Rethinking humanitarian accountability: Implementation of sexual and reproductive health services in two complex emergencies

Sarah K. Chynoweth

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Surname or Family name: Chynoweth

First name: Sarah **Other name/s:** Katherine

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Background: The UN estimates that 51.2 million people were displaced by conflict at the end of 2013. These communities have a right to reproductive health (RH) care, which is a minimum standard for humanitarian health service delivery. Yet implementation of RH services in crises remains sporadic and effective accountability mechanisms to enable provision are weak.

Methodology: This qualitative study explored the implementation of RH care after the 2008 Myanmar cyclone and 2010 Haiti earthquake. It applied a constructivist grounded theory approach to case study data. Three iterative phases of data collection were undertaken. The first explored barriers and enablers to RH implementation and identified socialising accountability, which refers to informal, interpersonal norms and behaviours among interdependent actors, as a key enabler. A second phase examined in more detail the role of socialising accountability within the two case studies and identified accountability to personal ethics as an additional critical enabler. The third phase explored the findings with humanitarian experts to assess the potential value and practical application of socialising and personal accountabilities in advancing effective humanitarian action.

Methods: Semi-structured interviews were held with 98 humanitarian staff representing 47 organisations. 15 focus group discussions were conducted with 349 displaced persons, and 11 medical facilities were evaluated using inter-agency assessment tools. Participant selection was identified through chain-referral and purposive sampling. Data were analysed using NVivo 10.

Results: The lack of effective formal humanitarian accountability mechanisms undermined RH implementation in both case studies. Socialising and personal accountabilities in part compensated for these gaps and helped to strengthen accountability processes as well as facilitate RH service implementation. This study proposes an ecological approach to humanitarian accountability that reframes accountability as an interdependent, contextualised process and practice rather than a static system focused on measurement.

Conclusion: Socialising and personal accountabilities play critical roles in humanitarian action. Practical application of the ecological approach, which engages formal, socialising, and personal accountabilities, could help augment a culture of "intelligent" accountability and enable effective humanitarian response. This warrants further exploration.

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I dedicate this thesis to all people struggling to survive in war and disaster and to women and girls everywhere.

List of Abbreviations

ALNAP	Active Learning Network for Accountability and Performance
AMI	Assistência Médica Internacional Foundation
ARV	Anti-retroviral
ASEAN	Association of Southeast Asian Nations
BPRM	Bureau of Population, Refugees, and Migration (U.S. Dept. of State)
CAAP	Commitments to Accountability to Affected Populations
CBO	Community-based organisation
CDAC	Communicating with Disaster Affected Communities
CDC	Centers for Disease Control and Prevention, U.S.A.
CEDAW	Convention to Eliminate All Forms of Discrimination Against Women
CERF	Central Emergency Relief Fund
CESVI	Cooperazione e Siluppo (Cooperation and Development)
CIOMS	Council for International Organizations of Medical Sciences
COMPAS	Centre on Migration Policy and Society
CRM	Complaints and response mechanism
DFID	Department for International Development, UK
DoH	Department of Health
DRR	Disaster risk reduction
EC	Emergency contraception
FGD	Focus group discussion
FGM	Female genital mutilation
GBV	Gender-based violence
GenCap	Gender Standby Capacity Project
GFDRR	Global Facility for Disaster Reduction and Recovery
GHD	Good Humanitarian Donorship
GHESKIO	Haitian Group for the Study of Kaposi Sarcoma and Opportunistic Infections
GHP	Global Humanitarian Platform
Groupe URD	Groupe Urgence Réhabilitation Développement
HAP	Humanitarian Accountability Partnership International
IASC	Inter-Agency Standing Committee
IAWG	Inter-Agency Working Group on Reproductive Health in Crisis Situations
ICPD	International Conference on Population and Development

ICRC	International Committee of the Red Cross
IDP	Internally displaced person
IEC	Information, education and communication
IFRC	International Federation of Red Cross and Red Crescent Societies
IMC	International Medical Corps
IMF	International Monetary Fund
INGO	International non-governmental organisation
IOM	International Organisation for Migration
IPPF	International Planned Parenthood Federation
IRA	Initial rapid assessment
IRC	International Rescue Committee
J/P HRO	Jenkins/Penn Haitian Relief Organization
MCFDF	Ministre à la Condition Féminine et aux Droits des Femmes (Haiti)
MDG	Millennium Development Goals
MDM	Medécins du Monde
MERLIN	Medical Emergency Relief International
MINUSTAH	United Nations Stabilization Mission in Haiti
MISP	Minimum Initial Service Package (for Reproductive Health)
MMA	Myanmar Medical Association
MoH	Ministry of Health
MPSS	Ministère de la Santé Publique et de la Population (Ministry of Health - Haiti)
MSF	Médecins sans Frontieres (Doctors Without Borders)
MSI	Marie Stopes International
MT	Metric tonne
NGO	Non-governmental organisation
ODI	Overseas Development Institute
OHCHR	Office of the High Commissioner for Human Rights
OSOCC	On-site Operations Coordination Centre
PAHO	Pan American Health Organization
PIH	Partners in Health
PMTCT	Prevention of mother-to-child transmission (of HIV)
PROFAMIL	Association pour la Promotion de la Famille Haïtienne
PROMESS	Programme on Essential Medicine and Supplies
PSI	Population Services International

RAISE	Reproductive health Access, Information and Services in Emergencies
RCRC	International Red Cross Red Crescent Movement
RH	Reproductive health
RHRC	Reproductive Health Response in Crisis Consortium
SC	Save the Children
SCHR	Steering Committee for Humanitarian Response (of the IASC)
SMS	Short message service
SPRINT	Sexual and Reproductive Health Programme in Crisis and Post-Crisis Situations
STI	Sexually transmitted infection
TCG	Tripartite Core Group
UN-HABITAT	United Nations Human Settlements Programme
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDAC	United Nations Disaster Assessment and Coordination
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNIFEM	United Nations Development Fund for Women (now UN Women)
UNISDR	United Nations International Strategy for Disaster Reduction
UNMAS	United Nations Mine Action Service
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
UNSW	University of New South Wales
USAID/DART	United States Agency for International Development/Disaster Assistance Relief Team
WASH	Water, sanitation, and hygiene
WCC	World Council of Churches
WHO	World Health Organization
WVI	World Vision International

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1. Chapter One: Introduction

This thesis explores the implementation of reproductive health (RH) services in two complex humanitarian emergencies and the accountability mechanisms in place to support these interventions. The United Nations High Commissioner for Refugees (UNHCR) estimated that 51.2 million people remained forcibly displaced due to conflict or persecution at the end of 2013—the largest number since World War II (UNHCR, 2014a). According to the Internal Displacement Monitoring Centre (IDMC), an additional 22 million people were displaced by natural disasters in 2013 (IDMC, 2014). Of any crisis-affected population, approximately 75% to 80% are women, young people, and children (United Nations Population Fund (UNFPA), 2000), reflecting population structures in much of the world, specifically low- and middle-income countries.

In less developed settings, RH-related problems are a leading cause of death, illness, and disability for women and girls of reproductive age (UNFPA, 2005). During humanitarian crises such as conflict or natural disaster, access to health services often decreases (Banatvala & Zwi, 2000) while RH needs increase (Austin, Guy, Lee-Jones, McGinn, & Schlecht, 2008). Indeed, of the ten countries with the highest maternal mortality ratios in the world, eight are currently or recently affected by conflict (World Health Organization (WHO), UNICEF, UNFPA, & World Bank, 2010). Newborn mortality is high in humanitarian emergencies (Lam et al., 2012), and sexual violence also increases in many crisis-affected settings, with one systematic review estimating that one in five forcibly displaced women and girls have experienced sexual violence (Vu et al., 2014). All people affected by humanitarian emergencies, particularly women and girls, need and have a right to RH care (UN, 1994a; UN General Assembly, 1966a, 1966b, 1979).

Priority RH services, as outlined in the Minimum Initial Service Package (MISP) for Reproductive Health, constitute an internationally agreed minimum standard in humanitarian service delivery (IAWG, 2010c; Sphere Project, 2011). The MISP includes a range of RH services and was developed to minimise RH-related death and disability among crisis-affected populations. It should be implemented at the onset of an emergency response, integrated into primary health care. Yet assessments undertaken by the Women's Refugee Commission, a leading research and advocacy organisation focused on

women and youth in crises, and other key RH actors have repeatedly shown that the services of the MISP have not been systematically implemented in humanitarian settings (Krause, Heller, & Tanabe, 2011; Women's Refugee Commission, 2003, 2005, 2007, 2008; Women's Refugee Commission & UNFPA, 2004).

These assessments focused on identifying the extent to which the services set out by the MISP are in place and whether the affected communities can access them. They also outlined recommendations for humanitarian actors to support MISP implementation. They have not, however, clearly identified what essential systems or factors need to be in place and working together to support systematic implementation of the MISP. Examining the ways in which humanitarian actors can be held accountable for implementing the MISP has also not been a key feature in these evaluations to date. This thesis seeks to address this gap and explores the barriers, enablers, and accountability processes related to MISP implementation in two complex emergencies, Cyclone Nargis in Myanmar in 2008 and the 2010 earthquake in Haiti.

1.1 Key concepts

1.1.1 Humanitarian assistance

Humanitarian crises are often categorised as natural or "man-made". Distinctions have also been drawn between sudden and slow onset natural disasters. Examples of the former are floods, earthquakes, and hurricanes, whereas the latter include drought, environmental degradation, and desertification. Man-made crises include technological disasters, such as nuclear accidents, as well as conflict-related complex emergencies. Complex emergencies are characterised by severe social and political disruption, often in conjunction with armed conflict, and a crude mortality rate of more than one per 10,000 people (WHO, 2013). Complex emergencies may be triggered or exacerbated by natural disasters.

The distinction between natural and man-made disasters has been criticised as artificial. Those arguing from this perspective assert that all natural disasters are ultimately man-made as the hazard itself does not cause the destruction per se, but is a result of poverty, poor infrastructure, and lack of preparedness in the country or area (Redmond, 2005).

However, the humanitarian community generally uses these discrete terms to classify crises.

The United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA) defines humanitarian assistance as “Aid that seeks to save lives and alleviate suffering of a crisis-affected population” (ReliefWeb, 2008a, p. 29). Humanitarian assistance is also termed humanitarian response or action. General Assembly Resolution 46/182 requires relief agencies to adhere to the key humanitarian principles of humanity, impartiality, and neutrality (UN General Assembly, 1991).

Humanitarian assistance has been conceptualised as distinct from development work in that it typically involves the provision of short-term, life-saving services. Again, the dichotomy has been critiqued as artificial (Holmes, 2009). The various phases of a crisis—acute response, early recovery, rehabilitation, reconstruction, and development—are not sharply distinct but merge with and overlap with one another. In complex emergencies and protracted settings, conflict may erupt sporadically and the situation may regress to an earlier phase. Relief agencies increasingly recognise the need to link with development agencies and to integrate development principles into their work, yet holistic, integrated approaches are rare and, if present, often require further strengthening.

Life-saving services that are essential for human survival have been defined to include food, shelter, health care, protection/security, and water and sanitation (Toole & Waldman, 1990). States are responsible for ensuring that their inhabitants have access to these critical services; many crises are managed by the country’s government. However, international assistance may be requested when a State’s capacity to effectively respond is overwhelmed.

Humanitarian “actors” include UN agencies, local and international nongovernmental organisations (INGOs), government institutions, the International Committee of the Red Cross (ICRC), and other organisations responding to an emergency. Although all seek to alleviate suffering of those affected, mandates, principles, and modes of operation vary.

The field of international humanitarian assistance is relatively young. It continues to develop and significant efforts are being made to increase its quality, efficacy, and impact, despite

political, financial, and other barriers. A history of humanitarian response is traced in Chapter 3.

1.1.2 Minimum Initial Service Package (MISP) for Reproductive Health

The UN and its member states define RH as:

> "[A] state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so" (UN, 1994b).

Comprehensive RH care includes family planning services, maternal and newborn health care, comprehensive abortion care, services for HIV and other sexually transmitted infections (STIs), clinical care for survivors of gender-based violence, care for reproductive cancers, and other gynaecological care (IAWG, 2010c).[1]

The MISP is the minimum standard in RH service delivery in emergency settings. In 1995 the MISP was developed by the Inter-agency Working Group on Reproductive Health in Crisis Situations (IAWG),[2] a group of approximately 40 UN, academic, governmental, and nongovernmental organisations that came together to address and advance RH in emergencies. Recognising that elements of comprehensive RH care, such as cancer screening, were not feasible or appropriate to implement at the beginning of a crisis, the group identified priority, life-saving interventions that compromise the MISP. IAWG proceeded to draft the first field manual on this issue in which the MISP as well as comprehensive RH services were outlined, *Reproductive Health in Refugee Situations: An Inter-agency Field Manual* (1999).

[1] Comprehensive reproductive health includes sexual health, or health related to sexuality rather than reproduction. For brevity, this thesis uses the term "reproductive health" and RH rather than "sexual and are reproductive health" and SRH.
[2] Formerly the Inter-agency Working Group on Reproductive Health in Refugee Situations

The MISP has five key objectives:

- Identifying a lead RH organisation to facilitate implementation of the MISP;
- Preventing sexual violence and providing appropriate assistance to survivors;
- Reducing the transmission of HIV;
- Preventing maternal and newborn death and disability; and
- Planning for the provision of comprehensive RH services, integrated into primary health care.

The IAWG field manual was revised in 2010 to include four additional life-saving activities: 1) the syndromic treatment of STIs, 2) provision of contraceptives, 3) provision of anti-retrovirals (ARVs) for existing users, and 4) provision of menstrual hygiene supplies (IAWG, 2010c). These additions to the MISP are being field-tested at the time of writing.

The MISP, like all humanitarian health interventions, is designed to minimise death, disability, and illness among communities affected by crises. Given the myriad of RH vulnerabilities faced by displaced women and girls, the MISP is particularly relevant for them. The MISP is an international standard that should be systematically implemented in conjunction with other life-saving interventions at the onset of a crisis response. Comprehensive RH services should be built on the MISP as soon as is feasible (WHO, UNFPA, & Escuela Andaluza de Salud Pública, 2009).

Women, men, youth, and children suffer serious consequences when the services of the MISP are not accessible. Sexual violence, obstetric and newborn fatalities, HIV transmission, unwanted pregnancies, and unsafe abortions are potential consequences of neglecting these services (IAWG, 2010c).

Although humanitarian guidance often emphasises inter-agency coordination, coordination is not usually explicitly included as a minimum standard. The MISP is uncommon in that it includes coordination as a key objective along with associated outputs and indicators. It also includes planning for future services as a core activity. This sets it apart from other traditional minimum standards, such as health, water, and sanitation, which focus exclusively on service implementation rather than coordination and planning.

Through IAWG's advocacy, the MISP was included as a standard in the 2004 revision of the *Sphere Humanitarian Charter and Minimum Standards in Disaster Response* for humanitarian assistance providers (Sphere Project, 2004). IAWG also successfully advocated for the MISP to be included as a life-saving criterion for Central Emergency Response Fund (CERF)[3] funding and as a minimum health standard in the Inter-Agency Standing Committee (IASC)[4] *Global Health Cluster Guide* (CERF, 2007; WHO, 2009a).

Nonetheless, despite increased awareness of the MISP and its integration into key international policies and guidance, systematic implementation in the field has yet to be fully realised (Onyango, Hixson, & McNally, 2013). Further, meaningful accountability systems to ensure access to RH services are limited within the international humanitarian architecture. This concern with inadequate MISP implementation spurred me to study these issues more deeply. The background and evolution of RH in emergencies along with the broader context of humanitarian response is discussed in Chapter 3.

1.1.3 Humanitarian accountability

Accountability in the field of humanitarian response has received increased attention in the last decade, and a number of initiatives promoting mechanisms and scholarship have been established (ALNAP, 2005; Buchanan-Smith, 2002; Davis, 2007; Featherstone, 2013; Gross Stein, 2009; Grünewald, Pirotte, & de Geoffrey, 2001; HAP, 2001, 2008a, 2008b; HAP, People in Aid, & Sphere Project, 2013; Lattu, 2008; Raynard, 2000; Steets et al., 2010; Zarnegar Deloffre, 2010; among others). Despite considerable progress in clarifying the concepts and practice of both accountability and RH in humanitarian assistance, conceptualisation of the interface of these fields and associated linkages and innovations has been limited.

Further, although accountability processes have increased in the humanitarian sector, their effectiveness remains ambiguous. Humanitarian accountability processes have historically focused on formal aspects, such as the development of minimum standards and reporting

[3] CERF is a pre-existing fund managed by the UN and includes windows for rapid response and under-funded emergencies. CERF funding is only disbursed to UN agencies, although these agencies often sub-grant to implementing partners, including international and national NGOs.
[4] The IASC is the highest level humanitarian coordinating body and includes UN and non-UN partners.

mechanisms for technical interventions as well as identifying responsibility for implementing these standards and guidelines. However, a number of scholars and practitioners have criticised humanitarian accountability mechanisms for their overly formal and technocratic emphasis. They suggest that this approach prioritises bureaucratic "box-checking" over meaningful impact, ultimately undermining humanitarian objectives (cf. Davis, 2007; Dempsey, 2007; Ebrahim, 2005; Everett & Friesen, 2010; Grünewald et al., 2001; Hilhorst, 2002; Ramalingam & Barnett, 2010; Tong, 2004).

Calls for a more expansive definition of humanitarian accountability, beyond technical standards for service delivery, have increased (cf. Crack, 2013; Featherstone, 2013; Grünewald et al., 2001; HAP, 2013; Hoffstaedter & Roche, 2011; Schmitz, Raggo, & Bruno-van Vijfeijken, 2012; Terry, 2002; Tong, 2004). One notion that has begun to be explored, mostly outside of the humanitarian field and which forms a major focus of the research presented here, is the notion of *socialising accountability.* This is discussed extensively in Chapter 7.

Briefly, socialising accountability refers to informal, inter-personal relationships in which individuals hold each other accountable through social means. Accountability scholar John Roberts (2001) defines socialising accountability in the context of interdependence between self and others, in which relationships are seen in both instrumental and moral terms (p. 1554). It is an ongoing, interpersonal process grounded in dialogue and authenticity. This is distinct from formal, technical, and hierarchical accountability, often manifest through contracts, compliance with standards, and specified mandates.

Socialising accountability has, however, only been superficially referenced in regard to the humanitarian field (Featherstone, 2010; HAP, 2013; Hilhorst, 2002; Lloyd, Warren, & Hammer, 2008; Ramalingam & Barnett, 2010; Steets et al., 2010; Stobbaerts & de Torrenté, 2008). Indeed, it is generally a marginalised area within the broader literature on accountability. Some writers have suggested that socialising accountability processes may be more effective for non-profit, inter-agency coordination and service delivery than formal accountability mechanisms (Romzek, LeRoux, & Blackmar, 2012, p. 442). Hodge & Coghill (2007) argue that, in privatised systems, socialising accountability and accountability to personal ethics form the basis upon which formal accountability mechanisms are built. As such, socialising accountability deserves further exploration within the humanitarian

context. Chapter 7 reviews the literature on humanitarian action and accountability, including socialising accountability, in considerably more depth.

