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Humanitarian Access, Protection and Diplomacy in Besieged Areas

Zenobia Ismail
University of Birmingham
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Question

What are the lessons learned with regard to the provision of humanitarian aid, the protection of civilians and humanitarian diplomacy in besieged areas, specifically Syria, Yemen and Iraq?

Contents

1. Summary

This rapid literature review examines the lessons learned in terms of providing humanitarian access and protection for civilians in besieged areas. The focus is on the following besieged areas: Syria (e.g. Raqqa, Aleppo, Deir-Ez-Zor and Eastern Ghouta), Hudaydah in Yemen and Mosul in Iraq. The recent literature is dominated by the conflict in Syria while there is very little in-depth analysis of humanitarian access in Hudaydah or Mosul. This review utilised grey literature produced by research organisations, Non-Governmental Organisations (NGOs) and humanitarian organisations as well as academic literature on humanitarian access. The findings reported in the literature were based on case study analyses which encompassed in-depth interviews with humanitarian actors and victims of conflict.

The Syrian conflict is distinct because of the notable presence of diaspora organisations and local humanitarian actors who are able to use their local knowledge and personal connections to gain access (Haddad & Svoboda, 2017). Consequently, the prominence of non-traditional, local humanitarian actors as providers of aid and access has grown in Syria. In contrast, the literature on humanitarian access in Yemen is focused on high level humanitarian diplomacy aimed at the Saudi coalition which is restricting access to Hudaydah port, the main conduit for food, fuel, aid and medical supplies (Coppi, 2018; WHO, 2018). Apart from one study of trauma units in Mosul this review did not find recent literature on humanitarian access in this area.

The following key findings with regard to humanitarian access in areas under siege emerged from the literature review:

- In besieged areas access has to be negotiated with a number of Non-State Armed Groups (NSAGs) (Haddad & Svoboda, 2017);
- There is concern that humanitarian principles may be compromised during negotiations with NSAGs (Carter & Haver, 2016). For example, the perceived neutrality and independence of humanitarian actors may be undermined;
- Humanitarian organisations do not negotiate with armed groups which are classified as terrorist organisations and cannot gain access to areas under the control of such groups (Grace, 2017);
- Local humanitarian actors play a prominent role in delivering aid and negotiating access with NSAGs in Syria (Haddad & Svoboda, 2017). The World Health Organisation is working in partnership with local NGOs in Hudaydah (WHO, 2018);
- Remote programming is becoming the norm as international non-governmental organisations are based across the border and liaise with local partners on the ground. Diaspora organisations such as the Syrian American Medical Society Foundation provide training, patient monitoring and even guided surgery via web cams (Haddad & Svoboda, 2017). The World Food Programme has expanded its beneficiaries through remote programmes (Coppi, 2018);
- Private for-profit healthcare providers were utilised to provide trauma relief during the battle of Mosul (Spiegel, Garber, Kushner, & Wise, 2018); and
- The literature repeatedly emphasises the role of humanitarian diplomacy for securing humanitarian access and protection of civilians in besieged areas.
- Many women and girls are trapped in besieged areas and there is an urgent need for prenatal and antenatal medical services (Coppi, 2018). Conservative NSAGs were reluctant to provide access for humanitarian initiatives which targeted women and

children or demanded that only female medics treat women. The community can occasionally pressure these NSAGs to make concessions so that services are available to women and girls (Haddad & Svoboda, 2017).

2. Sieges

The imposition of sieges which endanger civilians during armed conflict is prohibited under International Human Rights Law (IHL) (United Nations, 2014). This proscription includes the use of starvation as a means of warfare as well as the destruction of essential services. Furthermore, IHL requires that the parties in the conflict allow and facilitate access for humanitarian aid for civilians. This includes safe passage for essential goods which are necessary for the survival of the population. In some cases, besieging the civilian population is deemed collective punishment which is also prohibited under IHL and is considered a war crime. Attacks on medical facilities and medical personnel as well as the wounded and sick are not permitted by IHL (United Nations, 2014). IHL prohibits attacks against humanitarian organisations while the facilities are given protected status (United Nations, 2014). However, over the past decade there have been significant attacks on aid workers which has compelled several humanitarian organisations to withdraw from certain conflict areas (Stoddard et al., 2017).

