds responsibility for all UN humanitarian actions in complex emergencies. The ERC is also entitled to elect a HC for a country affected conflict and disaster (OCHA, 2020; UNHCR a, 2022).

The main objective of this collaborative approach is to fill responsibility gaps and to achieve a coordinated humanitarian response. It also aims to improve cross-sector partnerships as governments can co-lead clusters on a national level and NGOs are able to co-chair the cluster along the lead agency (UNHCR a, 2022). The Cluster approach enhances technical capacities for an overall system wide preparedness (OCHA, 2020). This cooperation should be in accordance with the humanitarian principles.

The figure below presents the Cluster approach with all currently existing eleven areas of humanitarian interventions lead by the responsible cluster lead agency through all phases of humanitarian coordination (UNHCR a, 2022).

Figure 3: The Cluster approach with the cluster lead agencies



(Source: UNHCR a, 2022)

As illustrated above, the UNHCR leads the Global Protection Cluster. Several areas of responsibility are included in this cluster as it protects the affected populations, in particular IDPs, from human rights violations (UNHCR a, 2022). Those areas are sub coordinated by agencies like UNICEF for child protection, the United Nations Population Fund for the protection against gender-based violence or the Norwegian Refugee Council or housing, land and property. Together with the International Federation of Red Cross and Red Crescent Societies (IFRC), the UNHCR co-leads the Global Shelter Cluster. The Global Camp Coordination and Camp Management (CCCM) Cluster has the UNHCR and the Internal Organization for Migration (IOM) as co-leads (UNHCR a, 2019). As stated in the Guidance Package for UNHCR's Engagement in Situations of Internal Displacement, the UNHCR is required to have a minimum cluster capacity in order to lead a cluster at country level. Skilled experts for leading the luster coordination or technical tools for information management are needed for an effective cluster response (Morris, 2006, p. 54). In case a level 3 emergency occurs, the UNHCR Representatives can request the UNHCR lead clusters to deploy technical capacities on a temporary basis (UNHCR b, 2019).

According to the policy on UNHCR's Engagement in Situations of Internal Displacement, the UNHCR leads the Shelter and CCCM Cluster at national level during a conflict induced crisis. As for the protection cluster, the UNHCR can lead both scenarios when a disaster-induced displacement requires the in-country presence of the UNHCR with the government request (UNHCR b, 2019). The UNHCR aim during all IDP interventions is to strengthen the internal tri-cluster synergies, including by mainstreaming protection across all sectors (UNHCR a, 2022).

The UNHCR has also been involved in other global clusters operating in internal displacement settings due to their expertise about IDPs. They have been part of activating early recovery clusters, as the UNHCR is interested in providing durable solutions for IDPs through reintegration and return interventions while working with involved NGOs. In the wash, sanitation and hygiene (WASH) cluster, the UNHCR has played an important role in developing guidance tools, providing technical capacities in field operations or in leading sub-project to enhance technical advice. As a member of the steering committee within the global health cluster, the UNHCR has been responsible for creating a Health-Nutrition Tracking System (UNHCR, 2009). Many deaths during humanitarian crisis are attributed rather to communicable diseases and malnutrition than to violence. Therefore, assessing the nutrition and health status of crisis affected people through an inter-agency evaluation framework is essential (IASC, 2007). Additionally, the Health Information System Toolkit is mostly used by the UNHCR to monitor the health data from crisis affected people, including refugees and IDPs. Information on vaccination status, HIV/AIDS status or number of maternal deaths are collected and stored among different sectors, such as the WASH Cluster (UNHCR, 2010).

Concerning HIV and AIDS among refugees and IDPs, the UNHCR plays a pivotal role in the international HIV response during humanitarian emergencies. As a cosponsor of the United Nations Program on HIV/AIDS (UNAIDS), the UNHCR brings together an Inter-Agency Task Team for the HIV response under the lead of UNAIDS. Having set up several HIV programs in African countries, the UNHCR negotiates between governments dealing with an HIV epidemic and other international organizations. Key areas of their HIV response operations include facilitating the availability of antiretroviral therapy for risk groups or the access to quality-assured HIV testing in refugee camps. Advocacy for including displaced population in national HIV plans as well as for programs against sexual and gender-based violence are among the responsibilities of the UNHRCR in the HIV response (UNAIDS, 2022).

4.2.3 The Joint UNHCR-OCHA Note on Mixed Situations

In a non-refugee crisis, the Cluster approach is used as governments are limited in their capacities responding to a larger crisis and a multi-sectoral humanitarian response is required. The Refugee Coordination Model is applied by the UNHCR in response to a refugee crisis. In case the crisis-affected population contains both refugee and IDPs, the Joint UNHCR-OCHA Note on Mixed Situations: Coordination in Practice gives practical guidance (UNHCR a, 2022). The note clarifies the role of the UNHCR Representative and the Humanitarian Coordinator in a mixed setting. The practical interaction between the IASC cluster coordination, primarily dedicated for IDPS, and the UNHCR coordination of refugees is proposed in the Joint Note (UNHCR b, 2019).