1.2 Introduction to research

This research examines MISP implementation and the role of socialising accountability in two complex emergencies: Myanmar[5] after Cyclone Nargis in May 2008 and Haiti after the earthquake in January 2010. The study seeks to answer three research questions through successive and deepening phases of inquiry:

- Phase I: How was the MISP implemented and what were the key enablers and barriers to MISP implementation during the crisis responses in Myanmar (2008) and Haiti (2010)?
- Phase II: How did socialising accountability manifest in these two settings and what was its impact on the RH responses?
- Phase III: What is the value of the concept of, and practical support for, socialising and personal accountabilities in advancing RH implementation in humanitarian emergencies? In what ways can they be strengthened?

When I commenced this study, my research concentrated solely on identifying the underlying barriers and enablers to MISP implementation in two emergencies; accountability was not a primary focus. However, during Phase I data gathering in Haiti, the need to address accountability in relation to MISP implementation was identified. This arose because the RH response to the January 2010 earthquake was, at the time, the most robust to date in terms of funding and the number of humanitarian agencies focused on RH implementation. Compared to previous international humanitarian actions, considerable progress in RH implementation was evident.

Yet disturbing and significant gaps remained and the lack of accountability for this was apparent. In particular, the widespread rape and sexual exploitation that occurred in the

[5] The original draft of this thesis used the term “Burma” instead of “Myanmar”. However, informants from Myanmar, particularly refugees, preferred the term Myanmar as they felt it was more inclusive. They stated that Burma implied the country belongs to the Burmese, the majority ethnic group, and excludes minority groups, such as the Chin, Shan, and Rohingyas, who make up the majority of the displaced.

months after the disaster and the lack of basic protection mechanisms, such as lighting for latrines, was unacceptable (Institute for Justice & Democracy in Haiti & MADRE, 2010; Krause et al., 2011; Stedman, 2011). In focus group discussions (FGDs) for this research, displaced adolescent girls reported that sexual abuse and exploitation were commonplace. Girls said that they or their peers had sex with other community members, soldiers, and aid workers in exchange for basic goods and services. I witnessed first-hand Western UN Peacekeepers "partying" with young Haitian women at my hotel. Some of the women appeared under 18, although this was not substantiated. Although I did not observe overt sexual exploitation, the situation appeared problematic given the vulnerabilities of Haitian women, the relative power of the Peacekeepers, and a history of Peacekeeper abuse in Haiti including transactional sex with underage girls (Bri Kouri Nouvèl Gaye, Mennonite Central Committee Haiti, Let Haiti Live, & UnityAyiti, 2011). Peacekeepers are explicitly forbidden to engage in abuse of power, including sexual exploitation and transactional sex (UN, 1999; UN Secretary General, 2003). In fact, since the earthquake, the UN has documented 30 allegations of sexual abuse and misconduct by UN Peacekeeping forces, including a high profile gang rape (Center for Economic and Policy Research, 2013; UN Conduct and Discipline Unit, 2014).

Effective reporting mechanisms for this type of abuse were seemingly not in place at the time; if they were, it was unknown to both the researcher and the members of the affected communities interviewed. These human rights violations occurred despite the significant attention and funding that has poured into addressing sexual abuse and exploitation in crisis settings over the past decade (UN, 2010). Indeed, the MISP was developed to ensure that these protection processes, as well as life-saving health services, are in place.

Other worrying practices were found, such as a group of local obstetricians who tried to repair the maternity ward of the main referral hospital in Port-au-Prince only to be forced to abandon their efforts by foreign government officials who claimed the ward for trauma patients only.[6] Sixty-three thousand women were pregnant in Port-au-Prince and the surrounding areas at the time of the earthquake with almost 10,000 in need of life-saving emergency obstetric care (RHRC, 2010). Women gave birth on the streets or in make-shift camps and many lost their lives. Health professionals who were aware that the

[6] The informant who shared this information did not disclose the names or agencies of the officials involved.

rehabilitation of the main maternity ward was being blocked did not know where to turn as the health sector was overwhelmed with other needs. This highlighted the importance of exploring how humanitarian aid providers can be held meaningfully accountable in the midst of a crisis, rather than holding them to account at a later date, in order to ensure the life-saving services of the MISP are implemented in real time.

In Myanmar formal accountability mechanisms were similarly lacking. Neither protection measures nor medical care for survivors of sexual violence was in place. The health sector did not prioritise addressing RH, and some health officials actively dismissed it. However, the role of socialising accountability emerged as a key enabler for the RH services that were put in place. Reproductive health professionals coordinated in an impressive display of trust, openness, collaboration, constructive criticism, and cohesion. Informal, inter-personal relationships as well as personal commitment to RH enabled more coordinated and comprehensive implementation of the MISP.

Socialising accountability as well as related factors including effective leadership and pre-existing relationships were identified as key enablers to MISP implementation in Myanmar. Lack of formal accountability processes, among additional factors such as inter-agency competition and exclusion of local organisations, were found to be primary barriers in Haiti. The experiences led me to develop a second phase in which I explored socialising accountability further in these two settings and probed what impact, if any, it had on the respective RH responses. In Haiti socialising accountability was not evident in Phase I data collection. However, upon further investigation in Phase II, I was surprised to find that socialising accountability did indeed manifest, albeit differently, in Myanmar. Phase II findings also revealed accountability to personal ethics as a key enabler in both settings.

As a result, I sought to more deeply explore if socialising and personal accountabilities had merit beyond these two crises. I questioned whether humanitarian experts considered these forms of accountability valuable to advance MISP implementation. Thus a third and final phase of inquiry was constructed. Tensions, gaps, manifestations, strengths, and weaknesses related to socialising and personal accountabilities in humanitarian settings were explored through interviews with key professionals working on health and RH in emergencies. This component extended from understanding the events and interactions

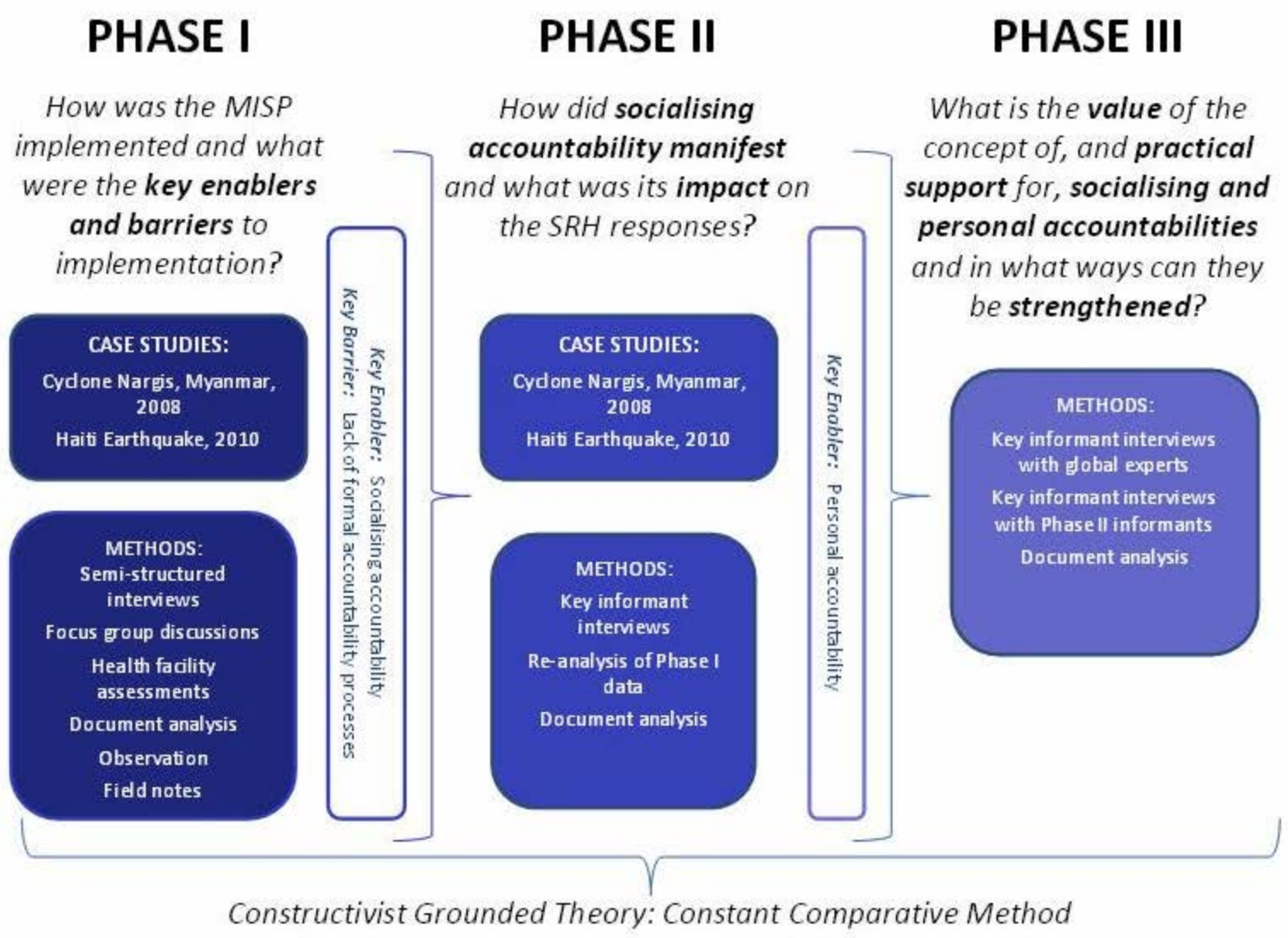
that took place in Myanmar and Haiti to examine the potential to build on the concepts of socialising and personal accountabilities into the future.

The study applies a constructivist grounded approach to case study data. That is, theorising or understanding is inductively created from exploring cases. An inductive approach for this study is helpful as there is a dearth of literature on socialising accountability in humanitarian response generally, and none to date on its relationship with RH. Using an inductive strategy with case studies supports flexibility and is a useful framework through which to answer “how” and “why” questions in under-researched areas (Edmondson & McManus, 2007). The constant comparative method, a fundamental constructivist grounded theory data analysis tool, was utilised; this involved continuous gathering, analysing, reviewing and comparing data immediately after collection (Urquhart, 2001). The constant comparative method enabled deeper engagement and analysis of the data and helped identify subtle, emergent aspects.

Constructivist grounded theory stresses a dynamic and flexible inquiry process in which theorising changes and evolves over time. The research uses this methodological approach through a series of iterative loops in the study. Compelling new data emerged from each loop, which in turn led me to examine these issues in more depth and construct the next phase to elaborate answers to emerging questions. The research unfolded in an organic fashion and is presented here in terms of the three iterative phases of framing the questions, collecting the data, and analysing the results (Figure 1.1).

Across the three phases, a total of 98 semi-structured and key informant interviews were held with humanitarian aid workers representing 47 different organisations, including international and national NGOs, UN agencies, government ministries, community-based organisations, and donors. Fifteen FGDs were conducted with 349 displaced persons, including women, men, and youth, in accordance with the *International ethical guidelines for biomedical research involving human subjects* (CIOMS & WHO, 2002). In addition, 11 medical facilities were evaluated to assess their RH service provision using tools developed by IAWG (IAWG, 2010a). Document analysis, field observation, and reflexive journaling were also undertaken.

Figure 1.1: Overview of thesis



At the broadest level, the study aims to contribute to advancing the health and well-being of people affected by crises. Sexual and reproductive health is part of the most intimate and vulnerable dimension to being human. Physically, one's sex organs, breasts and mouth are sensitive and private parts of the body. Emotionally, consensual sexual acts, sexual violence, contracting or transmitting an STI including HIV, giving birth, and experiencing a miscarriage or abortion are intense and intimate emotional experiences. When the RH parts of a person are sick, hurt, violated, or neglected, the consequences often extend beyond the physical and have mental health and social ramifications.

This thesis is, to the knowledge of the researcher, the first in-depth study on socialising accountability and RH in humanitarian settings. Although accountability in humanitarian emergencies has received increased attention (as discussed in Chapter 7 that follows), research in this specific area is limited. This study therefore contributes both empirical insights and observations as well as deepening theory and practice. It identifies some of the factors that lead to successful implementation of RH services in an emergency and the mechanisms through which to hold humanitarian providers accountable for this implementation. In addition, it proposes more nuanced conceptualisation of humanitarian accountability in which accountability emerges from diverse informal, formal, and personal elements working together in an ongoing, dynamic process. Understanding and engaging with this complex, emergent system and its various components encourages the advancement of RH services as well as the augmentation of humanitarian accountability processes, including those which operate through informal channels.

The findings from this study complement the work of RH groups such as the IAWG as well as humanitarian accountability initiatives such as the Active Learning Network for Accountability and Performance in Humanitarian Action (ALNAP).

The thesis is structured in ten chapters. The first introduces the research and provides key background information. Chapter 2 outlines the methodological approach of constructivist grounded theory as applied to the two case studies and presents the methods used for data gathering. The third chapter provides background to the evolution and current state of RH in emergencies. Chapters 4 through 6 constitute Phase I of the research. Chapters 4 and 5 explore MISP implementation in the two case studies, using seven areas of analysis. Chapter 6 synthesises these findings and draws out key barriers, enablers, and emerging

themes. Chapters 7 and 8 constitute Phase II, with Chapter 7 bridging Phase I to Phase II through reviewing the literature on accountability in humanitarian settings and introducing the concept of socialising accountability. Chapter 8 examines the manifestations of socialising accountability in Myanmar and Haiti. Chapter 9 makes up Phase III and explores insights from key experts in the fields of emergency response and RH on the potential value of socialising and personal accountabilities in humanitarian assistance. Chapter 10 discusses and analyses the findings from all three phases, ties them into the broader literature, and discusses the relevance and significance of what has been learned.

1.3 Role of the researcher

In any qualitative research study, but particularly when employing a constructivist approach, it is important to make explicit the researcher's background and experiences as these invariably influence the research itself, both in terms of the questions framed and the approach to answering them.

I was born and raised in Germany and later went to university in the U.S.A. where I studied sociology at New College, a public honours college in Florida. My undergraduate thesis, which included five months of field research and an oral defence, focused on the gendered division of labour on a kibbutz in Israel; it was awarded the college's Social Science Research Award. As my sociology training was heavily influenced by critical theory, I used a feminist socialist approach to understand and interpret my findings. Indeed, my early interest in Marxism prompted my decision to take leave from my university and focus on carpentry. French postmodernists, such as Michel Foucault, Gilles Deleuze, and Félix Guattari as well as gender theorists such as Judith Butler and Bell Hooks, influenced my thinking and the development of my *Weltanschauung* or worldview. In graduate school at Columbia University in New York, I concentrated in human rights and health while my interest in marginalised groups, particularly women and girls, continued to grow. At the same time, my attachment to historical materialism, post-structuralism, and feminist theory waned. I became less interested in theory and more interested in the practical realities of addressing people's most fundamental needs and rights, particularly in regards to health.

In 2003, while still in graduate school, I secured an internship with the Women's Refugee Commission's Reproductive Health Programme. The Women's Refugee Commission[7] is a research and advocacy organisation; it acts as a "humanitarian watchdog" by monitoring and assessing humanitarian responses to communities' needs with a particular focus on women and girls. It was through this internship that my interest in RH in emergencies solidified and deepened. I soon became employed as a staff member and worked with the Women's Refugee Commission from 2003 until 2009, leaving for one year in 2004 to co-found Circle of Health International (COHI), an NGO working on RH in resource poor settings.

In early 2009 I left the Women's Refugee Commission to oversee the Sexual and Reproductive Health Programme in Crisis and Post-Crisis Situations (SPRINT Initiative), an RH capacity building initiative housed with the International Planned Parenthood Federation (IPPF) covering their East, South East Asia and Oceania Region (Beek et al., 2013). I enrolled in University of New South Wales' (UNSW) PhD programme in 2009 and, after struggling to manage both work and research, decided to leave my position in 2011 to focus full-time on my PhD. Unfortunately, from 2011 to 2013 I grappled with challenging health issues and needed to take 1.5 years of medical leave, which impeded progress on my research. Most recently I have worked as a consultant for IAWG, synthesising the findings from the 2012-2014 Global Evaluation on RH in crises (Casey, Chynoweth, Cornier, Gallagher, & Wheeler, in press; Chynoweth, in press).

My engagement with the field of RH in emergencies has evolved over the past ten years. My early interest in gender and human rights brought me to the field in the first place. In the early 2000s, RH was still considered a secondary concern in humanitarian response with primarily a small group of people in IAWG pushing the agenda forward. Through assessments in humanitarian emergencies throughout the world, we identified key barriers to implementation: the lack of integration of the MISP into important policies and guidelines as well as a dearth of practical guidance on how to implement RH services during a crisis. As a result, with IAWG partners, I focused on global advocacy to integrate the MISP into critical policies and protocols such as the Sphere standards and the life-saving criteria of

[7] Formerly known as the Women's Commission for Refugee Women and Children; see http://womensrefugeecommission.org/about for more information.

the CERF, a global humanitarian fund established by the UN in 2005. I also worked on developing technical guides for humanitarian workers related to various aspects of RH, including HIV, STIs, emergency contraception, and the MISP.

Despite these advances, our assessments identified another layer of barriers: the dearth of qualified staff to coordinate and implement the MISP as well the lack of attention to development of national capacity. I was interested in addressing these issues and was hired to oversee the SPRINT Initiative in the Asia Pacific region, the first undertaking to systematically build capacity of national health staff to coordinate and implement the MISP. I guided training, advocacy, and MISP implementation for health actors in 28 countries in the region.

Again, further progress was made in advancing RH in emergencies. Yet despite the extensive work on advocacy, standard-setting, guideline development, national capacity building, and awareness-raising, MISP implementation remained sporadic, putting the lives and well-being of crisis-affected communities at risk. This brought me to the next significant gap in the field that I think needs addressing: how to hold humanitarian actors meaningfully accountable for implementing RH services in a crisis, which is the focus of my current research. My professional trajectory parallels the structure of this study in which new gaps in MISP implementation are identified and the next phase is constructed to address the issue on a deeper level.

It is important to make visible my role as both an “insider” and “outsider” within this research. “Insider” refers to researchers who are members of the group or population which they are studying (Kanuha, 2000). In my case I have been intimately involved with the humanitarian agencies seeking to address the needs of women and girls in emergencies. Identity, language, and core experiences are shared with many of the research informants (Asselin, 2003); thus the insider role can foster more rapid and deeper acceptance by the research participants (Dwyer & Buckle, 2009). “Outsider”, on the other hand, designates that the researcher does not belong to the population or group being studied. This can be beneficial in that the researcher is perceived as being “neutral” and having a greater objectivity (Fonow & Cook, 1991; Mullings, 1999). Other scholars have noted that these binary notions of insider/outsider are too simplistic and do not reflect the fluidity and

complexity of an ultimately dialectical approach (Dwyer & Buckle, 2009; Mullings, 1999; Ritchie, Zwi, Blignault, Bunde-Birouste, & Silove, 2009).