There is concern that the disregard for IHL during sieges may create a dangerous precedent for future conflicts (Fouad et al., 2017). As Peter Maurer, president of the ICRC, states: “The concepts as well as the practices of principal humanitarian action are increasingly being challenged by current conflicts. Parties to the conflict may themselves explicitly desist from this project of shared humanity for ideological or political reasons as witnessed in several instances over the recent years when the so-called enemy population is wholesomely and collectively dehumanised and degraded” (Maurer, 2014, p. 5). Furthermore, given that urban areas are likely to be besieged the destruction of infrastructure affects the provision of essential services such as water, power and medical facilities (ICRC, 2015).

The Syrian conflict has been characterised by sieges on opposition-controlled areas by pro-government armed forces. To a lesser extent armed opposition groups have besieged heavily populated areas which are aligned to the government (United Nations, 2014). For example, northern Aleppo has been besieged since 2012 by a number of militant groups. Government forces have imposed sieges on Homs, rural Damascus and Damascus since 2012 while Ghouta was repeatedly besieged since 2011. Initially the sieges were partial and civilians and goods were permitted to cross checkpoints, but as the conflict intensified the government forces prevented all entry of goods and people. Aerial bombardment destroyed essential infrastructure including hospitals, water and electricity plants leading to deteriorating living conditions for thousands of people trapped in besieged areas (United Nations, 2014).

In Yemen the port of Hudaydah was crippled in 2015 by airstrikes which damaged its four cranes and warehouses (Coppi, 2018). Thousands of people, including women and girls, were trapped in Hudaydah without access to sufficient food, water and medical care. It is estimated that almost 60,000 residents are living without access to clean water and famine is rising (Oxfam, 2018; Coppi, 2018). By the end of July 2018 there were 165,817 suspected cases of cholera, 290 confirmed cases and 293 deaths (Oxfam, 2018). Since August 2018 the conflict has intensified in parts of Hudaydah, especially in the southern districts of al-Duraihmi and Tuhayta, where medical facilities are no longer functioning (Oxfam, 2018).

In Iraq the battle for Mosul (2016 -2017) was the largest urban siege since the Second World War. Over 940,000 civilians fled and many were injured (Spiegel et al., 2018). The World Health Organisation was tasked with providing trauma relief for the civilians affected by the siege (Spiegel et al., 2018). A complex model for establishing trauma stabilisation points in partnership with humanitarian organisations and private for-profit health providers was implemented. Medecins Sans Frontieres (MSF) and the International Committee of the Red Cross (ICRC) declined to participate in the mission as they did not wish to be associated with Iraqi government forces - this would compromise their neutrality and independence. Since this was an innovative model for providing humanitarian assistance to civilians under siege there are lessons which may be learned from this intervention. The ICRC was not able to negotiate with both sides of the conflict and therefore it played a minimal role by maintaining its primary healthcare facilities which were already operational in Mosul.

3. Humanitarian access and protection

Humanitarian access denial

There is no universally agreed definition of humanitarian access but it is broadly understood as the provision of aid to people in need and the ability of people to access services (Svoboda, Barbelet & Mosel, 2018, p. 1). The Office for the Coordination of Humanitarian Affairs (OCHA) identifies three categories of access denial: bureaucratic constraints, intensity of hostilities and violence against humanitarian personnel or theft of assets (Labonte & Edgerton, 2013). There are few studies which examine the motivations of humanitarian access denial especially for state authorities. Labonte and Edgeton (2013) argue that states may impede humanitarian access for the following reasons: to protect their national image, to use humanitarian access for leverage during international negotiations, and to promote state security goals at the expense of civilian protection.