When IDPs and refugees are in a geographically separated setting, operational coordination and delivery is performed separately. The IASC Cluster coordinate and deliver service for IDPs and the UNHCR Sector applies their humanitarian response to refugees, while both parts share information on national level. If refugees and IDPs are in the same geographic area, the Emergency Relief Coordinator and High Commissioner decide if IASC Cluster or the UNHCR Sector is utilized for assistance delivery for both affected populations based on the available capacities. During an IASC Cluster for a geographically mixed situation, the UNHCR can enhance a protection working group and a refugee expert interacting within each cluster member for the needs of refugees. The Humanitarian Coordinator is accountable for IDPs and deployment of capacities during the delivery through the UNHCR Sector. Sharing information between the inter-cluster coordinator and the UNHCR refugee coordinated is substantial for mutual coordination. The note further outlines the role of the UNHCR Representative and Humanitarian Coordinator in different areas of responsibilities. An underlying rationale of the note is that the agency-specific response complies to the overall IASC coordination through sharing situational analysis of the humanitarian crisis and engaging in the Humanitarian Country Team. The arrangement seeks to avoid duplicated delivery and enable a coordinated response even in a mixed situation (UNHCR, 2014).

An additional IASC arrangement has been made through the United Nations Secretary General's (UNSG) Decision No. 2011/20 on Durable Solutions for IDPs and refugees returning to their country of origin (UNSG, 2011). The decision authorizes the Resident/Humanitarian Coordinator to guide the development of durable solution strategies together with national authorities (UNHCR b, 2019). At the country level, the decision designates inter-cluster working groups to develop Early Recovery Clusters with the coordination of the Protection Cluster. On the global level, the UNDP and UNHCR are selected as the lead agencies for Early Recovery and Protection through resources and expertise (UNSG, 2011).

4.2.4 Health Clusters

The Global Health Cluster, led by the WHO, focuses on alleviating suffering and restoring the well-being of affected population in humanitarian emergencies through coordination and provision of technical support (Health Cluster, 2022). As the Global Lead Agency, the WHO is accountable to the Emergency Relief Coordinator to fulfill its responsibilities. Those responsibilities involve incorporating the Cluster approach and following the protocols of the Transformative Agenda to build stronger partnerships with other global clusters. During a health cluster activation, the WHO commits to sharing leadership and coordination responsibilities with national authorities and NGOs working in the health sector (WHO, 2020). The Global Health Cluster also shows the interlinkages between health and human rights, as the Global Health Cluster works towards ensuring the right to health during emergencies which is integrated in the human rights protection of the cluster approach (GPC, 2010)

During a Level 3 emergency, the IASC humanitarian scale-up activation will be applied as a system-wide humanitarian response for a short-term period of six months. The urgency, complexity, and scale of the emergency are considered before the scale-up activation is initiated. The urgency criterion for the system-wide mobilization also looks at the number of people displaced and the crude mortality rates. Within 72 hours, a humanitarian country team will be established, and a Central Emergency Response Fund will be by deployed be the ERC. As stated in the Health Cluster Guide, the WHO is accountable for assessing the risk of an infectious disease event through information flows with their country offices, governments, the Global Outbreak Alert and Response Network and other UN agencies like the Food and Agriculture Organization of the United Nations (WHO, 2020).

The assessment of an infectious disease outbreak by the WHO is in alliance with the International Health Regulations from 2005. This process is also manifested in the Protocol for the Control of Infectious Disease Events, as the need for a scale-up response to a public health emergency, will be expressed by the Director-General of WHO towards the ERC and the United Nations Secretary-General within 24 hours. The final decision will be made by the ERC influenced by the Director-General of WHO and the IASC Emergency Directors Group (WHO, 2020). The figure on the following page presents the five key criteria for a scale-up activation.