Recognising the limitations of this dichotomy, I believe it is still important to elaborate my position in terms of the "insider" and "outsider" conceptualisation as this provides insights into my research lens. I am an insider in the sense that I have been working professionally in the field of RH in emergencies for more than a decade and contributed to the field on a number of levels. In many ways, it is through my status as an insider that I gained respect and have been able to establish rapport with many leaders in this field, which in turn has allowed me to access data for my research. Indeed, using Haiti as a case study was possible because of my professional connections and insider status that allowed me to participate in an inter-agency assessment and gain access to this setting. I am, however, also an outsider by not being affected by a humanitarian crisis or being responsible, at the present time, for the delivery of services or programmes. As a researcher, I am one step removed and seek to critically reflect on, and contribute to, the development of the field.

1.4 Summary

Through three iterative phases, this research provides an in-depth examination of MISP implementation after the 2008 Cyclone Nargis in Myanmar and the 2010 earthquake in Haiti. It identifies barriers and enablers to implementation and tries to make sense of the ways in which socialising accountability was enacted by the actors working to implement RH services in these two crises. It further considers the value of socialising accountability in advancing RH in humanitarian settings and weighs the input of leaders in this field. Its unique contribution to the field is timely in that accountability is presently a salient issue on the humanitarian agenda and new ways of holding relief providers accountable are being actively discussed. The following chapter introduces the methodological approach of this study and the methods used for gathering, interpreting, and analysing data.

2. Chapter Two: Methodology and methods

2.1 Introduction

This research is primarily qualitative in approach, allowing insight and nuanced understanding of the phenomena under study. Various categories of qualitative research have been identified by different scholars (Bassey, 1999; Creswell, 1994; Patton, 1990; Stake, 1995, among others). Merriam (1988) articulated five types of qualitative research: basic or generic qualitative study, phenomenology, grounded theory, ethnography, and case study. The five different research types can be distinguished by disciplinary orientation, function and form, but also can be used in conjunction with one another (p. 20). This research employs a combined approach of constructivist grounded theory and case study. Situating the research within these combined methodologies helped maximise understanding of the phenomena studied. After discussing the study's methodological underpinnings, the methods, analysis, validity, evaluative criteria, and ethical considerations are explored.

2.2 Methodology

2.2.1 Case study

The goal of a case study is to gain in-depth understanding of a situation or phenomenon within its own context (Stake, 1995; Yin, 2003). The case study approach allows the observation of data at a micro level, as opposed to quantitative methods, which often explore patterns in data at a macro level (Zainal, 2007). Case study research goes beyond evaluation and seeks to generate knowledge and holistic understanding, through systematic, critical inquiry, of a specific phenomenon (Simons, 2009). Yin (1994) has noted that the case study approach is particularly relevant when the lines between the situation or phenomenon and its context are blurred; that is, when it is difficult to separate the elements of the phenomenon being studied from its broader influences or context.

Case studies are flexible in their approach in that they use multiple data sources including quantitative data, FGDs, interviews, observation, and historical records, among others. It enables exploration and reflection of actions and constraints, and can promote problem-solving in a collaborative and supportive fashion. An important aspect to case study research is the bounded nature of the object of investigation (Stake, 1994, 1995; Yin, 1994). Distinguishing the conceptual parameters of the case has been identified by leading researchers as essential to case study methodology (Laws & McLeod, 2004; Merriam, 1988; Miles & Huberman, 1994; Stake, 1995; Yin, 1994). The data collection with respect to a case must be finite and limited. For example, identifying limits such as spatial, temporal, and contextual boundaries is important to understanding the case (Hyett, Kenny, & Virginia Dickson-Swift, 2014). Lack of clear parameters can result in inadequate data collection that undermines understanding of the phenomenon under study (Hyett et al., 2014).

Different types of case study methods have been elaborated (cf. Bassey, 1999; Merriam, 1988; Stake, 1994, 1995; Yin, 1994). Three categories as identified by Yin (1994) are often cited: descriptive, exploratory, and explanatory. Descriptive case studies offer in-depth, detailed description of the phenomenon being studied and are often useful in areas where little earlier research has been undertaken. Exploratory case studies are employed to generate questions, explanations, or hypotheses in fields with little theoretical knowledge (Siggelkow, 2007). Explanatory case studies examine data in an effort to answer “how” and “why” questions about the particular phenomenon and try to establish a cause and effect relationship (Yin, 2003).

As with any methodology, employing a case study approach has advantages and disadvantages. One advantage is the examination of the phenomenon within its specific context, rather than isolating the unit of study, which is the deliberate strategy of an experiment (Zainal, 2007). This contextual approach can provide rich and more textured understanding of the situation being studied and highlights the complexity of real life. Case study research often supports innovation and creative problem-solving, particularly in complex situations (Cohen, Manion, & Morrison, 2000). As the data are based in “real life”, the findings from a case study may be more persuasive as they tend to be accessible and relatable to people’s experiences (Cohen et al., 2000).

A primary criticism of the case study approach is that it provides limited basis for generalisation, particularly when juxtaposed with quantitative research, since it uses a comparatively small number of cases that are studied in great depth. Although strategies such as triangulation and cross-case analysis can be used to increase validity, case study research does not have (or aim for) the statistical significance of quantitative methods (Siggelkow, 2007).

Further, case study research has been described as being susceptible to lack of rigour, which can allow the bias of the researcher to influence or distort the findings (Yin, 1994). Finally, case studies are challenging. They generate a wealth of data, which can be difficult to manage and organise systematically in order to analyse effectively and rigorously (Yin, 1994).

Poorly conducted case studies may indeed be weak. I argue that those presented here offer in-depth analyses not readily available through other approaches. In addition, having identified the documented weaknesses of case studies, I have undertaken to enhance rigor and validity where possible by using guidance and evaluative criteria outlined in section 2.5.

2.2.2 Constructivist grounded theory

Grounded theory is a methodological approach that generates theory about people's behaviour and the meaning in their lives (Glaser & Strauss, 1967). Grounded theory was developed by sociologists Barney Glaser and Anselm Strauss and introduced in their seminal work, *The Discovery of Grounded Theory* (1967). Its approach has been labelled as inductive in nature in that it is derived from the data itself, rather than from pre-established theory (Morse, 2001). As such, the approach involves a process that starts with data collection and then moves to broader theory. Analysis and theory development are, in a sense, "grounded" in everyday life (Byrne, 2001, p. 1155); experiences and insights are documented and then analysed. This is in contrast with theory derived from logic alone, which may be based on "ungrounded" assumptions (Glaser & Strauss, 1967, p. 4). The approach of grounded theory marks a significant departure from conventional scientific methods and traditional social science research methodologies in which the researcher first identifies a theoretical framework through which to understand the object of study.

Two key ideas form the basis of grounded theory:1) the researcher must abandon pre-established theories or hypotheses and 2) “constant comparison” of the data is essential, forming the key method for this approach (Urquhart, 2001). The former does not require the researcher to be without beliefs or bias, as this is inherently unattainable. Instead, it necessitates that the study is not situated around a theory that the research aims to prove or disprove (Fernandez, 2005). The latter idea reflects the constant comparative method, which involves a continuous process of gathering, analysing, reviewing, and comparing data that commences immediately after collection. Categories and themes of the data are constantly identified, tested, and refined.

Grounded theory has evolved since its development in the 1960s, with various permutations articulated by different scholars. Constructivist grounded theory was developed by Kathy Charmaz, a former student of Glaser and Strauss. It stresses the interaction between the researcher and the research participants, taking into account their respective opinions, positions, and interests (Bryant & Charmaz, 2007). Indeed, Charmaz (1995) argues that this interaction “*produces* the data, and therefore the meanings that the researcher observes and defines” (p. 35, emphasis in the original). According to this approach, data and theory are not discovered, but co-created by those involved in the research process. Although the ontological and epistemological underpinnings of classic grounded theorists have never been clearly or definitively articulated, positivistic undercurrents have been identified, pointing to contradictory underlying assumptions of the existence of a “real” external reality (Mills, Bonner, & Francis, 2006). Charmaz’s approach lays this to rest by explicitly outlining a constructivist approach that rejects ideas of objectivity.

In constructivist grounded theory, the researcher, informants, data collection process, and context are all taken into account in the construction (or more accurately, “co-construction”) of knowledge (Charmaz, 2008). This is in contrast to the researcher’s “distant expert” role for which classic grounded theory has been criticised (Charmaz, 2000, p. 513). Indeed, constructivist grounded theory seeks to minimise the gap between the researcher and object of study and “to the extent possible, *enter* the studied phenomenon and view it from the inside” (Charmaz, 2008, p. 133, emphasis in the original).

Value is placed on ensuring that informants' perspectives are made visible in the final analysis to ensure fidelity to their experiences and voices (Mills et al., 2006). As opposed to earlier permutations of grounded theory, the constructivist approach does not seek generalities, but instead aims for contextualised knowledge and multi-layered understanding, embracing incongruities and differences rather than disregarding them (Charmaz, 2008). It situates the inquiry process within broader socio-political, cultural, and historical contexts and meanings (Charmaz, 2008).

The strengths of constructivist grounded theory include its reflexive and dynamic approach, which helps make explicit the numerous variables that influence knowledge construction, including the role of the researcher herself. It supports flexibility and inclusiveness in its methods to the extent that anything that is relevant to the study can be used as data. It also addresses some of the tensions in classic grounded theory by taking a clear epistemological position.

Weaknesses in this revised approach still remain, including debate around the approach and purpose of undertaking a literature review prior to a research project. In the original literature on grounded theory, authors argued against conducting a literature review prior to data collection in order to avoid being unduly influenced by existing theory and to maintain an open, fresh mind without preconceived ideas or orientations (Glaser and Strauss, 1967). Some key thinkers in this field have deviated from this position, including Strauss, one of the pioneers of grounded theory, and have advocated reviewing the literature at the beginning of the research study prior to the commencement of data collection (Dunne, 2010). Yet many grounded theorists, including Charmaz (2006), have maintained the original approach of postponing the literature review until a later point—during and after data collection—to ensure the researcher is able to develop her own unique ideas.

The approach has been criticised as risking the duplication of existing research; scholars have also argued that literature reviews are useful as they can stimulate questions, orient the researcher, and raise awareness of possible pitfalls in methodology (Chiovitti & Piran, 2003; Maijala, Paavilainen, & Astedt-Kurki, 2003; McGhee, Marland, & Atkinson, 2007; Urquhart, 2007). Without undertaking a literature review, the researcher leaves herself open to criticism (Dunne, 2010). Further, delaying the literature review is unrealistic for many researchers and PhD students, since funding, ethics reviews, and the basic structure of the

doctoral process are often contingent on developing a robust understanding and exploration of the literature as an initial step (Dunne, 2010).

A more serious critique of grounded theory is the lack of clarity and ambiguity in its stated goal of theory generation. The term “theory” has a wide variety of meanings and can refer to “systems of evolving explanation, personal reflection, orienting principle, epistemological presupposition, developed argument, craft knowledge, and more” (Thomas & James, 2006, p. 771). Thomas and James (2006) have heavily criticised the conceptualisation of theory in grounded theory methodology. They suggest that it conflates the process of inquiry used in the traditional scientific definition of theory, which entails developing and testing hypotheses to explain an event or pattern in the natural world, with qualitative approaches, which seek to provide understanding about an aspect of the world. According to them, the generalisations, explanations, and understandings derived from grounded theory are presented in ways that echo scientific theory production and, as a result, may overgeneralise the theoretical findings in ways that are out of scope for social science research.

Charmaz (2006) tries to address this in her usage of the term “theorising” rather than “theory”. According to her definition, theorising seeks to produce nuanced understanding, rather than explanation, of the object of study. She stresses the interpretive nature of theorising, which she sees as a practice rather than a goal. The researcher engages in theorising by “*seeing* possibilities, *establishing* connections. and *asking* questions” (Charmaz, 2006, p. 135, emphasis in the original). As a process, theorising changes and evolves over time, of which the researcher is reflexively aware. In acknowledging Charmaz’s refinement and thinking around theory construction, Thomas and James (2006) subsequently question her decision to situate her constructivist approach within grounded theory at all, given what they see as inherent tensions in its use of “theory”. In sum, scholars continue to grapple with the definition of theory generation in the grounded theory methodology, giving birth to new thinking, questions, and insights, which is at the heart of critical inquiry and scholarly research.

2.2.3 A combined approach: Case study and constructivist grounded theory

This research merges case study and constructivist grounded theory. Some scholars have advocated combining these two methodological approaches, while others have emphasised caution to ensure that the principles of case study method do not retard or warp theory generation (Glaser, 1998). Indeed, some aspects of each approach contradict one another. Perhaps the most fundamental example of this is in regards to the development of theory, which is undertaken before data collection in case study method (Yin, 1994), whereas constructivist grounded theory abstains from theory development at the beginning of a study. Other inconsistencies exist, such as their respective stances on when to undertake a literature review.

While it is apparent that such tensions are present, I argue they can be navigated. The combination of the two approaches has been largely accepted and even been used in what some scholars have labelled as among the "most interesting" and well-cited studies (Bartunek, Rynes, & Ireland, 2006; Eisenhardt & Graebner, 2007). For example, papers that merge these approaches were among the most highly cited articles in the Academy of Management Journal, a leading journal in management scholarship for more than fifty years; the journal's Best Article Award was bestowed to a study that employed this method (Eisenhardt & Graebner, 2007, p. 25).

The idea of theory-building case studies has been developed in the last ten years, with Kathleen Eisenhardt advancing thinking on this approach (Eisenhardt, 1989; Eisenhardt & Graebner, 2007). Eisenhardt (1989) outlined the first "roadmap" for the inductive case study approach, which clearly lays out the essential steps for the researcher, including how to get started, select cases, analyse data, and shape hypotheses (p. 533). However, Eisenhardt's approach is not strongly embedded within grounded theory generally nor constructive grounded theory specifically. Although she adopts an inductive strategy, Eisenhardt and Graebner (2007) caution against situating the theory-building case study approach within a grounded theory framework. They argue that traditional grounded theory can be confusing in that "theory" is not well defined and generalisability is limited.

Further, Eisenhardt's approach is not strongly constructivist and focuses on replication logic: "each case serves as a distinct experiment that stands on its own as an analytic unit"

(2007, p. 25). Cases are likened to laboratory experiments that are discrete and replicable (p. 25). The approach emphasises an analytic model where the goal is specific theory generation through comparison of different cases, rather than the more subjective and nuanced "theorising" that constructivism supports. Although this study also uses an inductive approach to case studies, it is underpinned by a strong constructivist approach and thus is distinct from Eisenhardt's frame.

In merging these two approaches, it is important to outline the parameters of the methodology and clearly indicate their roles in driving the research process. This study applies an overarching constructivist grounded approach to case study data. Theorising is inductively created from exploring cases. Given the dearth of literature on the intersection of RH, socialising accountability, and humanitarian response, using an inductive strategy with the two case studies helps answer exploratory "how" and "why" questions in this under-researched area.

The combined approach helps to situate each case in its broader context while highlighting the setting's multiple realities and the co-construction of knowledge and meanings. I also developed a hybrid approach to the literature review: I chose to delay the literature review, but only until after the first phase. The issues in Phase I were driven by prior knowledge, theory, and other research; the literature review helped situate emergent issues, specifically socialising accountability, to develop Phase II and Phase III research questions.

2.3 Methods

2.3.1 Overview

Methods are the ways in which a researcher gathers, interacts with, and constructs data (Charmaz, 2006). In the approach for this study, methods are tools to help the researcher see the phenomenon being studied through the participants' perspectives. All methods are applicable using the constructivist grounded theory approach, and data sources are not limited. While in the research setting, what the researcher hears, sees, feels, and senses is potentially useful to inform the understanding of what is happening in that setting. It is important to capture this "soft" data through reflexive memoing and integrate it into the

analysis. At the same time, it is essential to discern what data are useful, relevant, and credible, and what aren't; failing to do so results in unwieldy data.

2.3.2 Parameters of cases

The two case studies in this research are Myanmar after Cyclone Nargis in May 2008 and Haiti after the earthquake in January 2010. These were identified, in part, by their capacity to maximise richness in information gathered. For example, the 2010 Haiti earthquake was chosen as a case study because it was the most robust RH crisis response to date. The Cyclone Nargis RH response was also strong and was predominately led by national actors, which is rare. These yielded a great deal of relevant data. Typhoon Ketsana in the Philippines and the West Sumatra earthquake, both in September 2009, were also under consideration as case studies, but after initial scoping visits, I found the RH responses were limited.

The main criteria for selecting the two case studies included: 1) a crisis (conflict or natural disaster) with extensive population displacement (minimum of 50,000 people displaced); 2) the crisis took place within a specific timeframe: 2008 to 2010; 3) health staff who were trained in RH responded to the crisis; 4) RH trained staff worked to implement the MISP in said crisis; 5) a robust RH response; 6) consent of the organisations and staff involved; and 7) access by the researcher. The timeframe for data collection was six months after the crisis during the acute and early recovery phases.

2.3.3 Phases

For this research, primary methods for data collection included key informant and semi-structured interviews, focus group discussions (FGDs), health facility assessments, observation, field notes, and review of published and grey literature. The informants were predominately health staff from humanitarian and development agencies as well as representatives of the people affected by crises in the two settings. As outlined in Table 2.1 below, across all three phases, 90 semi-structured interviews and 16 key informant interviews were held with 98 unique humanitarian aid staff[8] representing 47 organisations,

[8] Eight informants from Phase I were also interviewed for Phase II.

including 28 INGOs, 11 UN entities, five local NGOs, one government ministry, one donor, and one inter-governmental organisation. Fifteen FGDs were conducted with 349 displaced persons, including women, men, and youth. In addition, 11 medical facilities were evaluated using RH assessment tools developed by IAWG.

Table 2.1: Data collection by method

	Semi-structured interviews	Key informant interviews	Facility assess-ments	Total no. of FGDs	FGD: no. of girls	FGD: no. of women	FGD: no. of boys	FGD: no. of men	Total FGD partic-ipants
Myanmar	49	6	1	1	--	20	--	--	20
Haiti	41	8	10	14	43	191	51	44	329
Global	--	2	--	--	--	--	--	--	--
Total	**90**	**16**	**11**	**43**	**211**	**51**	**44**	**349**	**15**

Three iterative phases of data collection were undertaken. The first explored barriers and enablers to RH implementation and identified socialising accountability[9] as a key enabler. A second phase examined in more detail the role of socialising accountability within the two case studies and identified accountability to personal ethics as an additional critical enabler. The third phase explored the findings with humanitarian experts to assess the potential value and practical application of socialising and personal accountabilities in advancing effective humanitarian action. The following section provides an outlines the methods used in each of the three phases.