Humanitarian access denial is a critical component of the Syrian government's strategy to defeat opposition forces (Meininghaus & Kuhn, 2018). The Syrian government requires that aid be delivered through the Syrian Arab Red Crescent (SARC). Convoys require approval by the government which can impose significant bureaucratic hurdles if it wishes to delay aid (Haddad & Svoboda, 2017). Since September 2013 aid convoys were refused entry with the exception of polio vaccines. In Ghouta aid was confiscated or stolen while medical supplies were withheld to prevent opposition groups from gaining access to them (United Nations, 2014). In 2016 it was estimated that between 4.5 to 5.5 million people were in besieged or hard to reach areas in Syria, which was a sharp increase from the previous year when it was estimated that there were 393,700 besieged people (Jongberg, 2016). Attacks on health workers and facilities especially by Syrian government forces may be a deliberate strategy for defeating the opposition (Fouad et al., 2017). Figure 1 depicts the escalating attacks on health facilities over the duration of the Syrian conflict.

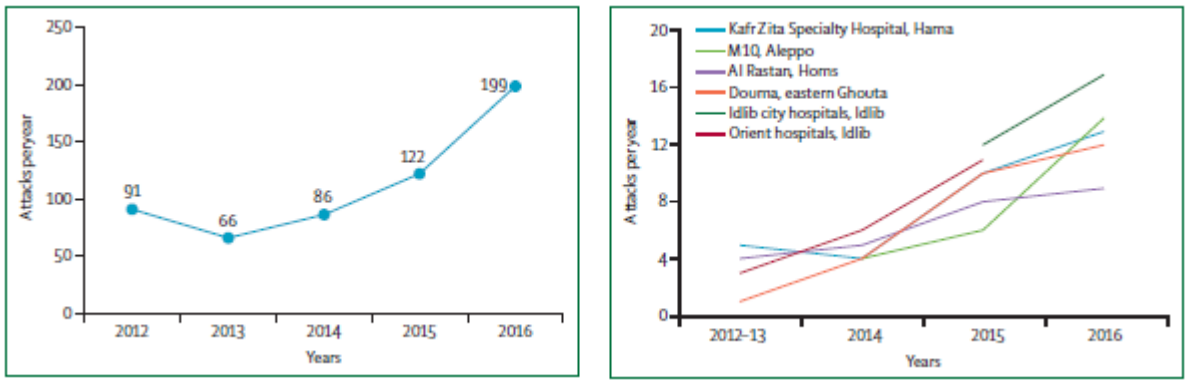

Figure 1: Number of attacks on health facilities in Syria

Source: (Fouad et al., 2017, p. 2519)

Fewer humanitarian organisations are able to respond to insecure emergency contexts regardless of funding or the needs of the population. The countries with the highest number of aid worker attacks have the lowest number of aid organisations responding per USD 100 million in funding (Stoddard et al., 2017). In practice a relatively small group of humanitarian actors will operate in high-risk locations, such as Raqqa and Aleppo. Moreover, humanitarian operations tend to be clustered in more secure areas within highly insecure countries, although capital cities are an exception as aid organisations are headquartered in these cities despite the risks to aid workers. For example, during 2013 and 2014 the declining security context in Syria and attacks on aid workers by pro-government and opposition forces severely limited aid operations (Haddad & Svoboda, 2017). International staff were no longer able to travel across the border from Turkey and at least two major International Non-Governmental Organisations (INGOs) ceased all direct cross-border implementation. There was a significant decrease of humanitarian aid in Raqqa and Deir Ez-Zor, which were under the control of the Islamic State (IS), and by the end of 2014 only five humanitarian organisations were still operational in these areas (Stoddard et al., 2017). Programming was concentrated in healthcare and water and sanitation as these services were considered more acceptable by IS. In contrast, the aid presence increased in Aleppo and Idlib as IS was routed from this region. Given the fluid nature of the Syrian conflict, access varies significantly over time and across locations depending on which militant organisation is in control of a place at a specific time (Haddad & Svoboda, 2017).