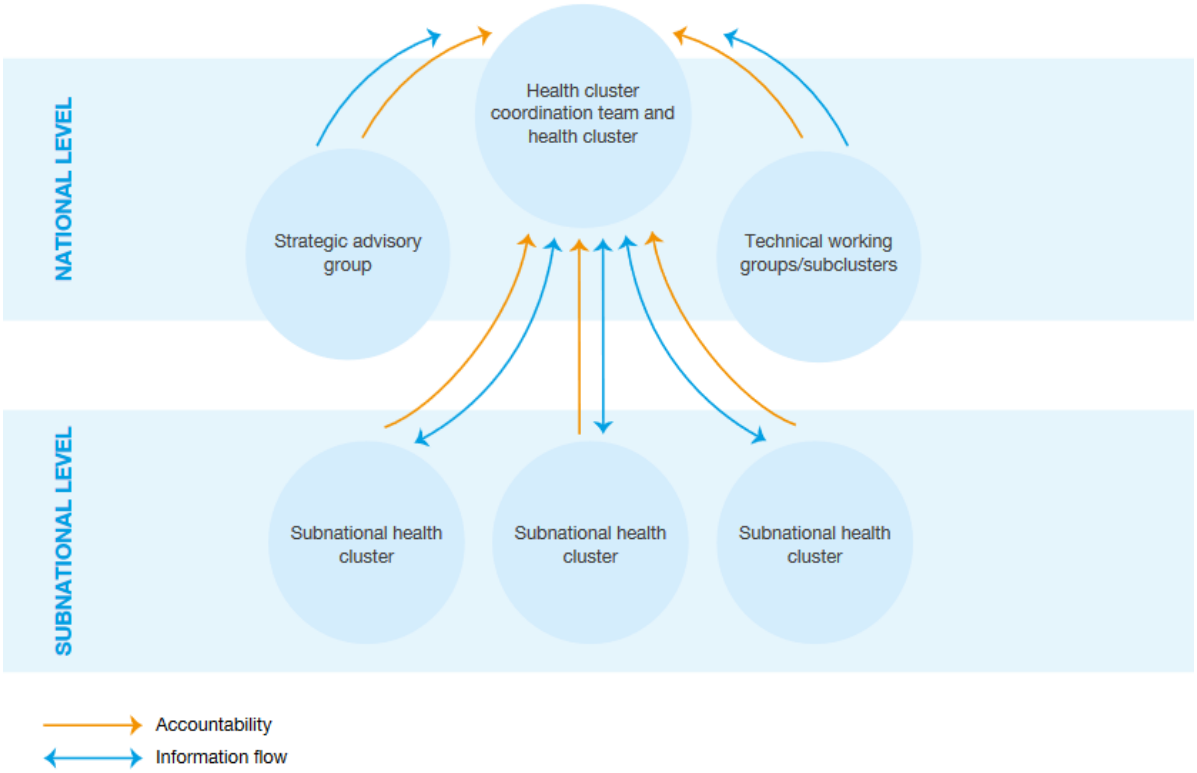
When a country health cluster is activated, all health agencies on a national level are encouraged to participate in the joint health emergency response for the affected area (WHO, 2020). Those partnerships with national health authorities or NGOs built upon the five principles of partnership. Developed by the Global Humanitarian Platform (GHP) in 2007, the principle consists of: equality, transparency, results-oriented approach, responsibility and

complementarity (GHP, 2007). At the current state, there are around 900 partners at country level of which 60 partners engage strategically at global level (Health Cluster, 2022).

The structure of the country health cluster is usually formulated in the Terms of Reference, which is a management tool released in the first five month of cluster activation. Depending on country and context, a health cluster at the national level involves a strategic advisory group and technical working groups. The strategic advisory group serves as a decisions-making forum of multiple health cluster partners through elected representatives. Providing technical support and guidance on a specific aspect of the health response, such as HIV and tuberculosis, relies on the technical working group. The decision to form a technical working group will be made by the strategic advisory group or the health cluster coordination team. Part of the IASC cluster system is also the Minimum Initial Service Package for sexual and reproductive health. At the onset of a humanitarian emergency, the WHO has to identify an agency, often the United Nations Populations Fund, which provides emergency and comprehensive sexual and reproductive health interventions. This approach goes beyond clinical care for the response of gender-based violence as the sexual and reproductive health coordinator and the health cluster coordinator cooperate with other sub-clusters, especially the protection cluster, for preventive measures. At the subnational level, the health cluster vary by region and local circumstances. As a more decentralized coordination mechanism, the subnational clusters are directly responsible for the implementation of the humanitarian response plan and work directly with local partners. Articulated in the Terms of Reference, the links are established between the national and subnational clusters through information sharing, regular meetings between both cluster levels and promoting compatibility of national health programs (WHO, 2020).

Other coordinating bodies participating in health emergency operations can be the Emergency Medical Teams (EMT). EMTs have been first initiated as a response to the earthquake in Haiti from 2010 and since then have proven to be effective, for instance in the West African Ebola (2014–2016) outbreak response. They comprise all clinical teams that are involved in the delivery of healthcare during an emergency response. As groups of health professionals, EMTs vary from doctors to paramedics and can stem from governments, NGOs, the military or international humanitarian networks, such as Médecins sans Frontières (WHO, 2021). The EMT Network can be coordinated by the ministry of health within the national health emergency operations center or by the WHO (WHO, 2020). For more clarification, the figure on the following page visualizes the country health cluster structure.

Figure 4: Typical country health cluster structure



(Source: WHO, 2020)

4.2.5 Health Cluster operations in IDP settings

To have a more practical view about the emergency health response to IDPs, this chapter provides an insight on the places and scope of health clusters activated in IDP settings. Health clusters have been implemented during internal displacement situations in countries around the world. Currently, there are 31 Health Clusters/Sectors, of which two are regional coordination mechanisms (Health Cluster, 2023).

An example for an effective emergency health response through the cluster approach has been seen in Pakistan. As a result of armed conflict in districts of the Khyber Pakhtunkhwa province and the Federally Administered Tribal Areas in 2008, 2,7 million people had to leave their homes. This led to a mobilization of 46 humanitarian partners within the health cluster led by the WHO and the local health authorities (Bile et al., 2011, p. 981). Delivering essential life-saving primary health care (PHC) services to the affected population, including returnees and IDPs, has been the main goal of the established health cluster. As 60 percent of IDPs were displaced mothers and children, relief interventions within the PHC delivery focused on maternal, neonatal and child health care. In advance, a rapid health needs assessment was conducted by the WHO field teams in the hosting communities. Disparities in access to healthcare were found between IPDs living in camps having better access to