Phase I. Phase I sought to answer the research question "How was the MISP implemented and what were the key enablers and barriers to MISP implementation during the crisis responses in the two case studies?" The field research undertaken was extensive since the

[9] As defined earlier, socialising accountability refers to informal, interpersonal norms, behaviours, and sanctions among interdependent actors.

original research design included this question alone. Data collection methods employed were:

- Semi-structured interviews with representatives from UN agencies, government, local and INGOs involved in the RH response using IAWG's *Staff Questionnaire for MISP Assessment* (2010d);
- Focus group discussions with the affected population using IAWG's *Focus Group Discussion Guide for Displaced Communities for MISP Assessment* (2010b);
- Health facility evaluation using IAWG's *Facility Assessment Checklist for MISP Assessment* (2010a);
- Observation of Reproductive Health (RH) Working Group meetings;
- Group discussions on initial findings with key RH actors;
- Field notes;
- Document analysis, including evaluations and reports of the response; relevant (and viable) quantitative data from other research studies.

The IAWG MISP assessment tools were developed by the members of the IAWG Secretariat, including WHO, UNFPA, UNHCR, Women's Refugee Commission, among others, to enhance standardisation of MISP assessments. The tools were originally developed in 2003 and then updated in 2010 to reflect changes in the revised *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings.* The IAWG tools were modified to include additional questions relevant to answering my specific research questions.

Access to the field sites was as a result of my professional connections as well as my position leading IPPF's SPRINT Initiative. I was hosted in each site by a key agency in the RH response: a UN agency (UNFPA) in Myanmar and a national RH organisation (PROFAMIL) in Haiti. As described below, data collection in Haiti was linked to an inter-agency RH assessment by CARE, IPPF, Save the Children, and the Women's Refugee Commission. Although not strategically planned beforehand, the variety of collaborating actors provided me with different perspectives in each response—local organisation, INGOs, and UN agency—which added to the depth of the data collection.

In Myanmar, in-country data collection was conducted from May 9 to 15, 2010. I travelled with the IPPF Regional Director and the IPPF Programme Coordinator to Myanmar to

undertake field research. Semi-structured interviews were held with 49 humanitarian health staff representing 12 organisations; one FGD was held with 20 internally displaced women, and one health facility was assessed.

In Haiti, in-country data collection took place from May 16 to 22, 2010, approximately four months after the earthquake. The research team was led by the Women's Refugee Commission and comprised of the following others:

- Janet Meyers, Senior Advisor for RH and HIV in Emergencies, CARE USA;
- Guerda Benjamin, Gender-based Violence Advisor, CARE Haiti;
- Dr. Ribka Amsalu, Emergency Health Advisor, Save the Children;
- Dr. Yves Thermidore, Deputy Health Advisor, Save the Children;
- Sandra Krause, RH Programme Director, Women's Refugee Commission;
- Lauren Heller, RH Programme Officer, Women's Refugee Commission;
- Mihoko Tanabe, RH Programme Officer, Women's Refugee Commission;
- Five local translators.

The large assessment team helped maximise coverage in a short period. The team split into three groups and focused respectively on Port-au-Prince, Léogâne, and Jacmel. The three settings were among the most affected by the earthquake. Selection criteria for the three settings included minimum of 50,000 people affected, accessibility, urban and rural diversity, and an ongoing humanitarian response. Semi-structured interviews were held with 41 staff representing 22 agencies; 14 FGDs were held with 329 displaced people, and ten health facilities were assessed.

The discrepancy between the number of FGDs held and facilities assessed in the two settings was a result of 1) restrictions placed on field access by Myanmar authorities (described below in section 2.4 on limitations); 2) and the composition of the inter-agency assessment team whose thirteen members were able to cover a broad geographical and population range.

Due to the difficulty of accessing research participants in crisis-affected settings, informants were identified through snowball, also known as chain-referral, sampling (Noy, 2008). Purposive sampling (Palys, 2008) was also used with guidance from UNFPA, the agency that led the RH responses in both settings, to identify informants. Criteria for informant

selection included active participation in the RH or health responses within the first six months after the crises. Representatives from UN, international, national, community-based, and government agencies were included to capture diverse organisational experiences. Notes and transcriptions from the interviews were triangulated with team members' and typed up within two weeks after the trips.

Focus group discussion sites were chosen through convenience sampling based on suggestions by humanitarian agencies as access to affected communities in both settings was limited. Purposive sampling was used for FGD participant selection. In Myanmar, government authorities allowed only one FGD with married and unmarried women. A local doctor from a nearby clinic provided simultaneous translation; a Myanmarese UN officer supported and verified translation. Notes from this discussion were taken by all members of the research team: the lead researcher (myself), the SPRINT Programme Coordinator, and the Regional Director of IPPF. These were later triangulated for accuracy.

In Haiti, 14 FGDs were held with 329 displaced men, women, and adolescent girls and boys: two groups of men (44 men total), six groups of women (191 total), three adolescent boys groups (51 total), and three adolescent girls groups (43 total). Adolescents were defined as those ranged from 10 to 25 years of age. Six FGDs were held in Port-au-Prince, five in Léogâne, and three in Jacmel. Specific efforts were made to ensure inclusion of women, men, and youth representing different ages, vulnerabilities, and locations (urban, peri-urban, rural.) Simultaneous translation of FGDs were conducted with the support of experienced local translators fluent in English, Creole, and French.

Focus group discussion participants were informed of the purpose, process, and use of information; the assessment team's commitment to confidentiality; the importance of participants' respect for confidentiality among the group; and their right to refuse to participate, to leave, or to remain silent. In Haiti, written consent was obtained from one representative on behalf of the group. In Myanmar, verbal group consent was obtained as women did not want to sign individually. Written consent was obtained from informants and staff at health facilities for the facility assessments.

Health facilities were assessed regarding the availability of emergency obstetric and newborn care, post-abortion care, clinical management of rape, family planning, and HIV

services. Data on general infrastructure, financial support, and human resources were also collected. The facility assessments used interviews with key staff, clinical register review, and room-by-room inventory of essential supplies and equipment.

In Myanmar, due to access restrictions by government authorities, only one health facility (in Dedaye, Pyapon District) was assessed. In Haiti, ten health facility assessments were conducted: three hospitals and one mobile clinic in Port-au-Prince; two field hospitals and one camp clinic in Léogâne; and one mobile clinic, one referral hospital, and one dispensary in Jacmel. A sampling frame of 128 functioning health facilities was generated with data from the U.S. Centers for Disease Control and Prevention (CDC) and the Health Cluster. Facilities were selected randomly by the CDC.

Field notes were taken during in-country data collection to record observations and informal conversations. In Haiti, observation of an RH Working Group meeting was undertaken to document topics discussed and explore participation, group dynamics, and facilitation.

Extensive document review of internal and external evaluations and published papers on the crisis and the subsequent humanitarian response was conducted. Documents were found by searching ReliefWeb, UNOCHA, UNFPA, WHO, and ALNAP websites as well as UNSW's electronic library.[10] Findings were triangulated and verified with assessments and research conducted by other agencies and available information sources.

In Myanmar, daily debriefings were held with the SPRINT Programme Coordinator to discuss and triangulate data and identify initial findings. At the end of the field mission, findings were shared and discussed in two two-hour meetings with key representatives from UNFPA-Myanmar. In Haiti, the assessment team dedicated the last day of the trip to a group debriefing and discussion of the findings from the various settings. Follow-up with team members and informants was undertaken for several months after the field missions to verify and triangulate findings.

Written summaries of Phase I findings were shared with selected informants for review to ensure their input was adequately reflected. Initially, simplified reports translated into the

[10] The UNSW electronic library can be found here: http://library.unsw.edu.au/.

local language were planned for the members of the displaced population who were consulted in the research. However, this proved to be infeasible as it was not possible to track the displaced informants after the consultations undertaken by the evaluation teams.

One year after the Haiti field mission, the Women's Refugee Commission (2011) published a report based on the findings from the assessment, *Priority Reproductive Health Activities in Haiti: An Inter-agency MISP Assessment.* The other team members and I reviewed the report. My findings and analysis were triangulated with the report after both the case study and the report were written.

Phase II. As part of a spiralling research process linking the three phases, Phase II was developed as a result of the key findings from Phase I. A primary enabler identified in Phase I was the role of socialising accountability in advancing MISP implementation. A significant barrier was the lack of effective formal accountability mechanisms to hold humanitarian actors accountable for MISP implementation. In an effort to explore this issue deeper, the Phase II research question asked "How did socialising accountability manifest in these two settings and what was its impact on the RH responses?"

Methods included:

- In-depth, key informant interviews with the selected actors in the RH response in both case study settings;
- Document analysis, including accountability assessments and other reports related to the response;
- Re-analysis of Phase I data.

For the Myanmar case study, six extensive key informant interviews were conducted in October 2011 with staff from two UN agencies, one INGO, and one non-UN/non-NGO international organisation. All were Myanmar nationals. Three interviews were conducted in-person at an international conference abroad[11] and three were conducted remotely by Skype. Phase I data were also re-analysed for references to socialising accountability. Of the 49 humanitarian informants, 38 representing nine agencies including six INGOs, two

[11] The 6th Asia Pacific Conference on Reproductive and Sexual Health and Rights in Jogjajarta, Indonesia (October 20-22, 2011)

UN agencies, and one local NGO discussed or referenced different forms of accountability. These data were integrated into the analysis.

For Haiti, eight in-depth interviews were conducted by Skype in December 2012 with representatives from one UN agency, five INGOs, and one national organisation. Phase I data were re-analysed: 17 out of 41 interviewees representing eight INGOs, one national agency, and one UN agency referenced accountability.

Informants in both settings were purposively selected on the basis of their role in the respective RH responses and coordination mechanisms. RH Focal Points, who coordinated the RH Working Groups and oversaw the RH responses, were prioritised as informants. Other respondents were chosen based on their consistent engagement with the RH Working Group. Using chain referral (snowball) sampling, these key actors recommended other possible informants who were actively involved in the RH response. Additional criteria included at least one informant from the UN and national and international NGOs responding to the crisis each setting. Representatives from the respective Ministries of Health were contacted for an interview but did not respond.

Verbal or written consent was obtained from all informants. All interviews were recorded and transcribed within one week of being conducted. Interviews averaged one to two hours in length. Additional follow up questions were sent via email. Some informants were interviewed multiple times as further questions arose during data analysis. All interviews were conducted in English.

The interview guide used open-ended questions about the informal, interpersonal ways in which participants held other RH actors accountable for MISP implementation. Norms and behaviours that reflect socialising accountability as well as challenges to socialising accountability were explored. In keeping with the tenets of constructivist grounded theory, the interview process remained fluid and included questions to probe for deeper understanding. Summaries of the main points were made throughout the interview to clarify each informant's input.

Categorisation and analysis of data was based on a model of inter-agency informal accountability developed by Barbara Romzek and colleagues (2013). The framework

identifies social norms, facilitative behaviours, informal rewards and sanctions, and challenges that create or undermine the dynamics of informal accountability in inter-agency service collaborations. The model was used to organise and synthesise the findings in relation to this emerging area, but not to guide data collection, keeping in line with the constructivist grounded theory methodology. This approach allowed flexible and organic thinking from handling the data; the process was not constrained by pre-determined categories or theory. I modify, build upon, and extend Romzek and colleagues' model by layering it into a humanitarian setting that revealed new dimensions of socialising accountability processes. This is addressed in-depth in Chapter 8.

Phase III. Findings from Phase II demonstrated the importance of socialising accountability in advancing MISP implementation in the two settings. Further, Phase II data analysis revealed accountability to personal ethics as an additional key enabler. However, the practical value of these findings beyond the case studies was unclear. This raised a third and final question, which formed the basis of Phase III: "What is the value of the concept of and practical support for socialising and personal accountabilities in advancing RH implementation in humanitarian emergencies and in what ways can they be strengthened?" This phase provided an opportunity for deeper reflection on the research and its possible contribution to not only the literature but the field as well.

Methods included:

- In-depth, non-structured conversational interviews with key informants;
- Re-analysis of Phase I and Phase II data;
- Desk research on socialising accountability and humanitarian accountability systems.

In-depth, non-structured interviews were held with two senior officials from two different UN agencies involved in humanitarian health responses. One was a representative working on RH in emergencies and a member of the IAWG Steering Committee; the other focused on health and emergency disaster management, including accountability. Criteria for selection included 1) significant experience in health and emergency relief; 2) experience working with a UN agency, NGO, as well a community-based organisation; 3) a senior position within a leading health and/or RH agency; 4) one senior IAWG member working on RH in

crises; 5) one non-IAWG, non-RH representative working on health and accountability in crises.

One interview was conducted by Skype, and one was conducted in person at the 2013 IAWG Annual Meeting in Kuala Lumpur, Malaysia. Both were conducted in English. Discussions were audio recorded and transcribed within three days. Verbal consent was given by the informants.

Interviews involved sharing the key research findings regarding socialising and personal accountabilities in Myanmar and Haiti and asking informants questions about their thoughts and experiences related to the findings broadly, the value of the findings, and their reflections on how these accountabilities could be strengthened. Discussions were non-structured, informal conversational interviews designed to elicit the informants' insights with nominal predetermined categories.

The respondents were not familiar with the terms socialising, informal, peer, or personal accountability. They associated accountability with its technical forms and thus *socialising and personal accountabilities* were unfamiliar. It was more useful to discuss the concepts and the expressions of socialising and personal accountabilities rather than use terms that did not resonate with the informants.

In addition, during Phase II data collection, the 14 respondents were asked how socialising accountability could be strengthened in humanitarian crises. These responses were coded and included in the Phase III analysis.

2.4 Analysis

Data analysis was predominantly conducted through the constant comparative method, a key component of grounded theory. Although the term "constant" may be somewhat overstated, the idea is that the data are compared, organised, interpreted, and explored in an on-going manner. Coding of data is an essential component of this method. Charmaz (2006) identifies two key types of codes: the initial coding, which involves going line by line in a text, for example, and naming or categorising each idea. The second step is selective

or focused coding that involves identifying and constructing relationships, which is a component of the theory generation. After data-gathering for each phase, initial coding into basic categories was undertaken followed by several waves of increasingly refined analytical coding.

Categories and connections were made inductively and then compared (or triangulated) with other data for validity. Notes and transcripts were coded and entered into QSR International's NVivo (Versions 9 and 10), a qualitative data management software. NVivo was a primary organising and analysis tool for this research. I attended two week-long trainings on NVivo with qualitative data analysis expert Dr Pat Bazeley, which enabled me to maximise usage of this powerful tool. In addition to organising data and managing coding, it helped cross-examine information and identify trends. NVivo can also cluster codes and generate models and diagrams, which helped with the interpretation of the data. Further, working with Dr Bazeley was useful as we discussed my coding at length and she provided valuable insights and suggestions.

Memoing, or keeping a reflective diary, is another means of analysis and reflection that I employed. It helps capture and process thoughts, comparisons, and initial analysis of the data. Memoing was consistently undertaken throughout this study and contributed importantly to the method of analysis.

In addition, I regularly shared my coding and writing with my PhD advisors and engaged in consistent discussion about the value of the data and the logic of my analysis. I was also a member of a PhD team comprising three other students researching related topics, all concerned with RH in humanitarian and development settings. This group collaboration provided a shared space for critical discussion and additional feedback on written work.

Finally, theoretical sampling was undertaken as a more advanced step in data analysis. Strauss and Corbin (1998) define theoretical sampling as "Data gathering driven by concepts derived from the evolving theory and based on concept of 'making comparisons', whose purpose is to go to places, people, or events that will maximise opportunities to discover variations among concepts and to densify categories in terms of their properties and dimensions" (p. 201). This process entails reflecting on the data gathered to date, making connections and initial theorising, and then deciding where to go next to further test

this initial analysis. Through the theoretical sampling process, the three inductive and deductive phases were developed that helped to articulate, focus, and refine my thinking and theorising. Under-researched concepts were identified in each phase and led to constructing a next phase to explore the emerging ideas in greater depth.

2.5 Validity and evaluative criteria

Validity refers to the extent to which the research measures what it intended to or how "accurate" the findings are. The concept of validity comes from the positivist tradition and has historically been used to evaluate quantitative research. Validity in qualitative research has however been redefined by different scholars. Lincoln and Guba (1985) define validity in qualitative research in terms of credibility, neutrality or confirmability, consistency or dependability, and applicability or transferability. In traditional grounded theory, Strauss and Corbin (1990) identify fit, understanding, generality, and control as qualitative standards. These are examples of criteria by which one is able to evaluate the quality of a study.

For constructivist grounded theory studies, Charmaz (2005) outlines four evaluative criteria:

- *Credibility* – the researcher's familiarity with the situation being studied, systematic comparison of data and initial theorising, logic of arguments and findings, and robustness of data;
- *Originality* – the freshness of categories, insightfulness, social and theoretical significance, and contribution to field;
- *Resonance* - capturing the complexity of phenomenon, liminal or taken for granted meanings, sound and insightful analytical interpretations;
- *Usefulness* - application of the analysis to daily life, identification of generic processes, potential for further research, and contribution to society (p. 528).

This research aimed to abide by these criteria. A self-assessment is conducted in Chapter 10.

2.6 Ethical considerations

Approval for this research was received from the UNSW Ethics Committee in June 2009 (HREC 09101); in April 2010, modifications to the research were approved by the Ethics Committee. During the first year and a half of my studies, I was employed by IPPF's SPRINT Initiative, based in Kuala Lumpur, Malaysia. My research and work overlapped at times, and thus a Memorandum of Understanding between IPPF and UNSW was developed that outlined the parameters of data collection and use. This entailed my providing regular updates on research findings to a selected IPPF focal point and a mutual acknowledgement that the thesis copyright belonged to me. A conflict of interest was not identified.

A letter outlining support for the research was obtained from the humanitarian agency[12] that hosted me in each site. Consent forms were developed for humanitarian actors and a simplified version developed for displaced communities. Where written consent was not possible (such as in large FGDs), verbal consent was obtained. Summary of research findings were shared with selected participants for their input and to ensure accurate representation of their views. However, feedback from the displaced persons who participated in the study was challenging given follow-up difficulties, pre-literacy limitations, and access to information technology. Zwi et al. (2006) have highlighted challenges facing researchers wishing to share findings with crisis-affected participants; they recommend identifying short-term reciprocal benefits since providing feedback on findings at a later point may not be feasible. The primary way in which participants benefited from taking part in this research was through accessing information on where, how, and why to receive RH care in their specific setting.

Ethical considerations are critical when engaging with displaced populations directly. Displaced populations are vulnerable, meaning they lack power and the capacity to protect their own interests (CIOMS & WHO, 2002). Participating in research may put them at risk, such as backlash by camp or military authorities for divulging negative practices (Pittaway, Bartolomei, & Hugman, 2010). Informants who disclose experiences of violence or suffering may be retraumatised (Pittaway et al., 2010). Indeed, research exploring sensitive and

[12] Specifically, PROFAMIL in Haiti and UNFPA in Myanmar

intimate issues such as sex, sexual violence, childbirth, and HIV must be conducted within a strong ethical framework.