In Yemen there is a risk that the internationally recognised government and its coalition forces will close the main road junction which may obstruct access from Hudaydah to the northern areas (Oxfam, 2018). This will result in thousands of families not receiving essential goods and humanitarian aid, thus increasing the risk of death and injury as well as prohibiting escape. Moreover, millions of civilians may face starvation if the ports of Hudaydah and al-Saleef are not fully functional. It is estimated that two-thirds of Yemenis rely on Hudaydah port to gain access to basic necessities while 90% of the country's fuel is transported through Hudaydah (Oxfam, 2018). The World Health Organisation has been unable to provide much-needed medical assistance in parts of Hudaydah due to the siege (WHO, 2018).

Humanitarian access strategies

The following strategies have been used by humanitarian organisations to gain access to besieged areas, especially in Syria. In the case of Syria humanitarian actors began to rely more on these strategies as Turkey became less willing to facilitate cross-border humanitarian relief and as the threat to international staff increased (Svoboda et al., 2018).

Remote programming

INGOs increasingly prefer to utilise cross-border remote management. There are various degrees of remote management which range from cases where INGO staff make all the decisions remotely to instances where local staff on the ground operate with very little oversight (Spiegel et al., 2018). In Afghanistan remote management has been used from time to time since the 1980s and it has become essential because of humanitarian access problems in besieged areas in Syria. Remote management is facilitated by technology which includes Skype, WhatsApp and Viber. Such technology can be used for remote training sessions including medical and surgical techniques. The Syrian American Medical Society Foundation (SAMS) enables volunteer doctors to monitor vital signs, medication doses and patients in real time using web cams. Doctors based in the US can guide local doctors and nurses in besieged areas through complex procedures including surgeries. Furthermore, technology has been used to provide training on protection work and to facilitate monitoring and evaluation as projects are documented using videos, photographs and GPS (Haddad & Svoboda, 2017). In 2015 the World Food Programme (WFP) began remote data collection and monitoring in Yemen (Coppi, 2018). The WFP also implemented a remote voucher programme, the Commodity Vouchers through Traders Network in hard to reach locations like Sanna, Aden and Taiz in Yemen. The WFP was able to expand the number of beneficiaries from 120,000 to over 600,000 with the remote voucher programme (Coppi, 2018). The ICRC is using WhatsApp as a dedicated hotline to report incidents and request help in Yemen (Coppi, 2018). Social media is used to exchange information and provide advice as well as moral support in Syria. Although remote management should be a last resort, it is increasingly becoming the default option for many humanitarian actors because of security and access constraints (Svoboda et al., 2018). However, several INGOs have a shallow presence in conflict areas and are less able to provide insurance or other benefits for the local staff working on the ground in highly insecure areas.

Local partnerships

In Syria humanitarian assistance is provided mainly by local groups working in partnership with INGOs (Haddad & Svoboda, 2017). Although it is difficult to quantify the contribution of local organisations it is widely believed that they and the Syrian Arab Red Crescent provide the vast majority of frontline relief (Svoboda et al., 2018). Although direct funding to Syrian organisations accounts for only 0.3% of all humanitarian funding for the country, it is anticipated that these organisations receive additional funds indirectly through partnerships with traditional humanitarian actors. Coordinating bodies have arisen which facilitate links between traditional donors and new Syrian organisations. In early 2014 a system of validation was developed by the UN. The OCHA set up a pooled fund for Syrian organisations whereby donors fund OCHA, which in turn funds local NGOs and also takes responsibility for conducting due diligence checks (Svoboda et al., 2018).

The local or non-traditional humanitarian actors in Syria include medical groups, faith-based charities and anti-government activists (Svoboda et al., 2018). The size and scale of these organisations varies considerably. The local groups are connected with families or tribes and rely on their personal contacts to operate. In addition, local humanitarian organisations rely on trust which they have established with community leaders, religious leaders, NSAGs and other stakeholders as well as local knowledge to gain access (Svoboda et al., 2018). Consequently, their geographic scope may be limited to areas where they have connections. However, some local groups have begun to form partnerships and coalitions to expand their reach and thus operate in multiple geographic areas (Haddad & Svoboda, 2017).