healthcare than IDPs hosted by families. Strengthen PHC capacities in hospitals and local facilities has been a response of the health cluster partners to this emerging disparity. Official registration of all IDPs was initiated by the National Disaster Management Authority through the technical support of the National Database and Registration Authority and the UNHCR (Bile et al., 2011, p. 982 f.). Within the registration process of IDPs, the protection cluster was responsible for registering 1100 unaccompanied children as well as about 3500 families headed by children or women. The detection of communicable diseases in the humanitarian crisis was enabled through Disease Early Warning System surveillance networks. Noticeably, higher diarrheal outbreaks rates among IDPs as result of cholera were detected compared to outbreaks during the earthquake in 2005. To prevent further infectious diseases, safe water access through water chlorination and equipment of sanitation facilities with hand washing sinks was established (Bile et al. 2011, p. 986 f.).

More recent examples of activated health clusters give countries like Iraq. The Humanitarian Response Plan of 2022 reports that 2.5 million people are in need, out of which 961,000 people require acute humanitarian assistance (OCHA, 2022). As the infrastructure and livelihoods of millions has been damaged due to military operations against the Islamic State of Iraq and the Levant since 2014, 6.1 million people have been displaced. Although 80 percent of the displaced people were able to return home after four years, 1 million people remain classified as IDPs. Despite having built up a more stable environment during their protracted displacement, informal settlements, lack of healthcare access and sanitation facilities put IDPs in the most vulnerable position. In total, 180.000 IDPs living in camp, 234,000 IDPs out of 549,000 IDPs living out of camp, and 577,000 out of 1.7 million returnees are critical humanitarian need. They constitute as a heterogenous groups as they face different needs. For instance, IDPs living in camps often lack a member of their household and have lack of civil documentation. As result of high dependence on governed assistance and humanitarian aid, access to healthcare, water and sanitation varies on the contingent of the provider. Out-of- camp IDPs have developed different coping strategies due to critical shelter and limited access to basic services such as PHC (OCHA, 2022). According to the Health Custer Bulletin of August 2021, the Health Cluster in Iraq has provided basic emergency healthcare in IDP camps and return areas. Vaccination efforts against COVID-19 were also implied in the c, as the UNHCR has reported high number of COVID-19 cases in IDP camps. The Health Cluster in Iraq comprises 29 partners, such as 5 international NGOs, 10 national NGOs, 4 UN agencies and 2 National authorities (Health Cluster, 2021).

A decrease in partners and funding took place in 2021, which leaves the government and development actors responsible for establishing longer-term recovery services. The Humanitarian Response Plan estimated the financial requirements for the Iraq Health Cluster in 2022 of 46.8 million USD. Contribution to achieving durable solutions has been made

through public health system strengthening efforts. More specifically, Cash and Voucher Assistance to reduce financial barriers for health services has been developed by the Cash Working Group, the Health Cluster and the Protection Cluster and will be continued by the Ministry of Health (Health Cluster, 2021).

4.3 Health funding for IDPs

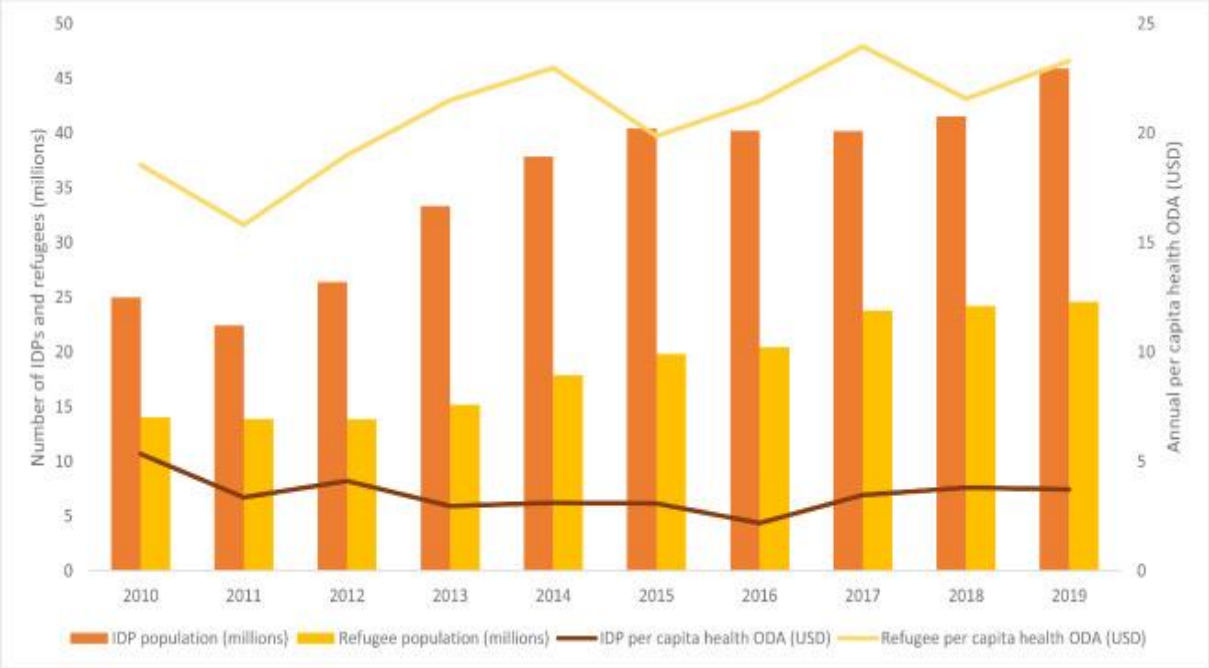
The last section of the results comprises an insight of the health overseas development funding for IDPs.