International Ethical Guidelines for Biomedical Research Involving Human Subjects (2002), by the Council for International Organizations of Medical Sciences (CIOMS) and WHO, were used as overarching guidelines for engagement with displaced populations. Three basic ethical principles frame these guidelines: 1) respect for persons, which includes respect for autonomy and protection; 2) beneficence, which refers to maximising benefit and minimising harm; and 3) justice, which involves equitably distributing the benefits and burdens of participating in the research (p. 10-11).

Two additional guidelines were used in this research. The Women's Refugee Commission's *Ethical Guidelines for Working with Displaced* Populations (2009), which were adapted from International Rescue Committee's *Guidelines on Privacy and Protection* (n.d.) and UNICEF's *Ethical Guidelines for Reporting on Children* (2003), provided detailed guidance on working with displaced populations specifically, including physical and psychological safety, filming and photographing, gifts and compensation, choosing participants, and informed consent (including working with pre-literate participants). WHO's *Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies* (2007) was also used to guide data collection around sexual violence. Essential tenets that I followed include ensuring confidentiality and safety as well as only conducting research in areas with established referral systems for rape survivors.

In addition, more than ten years of experience conducting field research with vulnerable populations on these issues has strengthened my ability to engage with respondents in an ethically sound manner.

2.7 Limitations

This research had limitations, including time and access constraints. In Myanmar, visas for in-country data collection were difficult to obtain and required the head of the UN Country Team (the UN Resident Coordinator) to advocate to government officials for approval. Due to these delays by Myanmar authorities, field data collection took place more than one year

after Cyclone Nargis. However, Skype discussions with in-country actors during the crisis response mitigated the consequence of the travel delay and allowed for a real-time interaction with key informants.

In-country travel was also restricted in both settings. In Myanmar, although the research team was initially given approval to travel to two affected sites in the Ayeyarwady Delta (Dedaye and Bogale), the day before arrival, authorities decided to grant access only to Yangon. The IPPF Regional Director was allowed to travel to the capital, Napitaw, and was able to convince an official from the Ministry of Social Welfare's Relief and Resettlement Department to grant access to the research team to at least one site in the Delta (Dedaye.) Due to these travel restrictions, only one facility assessment and one FGD was conducted, although the focus group did provide a valuable snapshot into the affects of the cyclone on RH. The facility assessed had been repaired since the crisis. Therefore, it was not possible to determine through a physical assessment what services were provided at the time of the crisis, and data for the health facility assessment were collected from informant responses only.

In Haiti, destruction of roads and insecurity limited some travel within Port-au-Prince and to remote areas.

From 2011 to 2013 I experienced significant personal and health issues and took 1.5 years of medical leave. This resulted in a lengthy gap in data collection between Phases I and II. As data were self-reported, selective memory is a potential source of bias. Conversely, it may have provided the participants with an opportunity to reflect more deeply on their experiences over time.

The health issues as well as financial constraints prevented in-country travel for Phase II data collection. However, this was not necessarily a limitation as interviews were easily conducted remotely by Skype.

Snowball or chain referral sampling was appropriate given the difficulty in accessing informants. However, concerns with snowball sampling include a lack of representativeness of the sample and sampling bias. Attempts to address these issues were made by

triangulating participant referrals with other informants and through desk research on key actors in the respective responses.

Translation error may have occurred during Phase I data collection since interpreters were used in both settings. Back translation was not possible because translation was verbal and in real-time. However, measures were undertaken to increase quality control. Criteria for selecting interpreters included being a native speaker as well as fluent in English. Verbally summarising and repeating key points back to the informants and conferring with other bilingual people during the translation process also helped minimise translation-related problems (Whelan, 2004). In Myanmar, multiple translators were on-site: a lead translator and another bilingual coordinator who assisted with translation.

In Myanmar, some of the informants were concerned about possible governmental repercussions to their organisation. Although they consented to the interview, certain comments were “off the record”, particularly when speaking critically of the government or of issues sensitive to the government, such as sexual violence. These were often useful insights that added depth to the research, but unfortunately could not be included in the findings.

Finally, a possible improvement to the study could have been interviewing representatives from humanitarian accountability initiatives, such as ALNAP, HAP, or the Overseas Development Institute (ODI). This could have provided valuable insights into the practical application of socialising accountability. Despite reaching out to six possible informants through email, none responded to requests for interviews.

2.8 Summary

This chapter outlined the theoretical underpinnings of the study, the research questions and design, and the methods and tools employed to answer these questions. The flexible, reflexive, participatory, and anti-positivist approach of constructivist grounded theory aligns with my own philosophical stance as a researcher. The constructivist paradigm was well-suited to explore the two case studies and describe the journey of this research. It facilitated the organic unfolding of the research, which was organised into three iterative

phases with three correlated questions, with each phase probing more deeply into emergent, under-researched aspects of MISP implementation and socialising accountability. A broad range of qualitative methods were used to collect data, and tools such as NVivo and Romzek's model on informal accountability helped organise and analyse the data.

Before embarking on the findings from Phase I, the study must first be contextualised. As such, the following chapter provides background on the field of RH in emergencies and grounds the research in the evolution of the field.

3. Chapter Three: Background – Reproductive health in humanitarian emergencies

The following chapter grounds the study in two key areas of this research: humanitarian action and RH. The chapter outlines the history of humanitarian response and recent reforms to the so-called international humanitarian system. The inclusion of RH on the humanitarian agenda is chronicled and current gaps and trends in the field are explored.

3.1 Historical overview of humanitarian response

Humanitarian action to help alleviate suffering was first codified in the form of charitable acts in the teachings of such major religions as Christianity, Islam, and Buddhism (Macalister-Smith, 1985). However, not until the founding of the International Committee of the Red Cross (ICRC) in 1863 was an organisation dedicated to providing humanitarian aid established. The Geneva Conventions outlining the rights of victims of war, including civilians and prisoners of war, were developed in the following year. As of November 2014, 196 countries have ratified, in whole or with reservations, the most recent version (1949) of the Conventions (ICRC, 2014).

Although the atrocities and destruction of WWI and WWII brought about significant advances in international humanitarian, human rights, and refugee law, humanitarian response—in terms of the number of humanitarian agencies, number of aid operations, and funding—did not expand significantly until the 1970s and 1980s, primarily through the rise of NGOs (Ryfman, 2007). As the humanitarian community expanded, the relief context became increasingly complex. The concept of “neutral” humanitarian assistance was challenged as aid became politicised and “relief agencies became part of war dynamics and war economies” (Heyse, 2003, p. 179). Civil conflicts rapidly replaced wars between countries.

Despite these trends, guidelines and standards on provision of humanitarian response were scarce. The disastrous response by the humanitarian community to the Rwandan genocide prompted the launch of the Sphere Project, an attempt to set up a system of accountability and monitoring of humanitarian assistance (Buchanan-Smith, 2003). The Sphere Project was significant because it marked the first time that relief actors worked together to

establish standards for humanitarian response and to monitor their activities in emergencies (Ouyang, Vanrooyen, & Gruskin, 2009).

Further, the Sphere Project integrated human rights discourse into international humanitarian frameworks (Ouyang et al., 2009). Although Sphere has been criticised for not fully embracing a rights-based approach, it marked a watershed moment in the history of humanitarian relief as it attempted to articulate the provision of humanitarian assistance within a human rights framework—rather than a needs-based approach—and placed responsibility for those rights on the agencies responding to the emergencies, including NGOs and UN agencies (Ouyang et al., 2009). A rights-based approach to humanitarian response is now widely accepted (Slim, 2002b).

3.2 A global humanitarian system

In 1991 the UN General Assembly passed Resolution 46/182, which set forth a framework for international humanitarian assistance (UN General Assembly, 1991). The resolution spearheaded the establishment of Inter-Agency Standing Committee (IASC), a body of UN and non-UN agencies designed to coordinate and strengthen relief interventions. Resolution 46/182 also outlined a set of guiding principles that underpinned humanitarian aid: humanity, impartiality, and neutrality. Through this resolution, a more formalised global humanitarian architecture was established.

Over the next fifteen years, international humanitarian assistance evolved considerably with a proliferation of NGOs, specialised guidelines, and professionalisation of staff. Despite significant progress, humanitarian aid remained riddled with challenges and criticisms abounded (cf. Anderson, 1999; Cosgrave, 2007; DANIDA, 1996; Polman, 2003; Rieff, 2003). Key complaints included poor coordination, lack of accountability mechanisms, and ad hoc interventions.

A decade after the Rwanda tragedy, the fragmented and inefficient response to the 2004 Indian Ocean tsunami once again highlighted the overarching problems in the humanitarian field and prompted global action. To address these issues, the IASC launched the Humanitarian Reform Process in 2005. This undertaking aimed to enhance the efficacy of

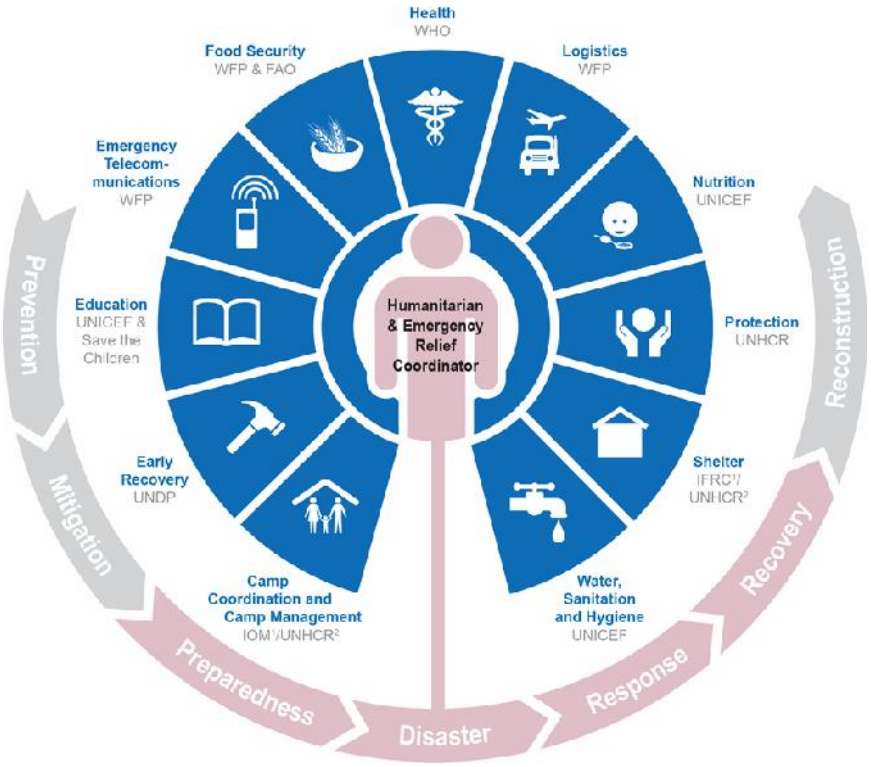
emergency response through promoting increased predictability, leadership, accountability, and partnership (UNOCHA, 2011d).

The essential elements of the reform process included: 1) establishment of the Cluster Approach, which entailed identifying lead agencies and defining their roles and responsibilities within the different sectors of the response; 2) strengthening the role and capacity of the Humanitarian Coordinator, who heads a humanitarian response; 3) more adequate, timely, flexible and effective humanitarian financing through the establishment of the Central Emergency Response Fund (CERF); and 4) the development of strong partnerships between UN and non-UN actors (UNOCHA, 2011d).

Understanding the Cluster Approach is important to this research and deserves additional explanation. The Cluster Approach is a coordination strategy designed to enhance cooperation and strategic planning among humanitarian actors. “Cluster” is equivalent to a sector. The nutrition sector, for example, translates into the Nutrition Cluster. Each Cluster is led by an organisation committed to ensuring an effective sectoral response. The Health Cluster, for example, is led by WHO. This agreed division of labour was designed to streamline accountability and coordination.

There are nine technical Clusters, which include health, education, protection, among others, and two service Clusters, including emergency telecommunications and logistics (Figure 3.1). Four cross-cutting issues have been established: age, gender, environment, and HIV/AIDS. The Cluster Approach is applied only in internally displaced settings since UNHCR is responsible for overseeing the humanitarian response in a refugee setting.

Figure 3.1: IASC Clusters with lead agencies



Source: (IASC, 2012e)

Despite this overhaul, assessments from 2006 to 2013 of the reform process showed continuing weaknesses and inefficiencies in accountability, coordination, and leadership, with implementation of the Cluster Approach considered particularly bureaucratic (Cosgrave, 2007; Humphries, 2013; IASC, 2006; Manfield, 2007; Steets et al., 2010). The failures of the Haiti earthquake and Pakistan floods in 2010 starkly brought these gaps to the fore and prompted discussion of additional reforms.

In 2011 the IASC launched the second phase of the Humanitarian Reform Process and established the Transformative Agenda. The Transformative Agenda was initiated to address the challenges identified in the first phase of the Reform Process and supported strategic, rather than automatic, activation of the Cluster Approach. It also emphasised increased engagement with national governments and local actors. Level 3 “mega-emergencies”, such as the Haiti and Pakistan disasters in 2010, activated a new system-wide mechanism in which pre-identified humanitarian leaders are deployed to oversee the response and a strategic statement with response priorities is developed within the first five

days based on initial rapid assessments to guide funding decision-making (IASC, 2013). At the time of this writing, an evaluation of the Transformative Agenda has not been published.

Although an increasing number of formalised global processes and mechanisms have been established, international humanitarian architecture remains fluid with a wide range of self-regulating actors and multiple systems and networks (Collinson, 2011; Labbé, 2013). Indeed, ALNAP suggests that the idea of a humanitarian system reflects a "degree of cohesion and uniformity of objectives that simply is not the case" (Harvey, Stoddard, Harmer, & Taylor, 2009, p.13). Nonetheless, ALNAP also asserts that the interdependence and engagement of international and national actors in humanitarian responses does constitute a type of "loosely configured" system (Harvey et al., 2009, p.13).

At the same time that efforts have been made to strengthen the coherence of international humanitarian interventions, the global system has not kept up with the increasingly complex and rapidly changing humanitarian landscape. Agencies delivering humanitarian aid have historically struggled with difficult and unpredictable operating environments. Yet since the commencement of the "war on terror" in the early 2000s, actors have been confronted with additional layers of social and political issues, such as terrorism and counterinsurgency tactics, increased involvement of government authorities and national actors, and multi-dimensional peacekeeping operations (Labbé, 2013).

Expectations of humanitarian actors have grown as well: agencies are expected to not only deliver goods and materials but also document atrocities, "win the hearts and minds" of the local communities, and bridge the gap between relief and development (Labbé, 2013). Effectively coordinating and engaging with a growing number and variety of actors, including local organisations and the military, poses additional challenges to the international humanitarian system, particularly as nations are increasingly asserting their state sovereignty (Harvey, 2010; Labbé, 2013). Agility and flexibility are requisite in order for humanitarian actors to effectively adapt and navigate their continuously changing environment.

3.3 RH on the humanitarian agenda

3.3.1 The first decade: 1994 to 2004

Reproductive health was recognised as an increasingly important component of humanitarian response in the mid-1990s, constituting a significant shift in the field (Schreck, 2000). A number of events coalesced to help put RH on the humanitarian agenda. Two key publications, a 1993 Lancet editorial (Editorial, 1993) and 1994 report by the Women's Refugee Commission[13] (Wulf, 1994) highlighted the lack of RH services in displaced settings. Also in 1994, the International Conference on Population and Development (ICPD) Programme of Action articulated RH as a basic human right for all people, including refugees and internally displaced persons (IDPs) (UN, 1994b). These rights were reaffirmed the following year at the Fourth World Conference on Women in Beijing (UN, 1995). The need for RH services for crisis-affected populations came to public attention as a result of the media coverage of conflicts in Yugoslavia and Rwanda. The outrage over the widespread rape and violence against women in both crises helped propel the movement forward (Schreck, 2000).

The momentum from these events resulted in the birth of two inter-agency groups in 1995 that aimed to increase access to RH services for refugee populations globally: the Inter-agency Working Group on Reproductive Health in Crisis Situations (IAWG)[14] and the Reproductive Health Response in Crisis Consortium (RHRC).[15] As noted in the Chapter 1, the IAWG was comprised of approximately 40 loosely associated UN, NGO, academic, and governmental institutions, while the RHRC was a smaller consortium of seven American agencies that collaborated more closely together.

In their first decade, the IAWG and RHRC focused on advocating the integration of RH into humanitarian policies and funding mechanisms, developing field tools on RH for humanitarian workers, and conducting assessments to evaluate implementation of RH programming in the field. They also held the first research conference on RH in emergencies in 2003. IAWG's key publication that articulated the MISP, *Reproductive*

[13] Formerly the Women's Commission for Refugee Women and Children; www.wrcommission.org
[14] Formerly the Inter-agency Working Group for Reproductive Health in Refugee Situations; www.iawg.net
[15] Formerly the Reproductive Health for Refugees Consortium; www.rhrc.org

Health for Refugees: An Inter-Agency Field Manual (1999), was endorsed by UNHCR, WHO, UNFPA, and the U.S. government, as well as a number of INGOs and academic institutions.

At that time, Palmer et al. (1999) published an article that explored to what extent RH was on the global relief agenda. They found an increase in conferences, articles, policies, funding and new NGOs addressing RH in emergencies. However, they also noted that these advances did not translate into service provision on the ground. Other important achievements included the integration of the MISP into the 2004 revision of the *Sphere Humanitarian Charter and Minimum Standards in Disaster Response* as well as a global evaluation on progress and gaps in RH in emergencies from 2002 to 2004. The evaluation documented advancements at the policy and implementation levels since the mid-90s, but significant gaps continued across all technical areas, specifically maternal and newborn health, family planning, gender-based violence, and HIV and other sexually transmitted infections (STIs) (IAWG, 2004b).

3.3.2 The second decade: 2004 to 2014

The first decade of the movement to advance RH in emergencies has been well documented (Bartlett, Purdin, & McGinn, 2004; McGinn, 2000; Palmer et al., 1999; RHRC, 1998, 2003; Schreck, 2000). Yet little has been published about the changes in the field from 2004 to 2014. Much of the following information is based on my position as an "IAWG insider" since 2003.

After 2004 the movement gained further traction as well as faced additional challenges. In 2005 the field received a windfall of funding from an anonymous donor amounting to an unprecedented USD 80 million. With this funding, the Reproductive health Access, Information and Services in Emergencies (RAISE) Initiative was launched in 2006. Led by Columbia University and Marie Stopes International (MSI), RAISE worked to address the full range of RH needs for refugees and IDPs by building partnerships with humanitarian and development agencies, governments, UN bodies, advocacy agencies, and academic institutions. Specifically, the Initiative provided funding to scale up comprehensive RH services in six protracted settings, facilitate clinical trainings and technical assistance, support and disseminate research, and participate in advocacy efforts for improved RH

(RAISE Initiative, 2010). The RAISE Initiative helped scale up RH services in several severely protracted settings, such as eastern Democratic Republic of the Congo, and helped increased awareness on the importance of RH in emergencies for key donor governments. RAISE has been criticised by its partners for overlooking the MISP and advocating comprehensive RH services from the onset of an emergency—which contradicts the MISP—as well as neglecting to fund local organisations (apart from one.)