In Syria many local organisations emerged from the 2011 uprising and some developed into local coordination committees (LCCs) which organised demonstrations and set up fundraising networks within the country and abroad. LCCs in areas outside government control undertook administrative functions from mid-2012 onwards, including service delivery and aid provision. Local administrative councils (LACs) arose later as parallel local governance structures which coordinate relief efforts, maintain justice and manage education and healthcare facilities. It is estimated that there were 750 LACs in operation in 2014 in opposition-controlled areas. The conflict forced many civil society activists to abandon their activism and undertake humanitarian relief work or provide medical and educational services. Since it was initially assumed that the conflict would be short-term there was little incentive to establish more formal structures.

There is much less analysis of humanitarian aid access in Yemen and Iraq. The World Health Organisation acknowledges that it is having difficulty in delivering aid to Hudaydah and that rapid response teams are unable to travel to 18 districts in Hudaydah because of security concerns (WHO, 2018). The World Health Organisation is prioritising the delivery of the minimum service package to 12 districts using local NGO partners. After October 2017 the number of humanitarian organisations working in Yemen increased and the UN Cluster System reported that 143 humanitarian organisations were in the country and 100 of these were national organisations (Coppi, 2018). It is anticipated that there are other humanitarian organisations which are not part of the UN system in working Yemen (Coppi, 2018).

Diaspora groups

A unique feature of the conflict in Syria is the presence of several diaspora groups which operate through local networks of personal and family connections (Haddad & Svoboda, 2017). The diaspora groups vary in terms of size, mandate and scope. Initially these groups operated independently from the traditional humanitarian system. They collected donations from the Syrian diaspora to fund their organisations and activities. Some diaspora groups rely on local groups which provide access in Syria and operate as contractors for institutional donors and the United Nations. For example, one diaspora organisation has over 900 workers and volunteers in Syria and the UK as well as an office in Turkey (Haddad & Svoboda, 2017). SAMS claims that it treated 2.5 million people in 2015 and the Union of Medical Care and Relief Organisations runs 16 field hospitals which provide treatment to 50,000 patients per year (Fouad et al., 2017). This review did not find any mention of diaspora groups operating in Yemen or Iraq.

Private providers

In Mosul private sector healthcare providers, NYC Medics and Aspen Medical, and an NGO, Samaritan Purse (which had experience in the Kurdish region) agreed to partner with the World

Health Organisation to establish trauma care facilities (Spiegel et al., 2018). Security was a paramount concern for the private medical providers and they worked closely with Iraqi security forces to ensure the safety of their personnel.

4. Humanitarian diplomacy

Humanitarian diplomacy is broadly defined as including the activities which humanitarian organisations undertake so that political and military stakeholders give them access and opportunity to provide humanitarian relief to those affected by conflict or natural disasters (Régnier, 2011). It includes negotiating access to civilians to provide them with humanitarian aid or protection, monitoring relief programmes and promoting respect for IHL. Humanitarian diplomacy takes place at the international level (mainly through the United Nations and other supranational bodies), the national level (with national governments) and at the local level (negotiations with local authorities or opposition groups). For example, the ICRC operates as a neutral intermediary which negotiates with all parties in the conflict to promote adherence to IHL (Régnier, 2011). The literature on the conflict in Yemen, Syria and Iraq makes frequent reference to the use of humanitarian diplomacy to negotiate access to areas under siege. The literature on Yemen tends to focus on high level humanitarian diplomacy with the Saudi coalition partners to gain access for aid (Oxfam, 2018; WHO, 2018) rather than negotiations with NSAGs which occurs in Syria.