A detailed insight on the health spending for IDPs gives the study by Roberts et al. published in 2022, which also remains to this extent the only one on this field. The study examines the health-related official development assistance for LMIC by international donors that target the health needs of IDPs. Official development assistance (ODA) can be provided by bilateral government donors, global health initiatives, such as the Global Fund, or philanthropic institutions, like the Bill and Melinda Gates Foundation. Recipients of ODA often are country governments, NGOs or UN agencies. The study gathered data on health ODA disbursement from 2010 to 2019 through the Creditor Reporting System database, which has been established by the Organization of Economic Cooperation and Development (OECD). The findings showed that there has been a decrease of health ODA for IDPs by 38 percent, as the health ODA per IDP capita changed form 5.4 US Dollar (USD) in 2010 to USD 3.72 in 2019. Main providers of ODA for IDPs are the Global Fund, the governments of countries like Germany, the United States, Canada as well as the European Union. Other donor agencies such as the Central Emergency Response Fund with 1.2719 million USD and the World Bank with 17.4977 million USD, whereas Global Alliance for Vaccines and Immunization (GAVI) reported none. The objectives of health ODA focused on funding basic services, such as malaria and tuberculosis control, followed by funding reproductive health programs targeting HIV/AIDS control. NCD control, including mental health services, received lower levels of ODA, despite the increasing burden of cardiovascular diseases and mental disorders in conflict affected people (Roberts et al., 2022).

Additionally, the study investigated on the health ODA for refugees. In contrast to the decrease of health ODA per IDP capita, the findings revealed the health ODA increased by 14 percent with USD 18.55 in 2010 and USD 23.31 in 2019. In general, the average health ODA spent for refugees is six times higher than that of IDPs. Possible explanations of this disparity can be the inclusion of IDPs as entitled citizens into domestic health services. The database may have also excluded data on health ODA for IDPs as they were already implied in pooled funding mechanism for countries dealing with internal displacement (Roberts et al., 2022). The authors conclude from the findings that IDPs are given lower priority by

international and national stakeholders due to a lack of international legally binding framework (Hakamies et al., 2008, p. 40; Cantor et al., 2021). This indicates that there is a general need to even up the health ODA for IDPs towards that of the refugees (Roberts et al., 2022). The figure below illustrates the ODA disbursement, and the number of IDPs and refugees.

Figure 5: Health ODA (USD per capita) explicitly for IDPs and refugees (2010–2019)



(Source: Roberts et al., 2022)

The lack of funding is not only an issue concerning IDPs, but also the cluster system. As for the Global Health Cluster which targets 97.8 million people in need, only 34 percent of the requested 3.2 billion USD have been funded (Health Cluster, 2023).

Besides the results of this study, the UN Secretary-General's High-Level Panel on Internal Displacement has already encouraged to strengthen the health financing for IDPs through its Action Agenda on Internal Displacement. In regard to finding solutions for internal displacement, the agenda puts forward the idea of integrating internal displacement solutions into systematic development financing. The UN Secretary-General's High-Level Panel on Internal Displacement also recommends establishing catalytic financing in cooperation with affected country governments and development actors to initiate the process (UN a, 2022). The UN Joint SDG Fund could also be enabled for scaling up the financing for IDPs through a thematic section within the SDG Fund. A Development Emergency Modality has already been installed by the UN Joint SDG Fund for financial response to countries affected by acute crisis (Joint SDG Fund, 2022). The capability of the private sector in IDP setting is also noted within the agenda as the private sector could be engaged in three to four test

operations while working with UN Resident Coordinators. This possible engagement in internal displacement contexts should build upon the five principle of partnership and the UN Global Compact (UN a, 2022).

5 Discussion

This chapter will be used for the reflection of the results and draws upon policy implications on internal displacement solutions. Strengths and limitations of this policy analysis will also be identified in the discussion.

5.1 Challenges of the Humanitarian Coordination System

The main findings focused on the humanitarian coordination system, specifically the IASC Clusters, the Global Health Cluster and the work of the UNHCR with IDPs.

The cluster approach has been widely recognized by the international community as an effective and valuable tool for a multi-sectoral humanitarian response. At the start of the Cluster initiative in 2005, important humanitarian sectors were missing, for instance the Education Cluster was established two years later. Despite achievements in cluster country operations, the Cluster approach has been criticized for being only applicable to UN structures and not to the involved of NGOs (Morris, 2006, p. 55). Although NGOs are part of the Humanitarian Country Teams, take part in regular meetings and even can co-chair the country cluster, they are underrepresented at the global picture of the IASC Cluster. The Cluster approach remains mainly UN centric, while NGOs often work on individual projects to remain visible and accountable for donors (Morris, 2006, p. 55). The IFRC has a large impact on the emergency health response for IDPs. They may have developed their own agency structure, but they oblige to the legal frameworks of the IASC as well as the humanitarian principles (Stumpenhorst et al., 2011, p. 590). Communication and cooperation between both parties is key for an effective response and to prevent overlapping interventions, especially at the initial relief work (Hakamies et al., 2008, p. 36). Through regular feedback meetings between all agencies and timely information sharing, communication problems can be minimized (Stumpenhorst et al., 2011, p. 591).