IAWG also began to change during this time. Starting in 1996, IAWG held annual meetings that were generally comprised of the seven agencies of the RHRC as well as UNFPA, WHO, UNHCR, U.S. Agency for International Development (USAID), and the U.S. Centers for Disease Control and Prevention (CDC) (IAWG, 2003, 2004a, 2006, 2007). Other agencies such as Médecins Sans Frontières (MSF), International Federation of the Red Cross and Red Crescent (IFRC), International Organisation for Migration (IOM), and International Medical Corps (IMC) attended periodically. The meetings tended to be small (from twenty to fifty people) and were held in New York, Geneva, or Brussels. In 2006, a representative from UNSW suggested holding the ninth annual IAWG meeting in Sydney, Australia, in an effort to highlight the RH needs of the region, particularly the Pacific, an area often overlooked by international humanitarian actors. Fifty participants from thirty-two organisations attended, such as UNHCR Timor Leste, UNFPA Pakistan, and Mercy Malaysia. The first regional IAWG was formed as result of the meeting, and IAWG has held its annual meetings in a different region ever since.

The Asia Pacific regional IAWG meeting served as the platform to spearhead the Sexual and Reproductive Health Programme in Crisis and Post-Crisis Situations, or SPRINT Initiative, in 2007. SPRINT was one of the first undertakings to work to build national capacity to facilitate implementation of the MISP. It used an innovative “country team” approach whereby members from different organisations within the same country were trained together on the MISP. These country teams were typically comprised of representatives from the local family planning association, UNFPA, and national Ministries of Health (MoH). Other agencies, such as the national Red Cross and WHO, were also sometimes involved. Training teams, rather than individuals, helped to develop the national RH coordination mechanism that is crucial to ensuring successful implementation of the MISP in a crisis.

Another innovative approach by SPRINT was its focus on developing national and local capacity as well as engaging development agencies. This approach fostered sustainability and helped to bridge the gap between relief and development as these actors are invested in their settings for the long-term. Further, local agencies provide the most important initial assistance in emergencies because they are often the first responders and are able to provide immediate relief, before any form of external assistance arrives (IFRC, 2004).

The objectives of RAISE and SPRINT were developed out of the findings of the 2004 IAWG global evaluation, and both sought to address the key gaps identified there. Although they hold similar goals, their activities were generally complementary in their approach: RAISE focused on clinical trainings and comprehensive RH, and SPRINT prioritised coordination trainings and the MISP.

Other significant changes occurred in the field after 2004. IAWG members successfully advocated integrating the MISP into the minimum standards of the CERF, a funding mechanism established through the Humanitarian Reform Process to pre-position funds for humanitarian action. The CERF exclusively supports life-saving activities, and the integration of the MISP helped legitimise its acceptance as a minimum standard in health service delivery.

Challenges to the institutionalisation of the MISP also arose, particularly in the Cluster Approach. Sub-clusters, also called “areas of responsibility”, are sub-working groups of a specific Cluster and also have a fixed led agency. For example, the Protection Cluster has a number of Sub-clusters, including Child Protection (led by UNICEF), Gender-Based Violence (led by UNFPA/UNICEF) Land, Housing and Property (led by UN-Habitat), and Mine Action (led by UN Mine Action Service).

WHO was identified as the agency responsible for overseeing the Health Cluster. Yet unlike the other Clusters, RH was not established as a Health Sub-cluster since RH was deemed to fall under the heath mandate. This occurred despite the fact that the establishment of a separate RH coordination mechanism is the first objective of the MISP. Further, it was recognised that UNFPA—the logical lead agency for RH—had limited capacity to respond to emergencies as it was traditionally a development agency and did

not become operational in emergencies until 2000. Instead, the Health Cluster, under the guidance of WHO, retained responsibility for RH implementation.

Despite its new mandate to ensure RH service implementation, WHO did not fully embrace its responsibility for RH implementation. For example, in 2007 the Global Health Cluster, led by WHO, removed RH as a core component of humanitarian response. Instead, only maternal and newborn health was included as one of the Health Cluster's core commitments in humanitarian health action. The exclusion, initiated by WHO, was not agreed by the wider Health Cluster and was not announced to key stakeholders. In reviewing draft guidance on the Health Cluster's core commitments, IAWG members, however, noted this significant change and took action. At the 2007 annual IAWG meeting, a Call to Action was presented to WHO on behalf of IAWG demanding it renew its commitment to comprehensive RH (IAWG, 2007). The advocacy was successful and also brought about increased participation by WHO in IAWG.

In 2009 global guidance on the Health Cluster was developed (WHO, 2009a). Although initially reluctant, WHO agreed that the Health Cluster was responsible for ensuring the establishment of an RH Working Group[16] at the onset of every emergency and integrated this activity into the global guidelines (WHO, 2009a). This marks the one of the most important advancements to date in integrating RH into the formal global humanitarian system.

Also in 2009, the *Granada Consensus on Sexual and Reproductive Health during Protracted Crises and Recovery* (2009) was drafted, which affirmed comprehensive RH as a right in protracted settings and fragile states. The following year a revised field-test version of the 1999 IAWG Field Manual was developed. The revision is significant as it included four additional life-saving activities to the MISP: syndromic treatment of STIs, provision of contraceptives, anti-retrovirals for existing users, and provision of menstrual hygiene kits (IAWG, 2010c). These additions to the MISP are being field-tested at the time of this writing.

[16] The agreed language is "RH Working Group" rather than "RH Sub-Cluster", although the latter is used informally.

Participation in IAWG also swelled. For example, the 14th Annual IAWG Meeting held in Kuala Lumpur, Malaysia in May 2013 included 122 individuals from 79 agencies and 30 countries (Krause, 2013), a significant increase from the 46 participants in 2004 (IAWG, 2004a).

From 2012 to 2014 a second IAWG Global Evaluation on the state of the field was conducted. The studies documented considerable progress in the field since the previous evaluation a decade ago. The findings demonstrated that funding and awareness had increased significantly and service provision had expanded. However, programmatic needs continued to outweigh financial support, implementation was not systematic and of variable quality, and evidence for programme efficacy remained scarce. The evaluation spotlighted the limited availability of comprehensive abortion care, poor commodity management and security, and lack of community mobilisation to increase RH service uptake as particularly glaring gaps (Chynoweth, in press).

The 2012-2014 IAWG Global Evaluation

Progress included:

- Increased number of emergency health and protection proposals appealing to implement reproductive health
- Reported growth in institutional capacity to address reproductive health in crises
- By technical area:
  - MISP awareness and implementation
  - Maternal health broadly
  - Post-abortion care
  - Anti-retrovirals for people living with HIV
  - Gender-based violence broadly, including documentation of prevalence of sexual violence in conflict settings

Key gaps included:

- Commodity management and security
- Community engagement to increase utilization of services
- Adolescent reproductive health
- By technical area:
  - Full, systematic MISP implementation
  - Emergency obstetric and newborn care
  - Comprehensive abortion care, including safe abortion and post-abortion care at the primary care level
  - Long-acting and permanent family planning
  - Emergency contraception as a family planning method
  - Prevention of sexual violence and comprehensive clinical management of rape services
  - Antiretroviral therapy at the primary care level
  - Diagnosis and treatment of sexually transmitted infections
  - Cervical cancer screening and treatment

Source: (Chynoweth, in press).

3.4 RH and human rights

The advances in RH in humanitarian settings can in part be attributed to the way advocacy and awareness-raising on the issue was framed. Advocacy on RH in emergencies arose out of the women's rights movement, which began situating women's issues within a human rights framework in the late 80s and early 90s (Ackerly, 2005).

Grounding women's rights within human rights law was an important and radical departure. Radhika Coomaraswamy, the former United Nations Special Rapporteur on Violence against Women, noted that, "The underpinning of women's rights with human rights would give women's rights discourse a special trajectory, emerging as a major innovation of

human rights policy within the framework of international law" (Coomaraswamy, 1997, p. 168). The women's human rights framework gave women (and men advocating on their behalf) a new language to articulate their grievances and helped translate women's rights into internationally accepted norms (Coomaraswamy, 1997). It was distinct from the traditional human rights approach that historically privileged the "public" arena and neglected the "private" sphere of home, family, and community in which women and girls primarily reside (Sloss, Mirsky, & Radlett, 1998). The IAWG and RHRC employed this women's human rights framework in their advocacy to advance RH in humanitarian settings (IAWG, 1999, 2010c). Other advocacy strategies, such as framing RH as a public health concern, were also used (cf. 2012-2014 IAWG Global Evaluation Supplement in Conflict and Health, in press).

RH rights are a composite of recognised human rights. The ICPD set out a framework for the realisation of reproductive rights:

> *"These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence"* (UN, 1994b).

International laws support the rapid and unobstructed implementation of RH services by humanitarian actors, including the Geneva Conventions (ICRC, 1977, 2005), Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (UN General Assembly, 1979); and the International Covenant on Economic, Social and Cultural Rights (ICESCR) (UN General Assembly, 1966b).

The IAWG and RHRC used the women's human rights framework to not only bring attention to the rights violations experienced by women and girls in crisis settings, but to also criticise humanitarian actors themselves for failing to provide RH services. Many prominent humanitarian health actors, including ICRC, IFRC, and MSF, do not systematically provide MISP services in emergencies. The IAWG and RHRC advocated—with varying degrees of success—to such agencies to respect the human rights of the communities they are seeking to serve (IAWG, 2004b; RHRC, 1998, 2003, 2004).

One shortcoming of the way in which the women's human rights framework has been employed is the conflation of RH with *women's* health. Although women and girls have more RH concerns and vulnerabilities (primarily due to their reproductive capacities), men and boys also have specific RH needs and have a right to have these needs met. Men are vulnerable to STIs including HIV, are at risk for urological problems including prostate cancer, may wish to limit or space fathering children, and are at risk for sexual violence, particularly in conflict settings. The movement to "engage men and boys" in RH has generally been designed to address women's RH issues, such as unintended pregnancies, domestic violence and single parenthood, and has not focused on the specific RH needs of men and boys (Sonfield, 2002).

Not all advocates have fully employed the women's human rights framework in their efforts to institutionalise RH into humanitarian response. Occasionally, problematic language, such as the term *promiscuity*, has been used by RH advocates. For example, the WHO Emergency and Humanitarian Action Department published a paper on internal displacement that notes that displacement can lead to an increase in hazardous behaviours, including promiscuity and gender-based violence (Leus, Wallace, & Loretti, 2001, p. 117). An IAWG Secretariat member used the term to describe negative RH behaviour (Carballo, Hernandez, Schneider, & Welle, 2005, p. 402). Another article on HIV and internal displacement includes promiscuity in list of problematic activities such as sexual abuse and sibling incest (Wexler, 2003, p. 16).

The Oxford English Dictionary defines promiscuity as "having or characterised by many transient sexual relationships" ("Promiscuity," 2011, p. 1148). Promiscuity is not inherently a public health threat. *Unsafe* sexual relationships—casual or not—are risky health behaviours that contribute to the spread of STIs including HIV. Safe sexual relationships, in any quantity, do not. Further, the use of the term promiscuity is questionable given its negative social construction. The concept of promiscuity has historically been used to discourage female sexual autonomy and agency (Klesse, 2005).

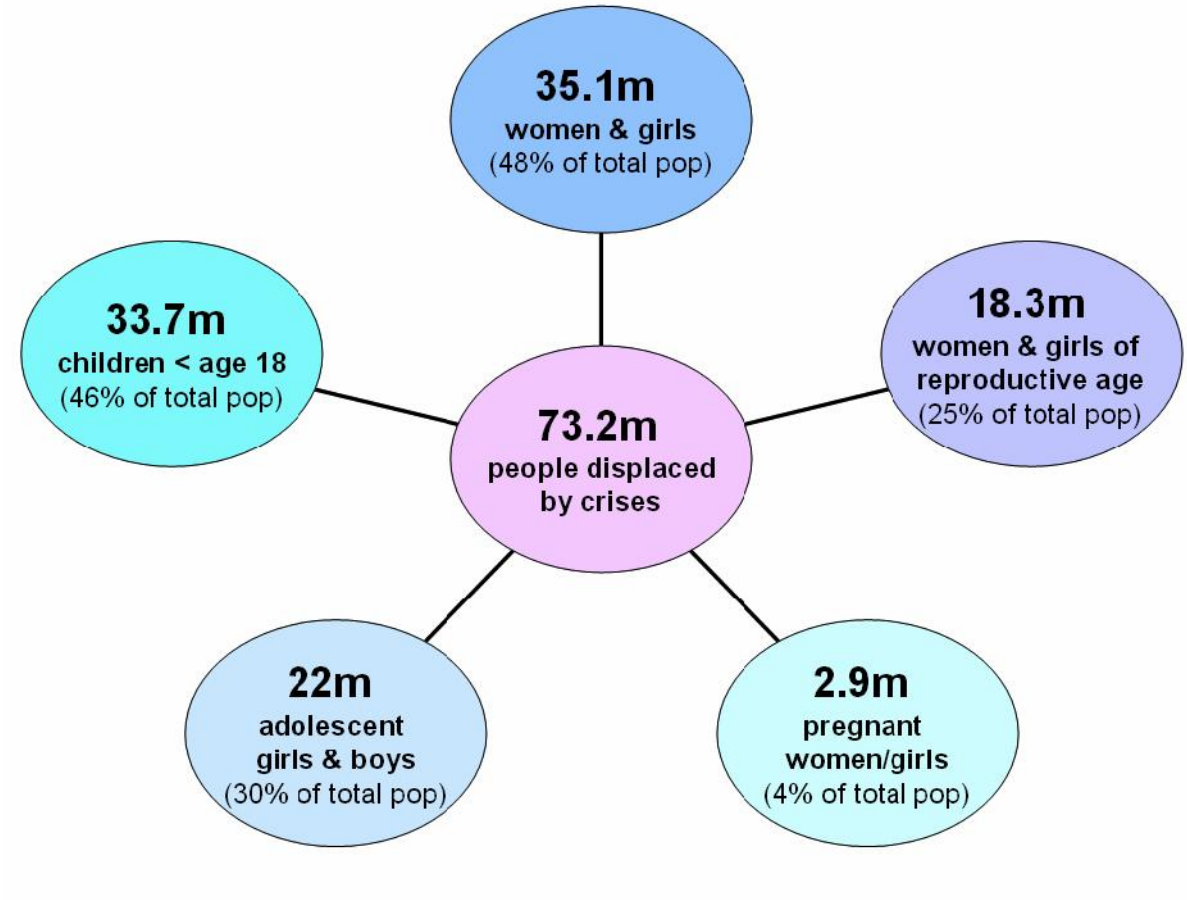
Other authors use problematic language such as "the *temptation* [for displaced women] to exchange sex for goods and protection" (Westhoff et al., 2008, p. 99, emphasis mine). The use of "temptation" in this context is problematic in that it connotes seduction and sexual desire when referring to a woman's painful decision to ensure the survival of herself and her

family. The usage of these terms undermines women's agency and experiences and appeal to a moralistic narrative that undercut a rights based approach. This is particularly problematic in the context of displaced populations, which are often poor, non-white populations—groups that have historically been constructed as highly sexualised, sexually immoral, and transgressive (Klesse, 2005).

3.5 Current gaps and challenges

By the end of 2013, UNHCR (2014a) estimated that 51.2 million people were displaced by conflict or persecution globally, averaging 32,200 people forced to flee from their homes every day. An additional 22 million were displaced by natural disasters (IDMC, 2014), totalling 73.2 million people displaced at some point in 2013. As presented in Figure 3.2, millions of displaced women, adolescents, and girls were at increased vulnerability to sexual violence, unsafe birth and abortion, unwanted pregnancy, and transmission of STIs including HIV (ICRC, 2013; RHRC, 2011).

Figure 3.2: Global scope of forcibly displaced women, youth, and children



Source: (IAWG, 2010c; IDMC, 2014; UNHCR, 2014a)

Despite the vast needs, the field continues to face a number of barriers. The 2012-2014 IAWG Global Evaluation on RH in crises identified poor supply chain management, inequitable funding, policy barriers, dearth of skilled staff, and lack of community engagement to increase RH service uptake as key gaps (Chynoweth, in press). Many of these issues are the same as those identified in the 2002 to 2004 IAWG Global Evaluation (IAWG, 2004b).

Funding for RH in emergencies faced additional setbacks in 2013. AusAID, the Australian Agency for International Development, had been one of two major donors for IAWG and is the primary donor for the SPRINT Initiative. It championed RH in emergencies for over a decade. In October 2013, at the behest of the Prime Minister Tony Abbott, AusAID merged into Department of Foreign Affairs and Trade and officially closed. The conservative government has planned to reduce AUD 4.5 billion in aid over four years (News.com.au,

2013). However, other donors, in particular DFID under the leadership of International Development Secretary Justine Greening, are working to fill this gap and in November 2013 pledged £21.6 million in new funding to assist girls and women in humanitarian emergencies (DFID, 2013).

Research and data on RH in emergencies are limited. A 2014 systematic review found only 36 peer-reviewed papers that evaluated RH programme in crises from 2004 to 2013 (Casey, in press). A 2013 study reviewed the evidence base of public health interventions in humanitarian crises and found only 31 RH studies that met their criteria; of these, just four were of high quality (Blanchet et al., 2013, p. 58). Rigorous research on effective gender-based violence interventions was particularly scant. Other studies indicate that data collection on RH in emergencies has been neglected (Anwar, Mpofu, Matthews, Shadoul, & Brock, 2011; Hynes, Sakani, Spiegel, & Cornier, 2012; Hynes, Sheik, Wilson, & Spiegel, 2002; McGinn et al., 2011).

Challenges to operationalise the IASC Health Cluster guidance remain. At the onset of a crisis response, the Health Cluster does not consistently identify an agency to lead the RH response. Further, agencies on the ground may not have the capacity to lead the RH response. Even when an RH lead agency is identified, it may prioritise non-essential services, such as provision of antenatal care, over MISP implementation.

3.6 An evolving field

In the 1990s, actors working on RH in humanitarian settings focused on camp-based refugees displaced by conflict. Indeed, UNHCR was founded in 1951 with a specific mandate to protect refugees. However, recent trends in displacement have forced the field to adapt accordingly. In 1982, when internal displacement-related statistics were first recorded, the IDMC estimated that only 1.2 million people were internally displaced by conflict in 11 countries (IDMC, 2010). By the end of 2012, approximately 28.8 million people were internally displaced from conflict in more than 40 countries (IDMC, 2013). The dramatic increase has largely been attributed to the end of the Cold War and resulting proliferation of internal conflicts (Cohen & Deng, 1998); since the early 2000s, the tightening of border controls has also limited international movement (Vogl, 2007). This shift has had a significant impact on the way in which relief agencies provide assistance,

particularly in terms of access and security. Resources and field tools, including the *Guiding Principles on Internal Displacement* (1998), were developed to highlight the rights and needs of IDPs and to provide guidance humanitarian aid agencies in their response. In recognition of the increase in IDPs and their particular needs, the RHRC changed its name from the Reproductive Health for *Refugees* Consortium to the Reproductive Health *Response in Conflict* Consortium in 2003.