Access negotiations

Negotiations for humanitarian access range from those at the highest level of the Security Council right down to negotiations with armed guards at local checkpoints. NGOs and private actors such as the Carter Institute engage in conflict mediation with a variety of NSAGs (Hoffman, 2016). Carter and Haver (2016) interviewed staff members at several humanitarian organisations and found that many were unsure if they were permitted to negotiate with NSAGs and unclear how to go about these negotiations. In addition, international staff were more likely to think that negotiations were acceptable compared with national staff, although there was considerable variation by country. For example, only 16% of national staff in Afghanistan believed that such negotiations were acceptable while in South Sudan more than half of national and international staff supported such negotiations. Svoboda et al. (2018) found that negotiations were often conducted in secret and some humanitarian organisations were reluctant to discuss them.

It has become essential to engage with NSAGs to gain humanitarian access in Syria (Meininghaus & Kuhn, 2018). Syrian LCCs and LACs function as intermediaries which negotiate access for local and international humanitarian relief organisations with armed groups. The capacity of these committees to provide assistance as well as their independence from local armed groups varies notably (Haddad & Svoboda, 2017). Improved coordination has enhanced the ability of local aid groups to negotiate more favourable terms for access. Local organisations work with local councils to conduct needs assessments and gain approval for projects, campaigns or deliveries. Larger local councils have established humanitarian coordination offices which work directly with NGOs. In areas where several different political groups compete for authority there may be a number of competing local councils and it is therefore necessary for local organisations to negotiate with each council to ensure that they are perceived as neutral. Relations between armed groups and local councils may be tense. In such cases local humanitarian organisations may have to negotiate with a variety of actors to gain access,

including community leaders or religious leaders. Community leaders appear to have more influence in rural areas especially those which can be regarded as tribal; for example, tribes play an important role in negotiations in Raqqa and Idlib (Haddad & Svoboda, 2017).

In some instances, local groups are required to negotiate directly with NSAGs primarily over access routes. Different armed groups may control different stretches of the same road. For example, about 40 NSAGs control different checkpoints of the 60 km road between Killis/Bab al-Salam and Aleppo. Hence, local organisations try to negotiate with the most powerful armed group first in anticipation that this may influence the other groups to cooperate. Local groups often tailor their message or ideology in order to appeal to different armed groups. For example, they may use more religious language when negotiating with Islamic militant groups. Interviews with local groups revealed that the strength of their relationships with different armed groups varied. They also stated that it was more difficult to negotiate with jihadist groups such as IS or Jabhat al-Nursa because these groups were less reliant on goodwill from the community since they derive their legitimacy through enforcing their interpretation of sharia law. Since armed groups can benefit from medical treatment, they are more receptive to facilitating access to these services while programmes relating to child protection or gender-based violence may be resisted (Svoboda et al., 2018). The local community was sometimes able to pressure armed groups to permit access or make other concessions to provide medical or educational services especially for women and girls.

The main barrier to negotiation with NSAGs is the designation of some of these groups as terrorist organisations (Svoboda et al., 2018). When this occurs, humanitarian organisations will not negotiate with particular NSAGs (such as Al Shabab in Somalia). There is also concern that NSAGs may use the negotiation process to boost their credibility and legitimacy with internal and external stakeholders (Grace, 2017). For example, the Sudan People's Liberation Movement-North permitted access in order to raise its international standing. Humanitarian organisations are sensitive to the reputational damage that would be caused by negotiating with terrorist organisations (Carter & Haver, 2016).

Humanitarian principles

The increasing reliance on local groups to negotiate access and deliver aid raises concerns regarding the politicisation of aid. Humanitarian organisations are expected to adhere to the following four core humanitarian principles (Federal Department of Foreign Affairs, 2014):

- Humanity- a commitment to protect life and health and ensure respect for all human beings;
- Neutrality - humanitarian actors must not take sides or engage in political, racial, religious or ideological controversies;
- Impartiality - there is no distinction on the basis of nationality, race, gender, religion, class or political opinion with respect to who receives aid or medical treatment; and
- Independence - humanitarian actors must be autonomous from political, economic, military or other objectives.