In reference to the Global Health Cluster, the WHO assists IDPs through their work as the lead agency for the Global Health Cluster. As the only identified humanitarian coordination mechanism for also targeting the health needs of IDPs, the work of the country health cluster has increased worldwide. The success of the health cluster relies in the partnerships formed with national health authorities, UN agencies and NGOs. Other humanitarian aid agencies such as MSF, IFCR, Medical Teams International or EMTs have effectively coordinated life-saving care within the activated health cluster (WHO, 2020). Despite these achievements, the lack of funding within the humanitarian system also affects the Global Health Cluster. The focus of the WHO during an emergency health response is not only on the health of IDPs rather on the health of all affected populations. This can comprise people returnees, host communities affected by a crisis and refugees. The WHO leaves the UNHCR with their

primary responsibility to provide protection and to find long-term solution for displaced populations.

As stated in the results, the UNHCR is the lead agency for protecting displaced people in humanitarian crises (UNHCR b, 2019). The consistent operational engagement with IDPs has not always been the case. In the early 1990s the UNHCR has noted their work with IDPs is only required in specific circumstances. Interventions by the UNHCR were conducted if they were requested by the UN Secretary General or other UN agencies. If governments were lacking the capacities for operational delivery towards IDPs, the UNHCR was able to operate with the consent of the affected government. Through their expertise with refugees and returnees, the UNHCR has the adequate resources and experience to prepare and deliver protection for IDPs with the involved State, if their staff safety is secured (UNHCR e, 2022). Over time, their engagement in internal displacement settings has expanded, especially through the involvement in the IASC Cluster approach (Morris, 2006, p. 55). Nowadays, the UNHCR works through a collective response with other agencies towards achieving durable solutions for IDPs (UNHCR b, 2019). The international responsibility to assist IDPs and the recognition of the growing numbers of IDPs has increased over the last decade.

The UNHCR has also released a number of documents clarifying their role with IDPs. This also comprises a proposal of innovative financing mechanism for supporting IDPs (UNHCR, 2020). One of the innovative findings mechanisms has been applied by Kiva's World Refugee Fund. Working together with UNHCR and NGOS, the international non-profit organization Kiva has launched the Fund for refugees and IDPs to provide loans for refugees and IDPs (UNHCR, 2020). Despite not yet implemented, a land sharing value capture in Somalia has been developed to give access to affordable housing, land, and property for IDPs. Another innovative financing mechanism has been the Humanitarian Impact Bond developed by the ICRC. The Program for Humanitarian Impact Investment raised 26 million Swiss franc for three new physical rehabilitation centers in Nigeria, Mali, and the Democratic Republic of Congo providing health care for victims of armed conflict (ICRC, 2017). This investment has accelerated social investments by the private sector (UNHCR, 2020). It illustrates that UNHCR is not the only international agency with the experience and skills provide emergency relief for IDPs, as the ICRC has been involved in numerous IDP operations. Similar to the UNHCR limitation on the core refugee mandate, the ICRC is also limited in their scope of work as they often leave after the crisis has cleared up (Cohen, 2009, p. 107).

However, the mandate of the UNHCR for IDPs remains variable, as the UNHCR mandate is not exclusive for IDPs (UNHCR e, 2022). The protection obligations for IDPs rely also on the

capacities of other UN agencies and the responsible national authorities. Without expanded accountabilities for IDPs within the UN system, a designated agency for the needs of IDPs and stronger legal frameworks, the situation of IDPs may worsen (Cohen, 2009, p. 108).

5.2 Barriers to health for IDPs

Despite existing health interventions through the Cluster approach and health-related NGO operations, IDPs face several barriers for obtaining high standards of health. As stated in the General Comment No. 14 by the CESCR, public health facilities and services should be equally available for IDPs and the host communities (CESCR, 2000). This availability is often not given, as internal displacements occur in resource starved LMICs. An example of already existing shortage of medication and laboratories in an internal displacement context has been reported in Iraq (Kaelin et al., 2010). The Iraq displacement review from 2006 by the International Organization for Migration (IOM) revealed that one-third of the interviewed IDPs do not have access to needed medication and many specialist care providers, such as gynecologists, have left the country (IOM, 2007). In terms of accessibility to health care, many IDPs experience financial hardships, long distances to health facilities, lack of transport, discrimination, and unsafe environments as barriers to health care (Kaelin et al., 2010). Victims of sexual violence might also fear stigmatization before even deciding to seek medical care (GPC, 2010).