The IAWG has broadened its scope in recognising the needs of not only those displaced by conflict, but communities *affected* by conflict, including host communities. As such, the revised 2010 field test version of the IAWG Field Manual (2010c) used the term "affected populations" rather than "refugee", "displaced", or "conflict-affected populations" as in previous publications.

The increasing number of persons displaced by natural disasters forms another significant trend. Natural disasters, such as typhoons and earthquakes, newly displaced 22 million people in 2013 (IDMC, 2014). Over five years, from 2008 to 2012, approximately 144 million in 125 countries people fled their homes due to disasters (Yonetani, 2013, p. 6). Many humanitarian agencies have historically responded to natural disasters in addition to conflict. Yet field resources and guidance for humanitarian actors have overwhelmingly focused on conflict-affected settings. Other displacement due to environmental degradation and climate-change, such as desertification and rising sea levels, is also increasing (Mohapatra, 2013). At the time of this writing, humanitarian agencies have generally not addressed environmental displacement, which also falls outside of the scope of UNHCR's mandate.

Collection on data on RH needs and services in natural disasters has been minimal. The first RH assessment after a natural disaster by an IAWG member was during the Haiti earthquake response in 2010.[17] In recognition of this gap, the IAWG highlighted RH in natural disasters in its 2010 annual meeting. To date, IAWG members have not yet discussed other forms of environmental displacement.

[17] The Women's Refugee Commission (2005) conducted an RH assessment after the 2004 tsunami, but the evaluation was explicitly focused on Aceh because it was a conflict-affected setting.

Another trend worth noting includes the increasing number of displaced living in urban settings. More than half of the world's refugees reside in urban settings, and only one-third are still in traditional camps (UNHCR, 2009). The global number of urban IDPs is unknown, although the majority of IDPs reside outside of camps in urban, rural, and peri-urban settings (Brookings-LSE Project on Internal Displacement, 2013). Despite this development, RH field tools remain largely camp focused, including the 2010 revised field-test version of the IAWG Field Manual.

Other emerging areas include disaster risk reduction (DRR), which entails identifying and reducing risks and vulnerabilities to a crisis, and new health technologies that could be modified and used in humanitarian settings. In 2011, the UN Office for Disaster Risk Reduction (UNISDR), created in 1999, formed a sub-working group on DRR and RH within the Thematic Platform for Disaster Risk Management for Health (WHO, 2012c). Policy guidance on DRR and RH has been published and field-based guidance is currently in development (WHO, 2012c). An IAWG sub-working group dedicated to researching new RH technologies and their applicability in humanitarian settings was launched in 2008 (IAWG, 2008).

3.7 Summary

This chapter provides background for the research presented in the thesis. It outlines the evolution of humanitarian response and the ways in which humanitarian actors have grappled with and tried to address the sector's growing complexities. Looking at the field through an RH lens, the impact of IAWG's efforts is reflected in the successful integration of RH as an essential component of humanitarian response. At the same time, the systematic implementation of an RH response remains challenging, particularly with its tenuous position within the Cluster Approach. Against this backdrop, I now turn to the two case studies that explored the barriers and enablers to MISP implementation in Myanmar and Haiti, respectively.

4. Chapter Four: Phase I – Implementation of the MISP after Cyclone Nargis in Myanmar

4.1 Introduction

This case study explores the implementation of the MISP after Cyclone Nargis in Myanmar in 2008. Seven factors were identified to understand the processes and mechanisms related to MISP implementation: composition of the response (e.g., the range of national and international actors), RH coordination, extent of MISP implementation, funding, policies, access/humanitarian space, and community involvement. Analysis of these seven factors provides a framework for understanding the barriers and enablers to MISP implementation. These are discussed in turn below.

4.2 Background

The Republic of the Union of Myanmar, also known as Burma, is the largest country in mainland South East Asia (World Bank, 2013). Shortly after its independence from British rule in 1948, armed conflict between the central government and insurgent ethnic groups such as the Karen and Shan in eastern Myanmar, sparked one of the longest running civil wars in the world (James, 2014). In 1962 the military seized power through a violent coup and established a dictatorship that subjugated its people and inflicted widespread human rights abuses. The military dictatorship officially ended in 2011, and in 2013, the World Bank described Myanmar as commencing a triple transition to democratic governance, a market-oriented economy, and possible "peace" (World Bank, 2013, para. 1). Despite important progress, violence against ethic minorities continues, threatening the fragile transition process (Mullany, 2014).

Myanmar suffered greatly under the years of repressive military rule. In 2014, it ranked 150 of 187 countries on the Human Development Index as well as the Gender Inequality Index (UNDP, 2014b). In 2008, at the time of the cyclone, Myanmar's health system performance ranked 190th of 191 countries, second only to Sierra Leone (WHO, 2008). According to WHO, households face fewer financial difficulties when government expenditure on health is greater than 5% to 6% of the GDP (Xu et al., 2010, p. 7). Yet in 2008, only 2% of

Myanmar's GDP was spent on health, the lowest of any country (WHO, 2011). A 2010 UNFPA report estimated that Myanmar had 14 health care providers (doctors, nurses, and midwives) per 10,000 population, well below WHO's minimum recommended minimum of 23 health care providers per 10,000 population (Women's Protection Technical Working Group, 2010). Although 70% of the population live in rural areas, the majority of physicians reside in cities (Women's Protection Technical Working Group, 2010). Severe poverty also limits people's access to health care services: as of 2013, mean per capita income was just USD 1,700 annually (U.S. Central Intelligence Agency, 2014a).

Availability of RH services prior to the cyclone was limited. In 2006, two years before the crisis, 13.1% of the government's total health expenditure was dedicated to RH in 2006 (UNFPA, 2010b). The *Five-Year National Reproductive Health Strategic Plan* (2004 to 2008) was reportedly underfunded by 75%, reflecting its low national priority (UNFPA, 2010b). Population-based indicators, as outlined in Table 4.1, remain poor. In 2013, the maternal mortality ratio was 200 deaths per 100,000 live births, one of the worst in the region (UNFPA, 2013). In 2012, HIV prevalence was twice the regional average (WHO, 2014e). Contraceptive prevalence was 49%, and only 52% of girls were enrolled in secondary education (UNFPA, 2013).

Table 4.1: Basic health profile – Myanmar

Selected indicators (2012)			
	Myanmar (national)	**Regional average**	**Global average**
Total population (thousands)	52,797	--	--
Population living in urban areas (%)	33	34	53
Total lifetime fertility rate (per woman)	2	2.4	2.5
Life expectancy at birth for both sexes (years)	66	67	70
Under-five mortality rate (per 1000 live births)	52	50	48
Adult mortality rate (probability of dying between 15 and 60 years per 1000 population for males (M) and females (F))	M: 242 F:184	M: 222 F: 149	M: 187 F: 124
Maternal mortality ratio* (per 100,000 live births)	200	190	210
Prevalence of HIV (per 100,000 population)	371	185	511

** Data refer to 2013*

Source: (WHO, 2014e)

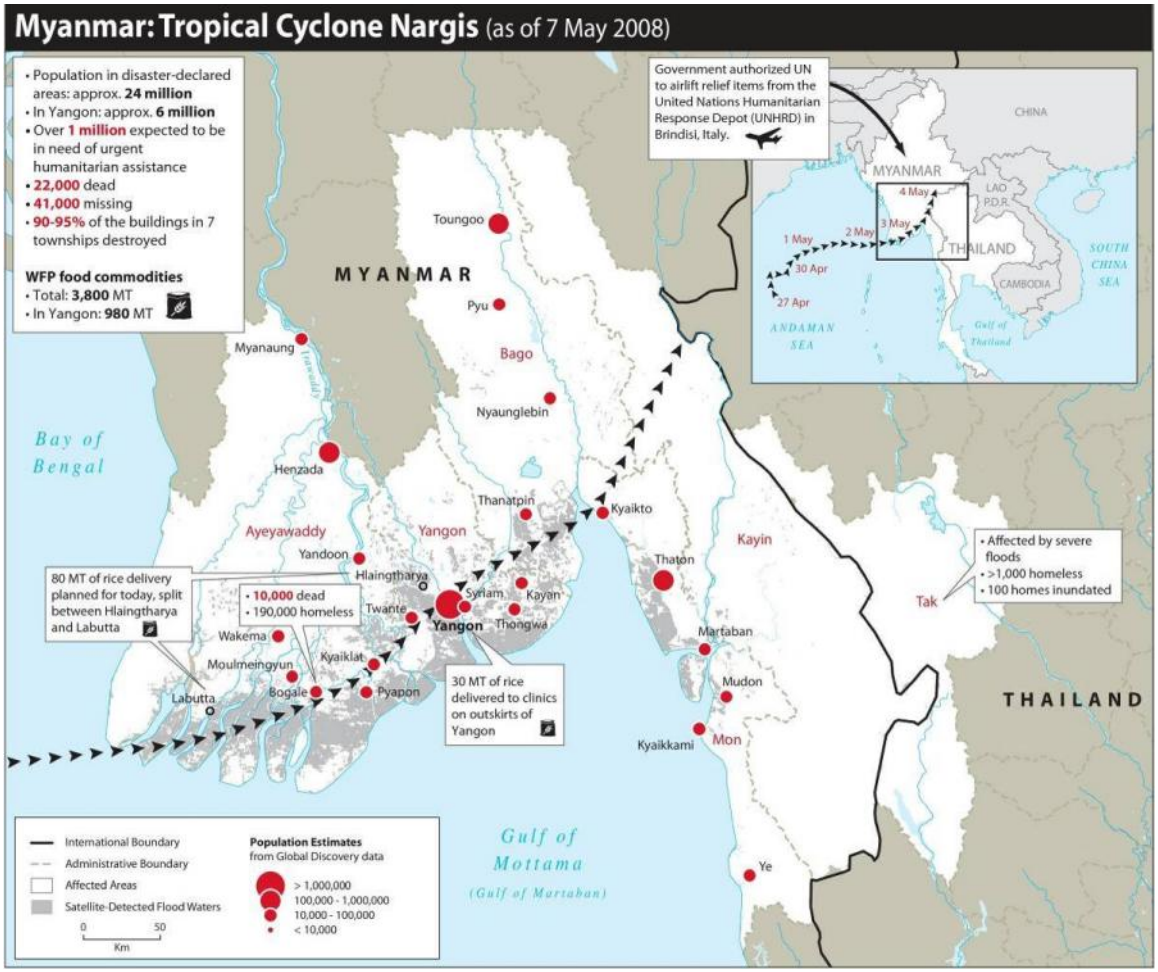
In early May 2008, Cyclone Nargis hit the Irrawaddy Delta and ravaged the country (Figures 4.1 and 4.2). With wind speeds of up to 200 km per hour causing waves more than three meters high, the cyclone affected 2.4 million people, resulting in almost 140,000 deaths and 20,000 injuries (Human Rights Watch, 2010; Wegerdt & Mark, 2010). According to UN estimates, the number of displaced immediately after the disaster may have reached up to 800,000 with over one quarter of a million people seeking refuge in temporary settlements (Featherstone et al., 2009). Twice as many women died as a result of the cyclone as men (Tripartite Core Group, 2008). In terms of impact, Cyclone Nargis was the worst natural disaster ever recorded in Myanmar's history, and one of the deadliest storms ever documented anywhere (Turner, Baker, Oo, & Aye, 2008).

Figure 4.1: Destruction by Cyclone Nargis

© Xinhua/Burma News Agency, 2008

The devastation wreaked upon Myanmar was not only a result of the cyclone itself, but also reflected the lack of government preparedness to deal with a disaster of this magnitude. The government was ill prepared to deal with a disaster of this magnitude: lack of relevant policies and planning, early warning systems, emergency services, and trained staff in addition to overall poor infrastructure and endemic poverty compounded the impact of the cyclone and led to preventable deaths (Stover & Vinck, 2008; Turner et al., 2008). Further, although the Indian Meteorological Department sent numerous warnings to the Myanmar Department of Meteorology and Hydrology that a severe cyclonic storm was approaching, widespread warnings to the population were not issued in time (Human Rights Watch, 2010). A meteorological analyst noted that whether "…through lack of communication, insufficient warnings or a failure to realise the severity of the threat to the delta regions of the Irrawaddy, the lack of [official] response to the warnings resulted in a far greater loss of life than needed to occur" (Webster, 2008, p. 489).

Figure 4.2: Cyclone Nargis-affected areas, Myanmar 2008



Source: (ReliefWeb, 2008b)

MT = Metric tonne

The day the cyclone hit, two UN representatives from Myanmar were finishing a SPRINT Initiative training session on the MISP in Kuala Lumpur, Malaysia. Upon return to Yangon, they spearheaded the RH response. They initiated extensive training and advocacy, led the distribution of supplies, supported implementing partners, and successfully advocated to UNFPA to establish an RH coordination mechanism with a lead RH person (referred to as Focal Point and who was not one of the two trainees). The training and orientation sessions reached over 2,000 people,[18] and informants reported that this contributed significantly to

[18] See Appendix A for breakdown of training and orientation sessions

the advancement of RH in the crisis. UNFPA noted that if it had not been for the SPRINT training, the MISP would not have received attention during the Nargis response.

Figure 4.3: MISP training by UNFPA three months after Cyclone Nargis

© UNFPA, 2008

4.3 Methods

The case study research sought to answer the question "How was the MISP implemented after Cyclone Nargis and what were the key enablers and barriers to MISP implementation?" Table 4.2 summarises the data collection by method and Table 4.3 cross-tabulates the sources of data by organisation and nationality. Semi-structured interviews were conducted with 49 people from 12 different organisations, including four UN agencies, five INGOs, two local NGOs, and one government donor. One health facility assessment and one FGD, both in the cyclone-affected area of Dedaye in Pyapon District, were conducted. Chapter 2, section 2.3.3 provides additional details on the data collection methods for this case study.

Table 4.2: Myanmar case study: Phase I data collection by method

Semi-structured interviews	Facility assessments	No. of FGD	FGD: No. of women
49	1	1	20

Table 4.3: Informants by agency and nationality

	UN	INGO	Local NGO	Donor	Total
Myanmarese staff	10	19	10	1	40
Expatriate staff	5	3	--	1	9
Total informants	**15**	**22**	**10**	**2**	**49**

4.4 Findings

The findings are organised and explored around the seven factors of analysis introduced earlier: the composition of the response (national and/or international actors), RH coordination, extent of MISP implementation, funding, policies, access/humanitarian space, and community involvement.

4.4.1 Composition of the response

The initial response to the disaster, including the RH response, was led by a variety of actors in-country: community-based organisations, national agencies, INGOs, and UN agencies already operating in Myanmar as well as a large number of spontaneous civil society responses. Despite the magnitude of the disaster, the government initially restricted access by external agencies seeking to respond and declared that the country was capable of managing the relief efforts. Visas for most expatriate humanitarian workers were denied, ships and airplanes were blocked from delivering supplies, and journalists were not granted access to report on the disaster (Human Rights Watch, 2010).

The initial obstruction of aid propelled an intense and surprisingly effective response by agencies and individuals in country. The civil society response in particular was significant: people throughout Myanmar collected food, blankets and other essential supplies and distributed the items themselves to the affected areas. Informants noted that medical students and other student groups left their studies and travelled, primarily by motorbike, to the Delta to help. However, the individual and community-based responses were also sometimes restricted by government officials, and reports of the military diverting aid were widespread (Human Rights Watch, 2010). Yet much needed assistance did reach the affected populations; and despite fears of widespread preventable deaths in the weeks after the cyclone, this did not occur (Turner et al., 2008).

After three weeks of intense international pressure, including a visit by the UN Secretary General Ban Ki-moon, the Prime Minister finally announced that the government would accept international aid as long as "there were no strings attached nor politicisation involved" (Deutsche Presse Agentur, 2008, para. 1). The UN and the Association of Southeast Asian Nations (ASEAN) worked with the Myanmar government to establish the Tripartite Core Group, which led the overall coordination of the response and negotiated to improve access to international humanitarian agencies to the affected areas (ASEAN, Government of Myanmar, & UN Country Team in Myanmar, 2008). Informants and evaluations noted that the Tripartite Core Group was critical in improving the effectiveness of the response.

4.4.2 Coordination

Coordinating humanitarian action is crucial to ensuring the effectiveness of the aid response. Coordination helps to identify and fill gaps in service delivery, prevent programme overlap, strengthen advocacy, and support accountability processes and promote the application of standards. Yet coordination among humanitarian actors has been notoriously weak, often due to lack of effective leadership, competing priorities, limited resources, and the urgent needs of the affected communities (Hedlund, 2011; Humphries, 2013; Stephenson, 2005; Zhao, John, Maitland, Tapia, & Ngamassi Tchouakeu, 2009).

Poor coordination of RH service provision had been identified in a variety of earlier evaluations as one of the key barriers in effective MISP implementation (Onyango et al.,

2013; Women's Refugee Commission, 2003, 2005, 2007, 2008; Women's Refugee Commission & UNFPA, 2004). In Health Cluster/sector coordination, RH is often subsumed under the myriad of competing health priorities in an emergency, and some Health Cluster/sector coordinators and service providers continue to view RH as a luxury, rather than an essential, priority humanitarian intervention. Further, RH coordination was identified as a critical factor that underpinned the RH response as a whole. Therefore, I explore RH coordination separately from the implementation of the other four objectives of the MISP.

In Myanmar the Cluster Approach was activated within the first few days after the cyclone (Kauffmann & Krüger, 2010). WHO and Merlin, an INGO that had been working in Myanmar since 2004, co-chaired the Health Cluster (Merlin, n.d.). According to some inter-agency assessments, the Health Cluster was reportedly one of the best-managed Clusters within the Nargis response (Kauffmann & Krüger, 2010; Turner et al., 2008). However, informants reported that the Health Cluster largely dismissed RH during the acute phase. For example, when one participant raised the importance of addressing RH in the response, the Health Cluster coordinator asked him to sit down and not bring up the topic during Health Cluster meetings, ostensibly because RH was not deemed a priority. One Myanmarese UN representative recalled:

> *"The chairperson of the Health Cluster said, 'Please stop, please stop' when we tried to raise the issue and share some points on RH. They only want to hear what they are interested in".*

Another Myanmarese doctor described how WHO, the Health Cluster lead agency, did not prioritise maternal health, although its importance was recognised by others:

> *"Maternal health is a priority among the people. It's quite funny, WHO—for them it is not a priority but in the community and the INGOs and NGOs [they] think it's a priority. And UNFPA. We are all working together".*

The Health Cluster focused on treating injuries and preventing infectious disease outbreaks. In a discussion on gender and RH, a Myanmarese representative from the Health Cluster acknowledged:

> *"We were not able to focus on [gender and RH]. We focused on other things".*

Some informants reported trying to raise awareness about RH to other humanitarian health actors. Another local UN official noted:

> *"Convincing those amongst ourselves [of the importance of RH] was the most difficult part*".