There is concern that local actors may not abide by humanitarian principles especially when they engage with NSAGs to negotiate access (Haddad & Svoboda, 2017; Meininghaus & Kuhn, 2018). In contrast, some local NGOs in Syria report that abiding by humanitarian principles such as neutrality is beneficial because it enables them to maintain access regardless of which armed

group is in control of a particular area (Haddad & Svoboda, 2017). Moreover, even traditional humanitarian actors might struggle to comply with humanitarian principles when operating in highly insecure areas or besieged areas.

> "Delivering aid in a war zone inevitably involves 'contradictions and ethical dilemmas', and applying principles in action is not about 'avoiding compromises or making concessions ', but rather about 'being aware of the options available, and determining whether, when and what type of compromise is worth it 'in besieged areas it is common for local councils to negotiate ceasefire agreements between government and opposition forces to secure access for aid" (Haddad & Svoboda, 2017, p. 22).

Compromises may be necessary in order to gain access for humanitarian aid. For example, negotiations in 2015 in northern Damascus resulted in government forces agreeing to allow the entry of food and medical goods in exchange for reconnection of the water supply which had been disconnected by opposition forces (Haddad & Svoboda, 2017).

After the 2003 invasion of Iraq humanitarian organisations struggled to maintain their neutral image partly because Iraqi society found it difficult to distinguish between military/political actors and humanitarian actors since many humanitarian organisations were funded by governments involved in the military action (Federal Department of Foreign Affairs, 2014). Consequently, there were attacks on aid workers forcing several humanitarian organisations to withdraw. In Mosul private healthcare providers breached humanitarian principles by working closely with one side of the conflict. In contrast, the ICRC refused to participate because it was unable to negotiate with both sides given that IS could not be approached. In Yemen some international and local humanitarian actors are mistrusted, including those associated with the UN, mainly because the UN has failed to denounce Saudi Arabia (its most important donor in the region) for causing many civilian causalities (Coppi, 2018). The perceived lack of neutrality and independence restricts access in Yemen and for these humanitarian actors (Coppi, 2018).

An additional concern is that the siege may contribute to the war economy in which intermediaries can control access to goods and earn large profits through inflated pricing. There is concern that aid might be diverted into the war economy or that local groups pay bribes in return for assistance or access which poses ethical challenges (Haddad & Svoboda, 2017). There is consensus that some diversion is unavoidable and that the key issue is to make sure that the level of the diversion remains acceptable. Humanitarian actors are particularly concerned that aid may be diverted to designated terrorist organisations such as IS or Jabhat al-Nusra (Carter & Haver, 2016). The international normative framework provides guidelines for negotiation with NSAGs. Specifically, this framework can help to define the boundaries within which to seek agreement on humanitarian access, identify options for operationalising humanitarian access and provide incentives for the negotiation (Federal Department of Foreign Affairs, 2014).

Civilian Protection

Civilian protection relates to the structures, policies and activities which aim to provide full respect for human rights and compliance with IHL during conflicts (Labonte & Edgerton, 2013). The literature on civilian protection is limited and with regard to Yemen and Syria the focus is on high level negotiations through the United Nations Security Council with the main stakeholders in the conflict. There is more literature on civilian protection in Iraq but this is more focused on explaining the dangers faced by civilians rather than proposing solutions.

Grace (2017) observes that the international community's engagement with NSAGs is focused on securing humanitarian access rather than civilian protection. Humanitarian actors may avoid discussing civilian protection with NSAGs because they fear this will undermine access negotiations or endanger their staff. NSAGs which view themselves as 'governments in waiting' may be more willing to comply with IHL and thus protect civilians to bolster their legitimacy (Grace, 201). NGOs and the Carter Centre have been more active in negotiating with NSAGs for issues beyond humanitarian access in sub-Saharan Africa (Hoffman, 2016).

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