Humanitarian agencies assisting IDPs can also face barriers. Identified barriers for humanitarian agencies consists of resource constraints and collaboration barriers, as sometimes agencies can compete for the same resources (Hakamies et al., 2008, p. 36-37). As mentioned in the theoretical part, attacks of humanitarian personnel have increased and can limit humanitarian agencies to operate in crisis affected areas due to security issues (OCHA, 2019). The reproductive health needs of IDPs are often multifaceted and require an inter-agency collaboration (Hakamies et al., 2008, p. 40). Regarding reproductive health care, the General Comment No. 14 already emphasizes the need for humanitarian interventions to respect medical ethics, cultural norms and ethnicity of individuals (CESCR, 2000). Reproductive healthcare behavior such as preferring a female traditional birth attendant can vary by gender specific needs (Kaelin et al., 2010). Another aspect of health service barriers can involve the quality of health services which is often limited in emergency settings (GPC, 2010). A shortage of qualified health personnel and missing awareness about the displacement-related health needs. Lack of quality medical services can reduce the effectiveness, waste the already limited resources and can cause actual harm (Kaelin et al., 2010).

This leads to the assumption that the implementation of legal frameworks such as the Guiding Principles or the General Comment on access to health services for IDPs by the CESCR, can have obstacles in practice. A sensitivity towards cultural and religious norms by humanitarian agencies can increase the acceptability of healthcare among IDPs (Kaelin et al., 2010).

5.3 Policy implications

In 2016, the UN Secretary General has already announced the goal to reduce 50 percent of new or protracted internal displacement by 2030 (UN, 2016). This has not yet been achieved so far, as the numbers of IDPs have accelerated over time with new conflicts and disasters creating high numbers of IDPs (UN a, 2022). Working towards durable solutions for IDPs is a major step to limit the hardships of internal displacement. Durable solutions for IDPs refer to the reintegration of IDPs into places of their origin or other local communities (UN, 2021). This also involves not being in the status of need any more as IDPs have adequate access to secure livelihoods, education, and social protection systems. Finding durable solutions can be a long-term and complex process (UN, 2021). Durable solutions for IDPs can be achieved through mainstreaming a holistic approach. This encompasses a whole-of-displacement approach as the needs of the host communities and those of the IDPs are included in the humanitarian assistance. Extending innovative financing mechanism for IDPs while integrating them into national systems will provide long term solutions for IDPs (UNHCR, 2020).

The holistic way also takes into account a whole-of government approach as all parts of the government should integrate internal displacement into national development plans (UN a, 2022). International humanitarian coordination systems should be integrated into national plans with clear accountabilities for IDPs instead of replacing them (Stumpenhorst et al., 2011, p. 588). Achieving durable solutions also shows the synergies between humanitarian assistance, peace building efforts to end conflict and development efforts for securing a stable life for IDPs (UN a, 2022). The engagement of development actors and the private sector should be in line with the humanitarian principles, as a foundation of all humanitarian interventions. Providing humanitarian protection and assistance, while working towards durable solutions and preventing further internal displacements is a comprehensive approach (UN, 2021). Prevention also implies the establishment of an early warning system for the population at risk (Cohen, 2009, p. 107). The figure on the following page shows the three interlinked goals, which cannot simply standalone but reach maximum outcome when they are combined (UN a, 2022).

Figure 6: Three interlinked goals

(Source: UN a, 2022)

Drawing upon the health needs of IDPs, a policy brief on internal displacement and health has been released as a result of a workshop by the Internal Displacement Research Programme and the Academy of Medical Science. These policy implications are in alliance with the findings of this paper. They give four policy implications for strengthening the health of IDPs. As IDPs often face worse health outcomes than other crisis affected populations, they should be more included in essential health services such as routine immunizations. IDPs have specific health needs and vulnerabilities such as reproductive health care. Assessing the health needs of IDPs in advance and streamlining specific health interventions into local plans is an important step for raising the health outcome. Another policy implication has been the community engagement of IDPs through participation in health programs, for instance through mental health support services. Assessing the health of IDPs can only be possible through available IDP health data. Data on internal displacement and should be consistently gathered by governments or agencies and shared between those entities (Researching Internal Displacement, 2021).

5.4 Strengths and Limitations

The results fit into the current research on IDPs. The theoretical background is essential for understanding the intentions and involvement of humanitarian actors in the IDP assistance. As the humanitarianism discourse has developed over time, these changes impact also the coordination and response to IDPs by humanitarian actors. Data on numbers, characteristics and causes of displacement for IDPs has been sufficiently covered by the IDMC, UNHCR and other UN agencies. As the UNHCR has increased their engagement with IDPs over time, they have released a number of IDP related documents relevant to this research.

While reviewing literature on the humanitarian coordination systems applicable for strengthening the health of IDPs, a lack of reference to IDPs was noted. This can be seen in the Health Cluster Guide, as IDPs have not been mentioned by the authors. Other scarcities of literature were found in the health financing for IDPs, as there has been only one study focusing on the health development aid for IDPs. The disparity on literature coverage between refugees and IDPs has been noted as well. This leads to the necessity of scaling up research investments on IDPs. Another limitation besides the scarcity of literature on health interventions for IDPs, is the complexity of the research topic. The scope of research was not narrowed down to one country affected by a IDP crisis but rather focused on IDP engagement of international actors worldwide. Not only leads this to a higher availability of data but reveals the broad research possibilities and the complexity of the IDP coordination.

6 Conclusion

Referring back to the theoretical foundation, the humanitarian principles lay the foundation for humanitarian action worldwide. The compliance to humanitarian principles has been extended with the Humanitarian Reform Agenda in 2005 and the Transformative Agenda in 2010 by the IASC. Humanitarianism seeks to alleviate suffering in an emergency setting while providing relief to its victims (Barnett & Weiss, 2012, p. 11). Both humanitarian strategies, the do-no-harm and comprehensive peacebuilding strategy, can be found in the UN humanitarian system depending on the context of the crises. The findings reflect the challenges of humanitarianism as humanitarian activities intersect with development actions for achieving durable solutions and increasing financial capacities. As development actions result often in private sector engagement, a compliance to the principles of partnership developed by the Global Humanitarian Platform is needed. Humanitarianism, peace building, and development work interact with each other more than ever. Having shared vision and transparent communication between these sectors leads to more effective interventions while creating durable solutions (UN a, 2022).

The Guiding Principles on Internal Displacement have increased the international recognition of IDPs and have supported the accountabilities of international actors and States for IDPs. The rights of IDPs are not only manifested in the Guiding Principles, but also in other or national legal frameworks, such as the Kampala Convention. International standards for health response in emergency settings such as the Sphere Handbook or the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings have been developed as well. Despite these accomplishments, there is no international binding legal framework specifically for IDPs. The lack of a global fund for IDPs or the lack of an international agency dedicated to IDPs add up to the problem of underrepresentation and underprioritizing of IDPs on the international agenda (Cohen, 2009, p. 103; UN, 2021).

Armed conflict and climate-related disaster will continue to trigger movements within country borders. The complexity and scale of conflicts has increased and left millions of people in new and protracted displacements. As several previous studies have confirmed, the mortality and morbidity of IDPs remains one of the highest among crisis affected populations (Cantor et al., 2022). A variety of health areas show worse health outcomes among IDPs, including communicable diseases, VPDs or mental health. IDPs are a heterogenous group with specific vulnerabilities and needs (Mitra, 2022). Recognizing different health needs of IDPs, such as or reproductive health care or mental health, will lead to a more effective and successful implementation of health interventions (Kaelin et al., 2010). Attaining high standards of health is strongly linked to other determinants of health including safe environment, education, or community engagement sanitation (Bermudez, 2022).

Strengthening humanitarian engagement is not only needed in the emergency health response but in all sectors concerning the well-being of IDPs. As identified in the findings of this paper, the Cluster approach serves has suitable tool for a coordinated emergency response, while giving clear responsibilities to each cluster (UNHCR a, 2022). But despite its achievements in their country operations, the IASC Clusters face financial constraints, lack of involvement of NGOs due to UN-centric structures and challenges within the agency's structures (Morris, 2006, p. 55).

The highest impact on the health of IDPs and long-term health interventions can only be achieved through a holistic approach. A whole-of-displacement approach with the inclusion of other affected populations such as refugees and the host communities will create more sustainable solutions (UN, 2021).

List of figures

List of abbreviations

CESCR	UN Committee on Economic, Social and Cultural Rights
EC	European Commission
EMT	Emergency Medical Teams
ERC	Emergency Relief Coordinator
GANHRI	Global Alliance of National Human Rights Institutions
GAVI	Global Alliance for Vaccines and Immunization
GHP	Global Humanitarian Platform
GPC	Global Protection Cluster
HC	Humanitarian Coordinator
HCT	Humanitarian Country Team
IASC	Interagency Standing Committee
ICRC	International Committee of the Red Cross
IDMC	Internal Displacement Monitoring Centre
IDP	Internally Displaced Person
IFRC	International Federation of Red Cross and Red Crescent Societies
IHL	International Humanitarian Law
IOM	International Organization for Migration
LMIC	Low- and middle-income countries
MSF	Medicine San Frontières
NCD	Non communicable diseases
NGO	Nongovernmental Organization
OCHA	United Nations Office for the Coordinator of Humanitarian Affairs
ODA	Official development assistance

OECD	Organization for Economic Co-operation and Development
OHCHR	Office of the High Commissioner for Human Rights
PHC	Primary health care
SDG	Sustainable Development Goals
UNAIDS	United Nations Program on HIV/AIDS
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
UNSG	United Nations Secretary General
USD	US Dollar
VPD	Vaccine preventable diseases
WASH	Water, sanitation and hygiene
WFP	World Food Programme
WHO	World Health Organization

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Appendix

Appendix 1: Literature search on PubMed on the health financing for IDPs

ID	Search terms/combinations for literature review on PubMed	Hits
#1	Search internally displaced persons [MeSH Terms]	16,516
#2	Search IDPs [MeSH Terms]	1,847
#3	Search internally displaced persons [MeSH Terms] AND health financing [MeSH Terms]	74
#4	Search health overseas development aid [MeSH Terms]	106
#5	Search health overseas development aid [MeSH Terms] AND internally displaced persons [MeSH Terms]	2
#6	Search health overseas development aid [MeSH Terms] AND IDPs [MeSH Terms]	1