Others mentioned that many UN and government agencies were more interested in the "hardware" of emergencies, such as clearing debris and establishing safe shelters, and did not understand the importance of RH.

Despite the lack of support from the Health Cluster, the two SPRINT trainees, with the backing of their separate organisations, approached UNFPA to establish an RH/HIV Technical Working Group at the national level to coordinate the health actors working on RH. UNFPA identified a local RH Focal Point to facilitate the Working Group, and the trainees supported him. Sub-national and field-level RH coordination, which was rarely established in emergencies at that time, was also set up and fed back into the national RH/HIV Technical Working Group. Later, a Women's Protection Technical Working Group was set up under the Protection Cluster.

All informants reported that the RH coordination was exceptional and this successful cooperation was the primary enabler for MISP implementation. National meetings were held weekly with approximately 30 agencies participating, although not all attended each meeting. Many agencies had lacked clarity regarding what RH activities to prioritise, and the Working Group was a forum to discuss priorities and strategise on how to implement the MISP. In addition to providing technical guidance and facilitating strategic planning, the meetings helped establish and reinforce strong links among members. A local program manager with an international RH agency noted how the Working Group supported and guided her agency:

> *"We didn't know what to do [for RH] especially when people are just trying to survive… When I attended the [RH/HIV] Technical Working Group Meeting, I hadn't realised until then how many agencies were working on RH. I realised we needed to work more with them to make sure we were on the same page. I didn't know if what we were doing was right…It was very encouraging for us to have them [Technical Working Group] at that time".*

Mirroring the overall initial response, the RH response was led by Myanmarese. All informants attributed the excellent inter-agency coordination to the fact that it was comprised of national actors with long-standing relationships: people knew each other—in fact, many had attended medical school together; they spoke the same language and held shared norms; they understood the local context and systems as well as the strengths and weaknesses of the various responding organisations; and there was little competition or territorialism among them. There was also very little, if any, staff turnover. These connections enabled a network of trust and mutual understanding of the complex political and cultural context of the affected communities. One Myanmarese UN representative said:

> *"Pre-existing relationship and friendship was the most important [for the RH response]. Networking each other is very important, otherwise we will not assemble the RH sub-cluster".*

Indeed, the IASC's *Inter-agency Real-Time Evaluation of the Nargis Response,* conducted in October 2008, found that the majority of the life-saving interventions were carried out by national actors, before the international agencies arrived, despite the fact that many did not have previous humanitarian experience (Turner et al., 2008). As a result, many grassroots organisations, which are often neglected in humanitarian coordination mechanisms (Krause et al., 2011; Women's Refugee Commission, 2007), were engaged and played a key role in the response. Local women's groups, for instance, raised awareness on RH and their findings and experiences fed back to the national RH/HIV Technical Working Group. While the Health Cluster was reportedly difficult to manage because of its size, the RH/HIV meetings were also effective because the numbers were smaller, averaging ten to 15 participants. Moreover, people knew and trusted each other, and the Working Group was led by a strong local facilitator. As one Myanmarese UN official poignantly noted,

> *"In these meetings we could really talk".*

The effective RH coordination was reflected, for example, in inter-agency collaboration to address emergency obstetric care. Transport to referral facilities for women experiencing obstetric emergencies was a significant barrier at the beginning of the response since many roads and bridges had been washed out or were obstructed by debris. As such, agencies worked together to procure boats to transport women to health facilities. They also pooled funding to provide financial support for women seeking care. Lack of supplies for emergency obstetric and newborn care at the township hospitals was another gap, and

agencies collaborated to identify the hospitals in need and provide the relevant supplies. Given the historic neglect of RH in crises as well as typically fragmented inter-agency humanitarian coordination, these efforts were striking.

Figure 4.4: UNFPA and partners used boats to distribute clean delivery kits

© UNFPA, 2008

The overall health response changed when new international actors arrived. One foreign informant who had worked for a number of years in Myanmar with an INGO commented:

> *"There were too many people from outside, helicoptered in who wanted to talk, but did not understand the Myanmar context. What we needed was the local actors".*

Competition grew with the increase in external staff, and staff turnover increased. Many new international staff arrived on short-term contracts. Although the RH/HIV Technical Working Group was not appropriated by the new expatriate actors, overall Cluster coordination reportedly weakened and national staff found it difficult to participate in Health Cluster meetings. One UN local staff member noted,

> *"At our office is only local people and during the [Health Cluster] meeting to have a voice is very difficult".*

4.4.3 Extent of MISP implementation

As outlined in Chapter 1, the MISP comprises five primary objectives as well as four additional activities:

- Identifying a lead RH organisation to facilitate implementation of the MISP;
- Preventing sexual violence and providing appropriate assistance to survivors;
- Reducing the transmission of HIV;
- Preventing excess maternal and newborn death and disability; and
- Planning for the provision of comprehensive RH services, integrated into primary health care.
- Additional activities include:
    - Syndromic treatment of STIs;
    - Provision of contraceptives;
    - Provision of ARVs; and
    - Provision of menstrual hygiene materials.

These objectives were met to varying degrees, as discussed below. Since coordination was explored previously, it is not included in the following section. The provision of RH supplies is included below because they are essential for all areas of MISP implementation.

4.4.3.1 RH supplies

In 1997 IAWG developed the first Inter-agency Reproductive Health Kits, or RH Kits, to support RH implementation in humanitarian emergencies (IAWG, 2011). They contain medicine, medical equipment, and treatment guidance. These twelve pre-packaged Kits can be ordered through UNFPA, which ships them to humanitarian emergencies around the world from their procurement centre in Denmark. The Kits are intended to support humanitarian agencies implementing RH services during the acute phase only, until supplies can be ordered through regular supply chains; they are not designed for long-term use.

In Myanmar the first batch of RH Kits arrived within the first two weeks. However, the Kits had to be given clearance by government authorities prior to distribution to implementing agencies. This created delays as government officials were not familiar with the contents of the Kit. Initially, they removed manual vacuum extraction supplies for post-abortion care,

Figure 4.5: RH Kits await distribution

@ UNFPA, 2008

which was perceived as threatening since authorities did not acknowledge that abortions occurred in the country. Post-exposure prophylaxis to minimise HIV transmission after rape was also removed. An informant quoted a government official:
"He said, 'The rape kit is not necessary because it [rape] doesn't happen here'".

However, many of the leading RH actors had long-standing relationships with Department of Health (DoH) officials. Thus, after persistent advocacy, government authorities gave clearance for distribution of the Kits. Later post-exposure prophylaxis was also allowed and distributed to affected townships, although it was not often used. Indeed, many township hospital staff were not familiar with the contents of the Kits and did not know how to use them. Agencies tried to address this by rolling out orientations on RH Kit usage.

4.4.3.2 Emergency obstetric and newborn care

An estimated 4% of any crisis-affected population will be pregnant and up to 15% of pregnant women will experience an obstetric complication such as obstructed or prolonged labour or complications of abortion (IAWG, 2010c). Furthermore, 5% to 15% of women who face complications require a life-saving Caesarean section (IAWG, 2010c). Lack of adequate care can lead to preventable maternal death or long-term health consequences, such as fistula.

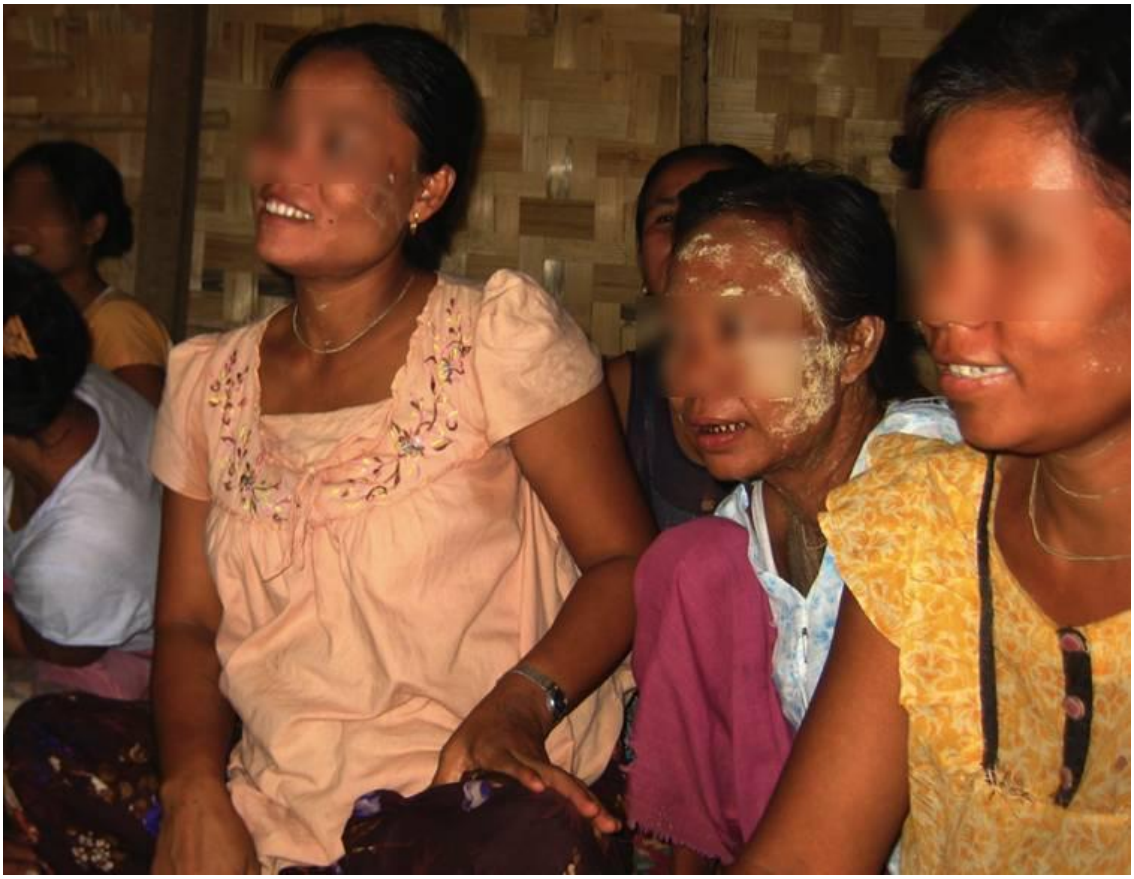
According to informants, agencies prioritised emergency obstetric and newborn care above other clinical components of the MISP, in part because maternal health was less politically sensitive than sexual violence and HIV, the other clinical MISP interventions. RH actors collaborated closely with one another, as described previously, to address maternal health

needs. Informants reported that funding for emergency obstetric and newborn care supplies was generous. UNFPA and implementing partners distributed thousands of clean delivery kits to pregnant women to promote safe home delivery. However, up to 75% of the health facilities in the affected area had been destroyed or damaged during the cyclone (Tripartite Core Group, 2008), which significantly compromised the effective provision of emergency obstetric and newborn care. In a FGD with 20 women who had survived the disaster, four of them were pregnant when the cyclone hit. One woman described giving birth while holding on to a coconut tree during the storm. The other two women also delivered without birth attendants or supplies in the first weeks after Nargis. One said:

> *"There were just the people around us to help us… I didn't even have a towel to cover up".*

While these three women and their children did well, the fourth woman had a spontaneous pregnancy loss four days after the cyclone. She needed a blood transfusion, which cost USD 70 and was prohibitively expensive for her. Because friends and families pooled their money, she was able to receive the care and transfusion that she needed. Although services at health facilities are technically free in Myanmar, corruption and under the table payments to among health care workers is not uncommon in part due to their low pay (Human Rights Documentation Unit, 2008). A local physician reported that a doctor's monthly wage was approximately USD 100.

Figure 4.6: Focus group discussion participants



Blurred to protect anonymity

Key informants agreed that financial barriers prevented women from accessing care. A post-disaster assessment of women's protection issues also confirmed that financial constraints were one of the biggest barriers to accessing health services (Women's Protection Technical Working Group, 2010). In addition to fees for care, transport costs were prohibitive for service users. Recognising these financial barriers, humanitarian agencies responding to the cyclone collaborated to support these costs for women experiencing obstetric emergencies but they could not reach all affected communities.

Other issues affecting emergency obstetric and newborn care were more difficult for agencies to address. For example, in Myanmar, a midwife requires only 18 months of training to obtain a certificate, which is not enough to properly equip them to deal with obstetric problems such as unsafe abortion (WHO, 2012a). According to informants, many doctors are unable to perform a Caesarean section. Each of Myanmar's 330 townships—of

which 37 were severely affected by the cyclone—has a referral hospital, all of which should be able to perform comprehensive emergency obstetric and newborn care (WHO, 2014f). Informants reported that, in practice, township capacity to perform emergency obstetric and newborn care lagged since remote hospitals struggled with staff attrition and limited or poorly skilled providers.

As noted previously, provision of manual vacuum aspiration for post-abortion care was also a challenge. Despite the fact that, as of 2004, unsafe abortion accounted for more than one-third of maternal deaths in Myanmar (UNICEF & Department of Health Myanmar, 2004), few doctors were trained to perform manual vacuum aspiration and thus, when the manual vacuum aspiration supplies were finally distributed, the equipment was often not used.

4.4.3.3 HIV transmission

Due to increased national political commitment and international funding, the estimated adult HIV prevalence has declined from 1.3% in 2005 (National AIDS Programme, 2005) to 0.6% in 2013 (World Bank, 2014b). Yet HIV prevalence is still among the highest in the region (WHO, 2012b). At the time of the Cyclone in 2008, adult HIV prevalence was estimated at 0.7% and only 15% of those in need of anti-retroviral therapy received it, one of the lowest coverage rates in the world (MSF, 2008b).

According to informants, addressing HIV transmission was initially not on the agenda of the health responders. One national medical doctor said that reducing HIV transmission:

> *"…is the least priority. HIV prevention was successful in many areas [before Nargis] but people do not relate HIV and emergencies".*

During the first month after Nargis struck, many blood screening supplies were not available and thus screening for blood borne diseases, including HIV, was not consistent. Informants reported significant gaps in the practice of standard precautions, in large part due to lack of basic supplies such as gloves and sharp boxes. Lack of running water was another major issue as well as how to manage medical waste. Each organisation had to plan for its own waste disposal. An informant reported that, in one setting, a government health facility dumped its medical waste into the local river that the community used on a daily basis for

eating and drinking water. Informants noted that these issues were problematic during the first month after the cyclone, but that they improved over time.

Condoms are effective in preventing HIV transmission when used properly; however, condoms were a sensitive issue in Myanmar. One assessment estimated that condom usage in the cyclone-affected areas was only 2.1% (Women's Protection Technical Working Group, 2010). During the acute phase, many agencies did not feel comfortable distributing condoms because they feared of government backlash. Indeed, informants reported that the DoH openly criticised the UN for distributing condoms during the disaster response, citing impropriety. A Myanmarese country director of an INGO recalled:

> *"There was a statement just last week by government. 'UNFPA brought in condoms after Nargis. This is an insult and culturally inappropriate.'"*

Despite this pushback, informants did not report problems with making condoms discreetly available in places like latrines. A few months after the Cyclone, Technical Working Group members worked together to establish condom campaigns, which were reportedly well received.

Figure 4.7: Free condoms available in clinic bathroom, Dedaye

© SK Chynoweth, 2010

4.4.3.4 Sexual violence

Informants reported that sexual violence occurred after the disaster, although the extent is unknown. A women's protection assessment that focused on communities most affected by the cyclone found that the main safety issue facing women and girls as identified by community respondents was rape (Women's Protection Technical Working Group, 2010). A complementary assessment found that approximately 60% of those interviewed lacked awareness on women's security or protection issues (Women's Protection Technical Working Group, 2010). The assessments also documented increases in sexual exploitation, such as exchanging sex for basic goods, after the cyclone (Women's Protection Technical Working Group, 2010), which was corroborated by the informants in this research. Another assessment also found that women and children were particularly vulnerable to abuse, exploitation, and violence post-Nargis (Featherstone et al., 2009). Despite this, prevention mechanisms, such as adequate lighting in camps and outreach to particularly vulnerable women and girls, were not put in place, and health facilities and staff were not equipped to deal with rape survivors.

Sexual violence is a controversial issue in Myanmar, in part because of the political sensitivities around rape perpetrated by government soldiers in the ethnic-minority states (Karen Women's Organization, 2004, 2007, 2008; Shan Human Rights Foundation & Shan Women's Action Network, 2002; Woman and Child Rights Project & Human Rights Foundation of Monland, 2005; Women's League of Chinland, 2007). Indeed, the 2008 HAP report *Quality and Accountability in the Nargis Response* stated that:

> *"Although the [humanitarian] agencies… are keen to develop a common CRM [complaints and response mechanism] there remains a general understanding that it should not tackle serious issues such as Sexual Exploitation & Abuse given the strong taboo about discussing such issues in Myanmar"* (HAP, 2008b, p. 1).

During a discussion about sexual violence with a Myanmarese informant, she lowered her voice and explained:

> *"We cannot show the sins of the people. As you all know the Myanmar government was accused for those kinds of crimes [rape] in the border area. So politically it is very sensitive. Government staff dare not raise up the issue".*

Prevention of sexual violence was not a priority of the agencies interviewed, despite its being a minimum standard in humanitarian response (Sphere Project, 2011). Many informants had heard anecdotal reports about rape in the days and weeks after the cyclone. According to them, government-run camps were the most problematic. Housing structures were sub-standard, and doctors visited only once a week. Only a few international agencies were allowed access to the camps. A Myanmarese doctor described the conditions that put women and girls at risk for sexual assault:

> *"The camp settings are very bad. At that time my concern is the camps, but we cannot reach, we cannot control that. We can imagine that no protection at all… Yes, I am sure no protection measures. In the worst hit township, there was a camp for a long time. Totally opposite from the guidelines. No lights, no secure place for girls and women, the toilets are very few and dirty. So we heard that several months [after the cyclone] some girls are pregnant. Single girls".*

Some humanitarian workers heard about sexual and other forms of violence against women in the camps, but said they did not know where to report it or to whom to talk. According to one expatriate UN official and member of the Shelter Cluster, land and property rights were prioritised over prevention of gender-based violence in the Nargis response, despite minimum standards that recognise security and safety as a critical element of emergency shelter (UNOCHA, 2008). She commented:

> *"My impression was that no protection mechanisms were implemented".*

In terms of the clinical management of rape, informants reported that doctors and nurses in Myanmar did not know the international standards on how to provide care for a rape survivor, and most of those interviewed were not aware of whether there was a national protocol in place for post-rape treatment. Informants thought that most health actors would refer the survivor to the police and not treat her directly, unless she needed significant injury care. Provision of emergency contraception to prevent pregnancy, post-exposure prophylaxis to prevent HIV transmission, and presumptive treatment of STIs—the minimum medical standard of care after rape—were largely unknown. A main concern among health professionals was that they would get into trouble with government officials if they treated a rape survivor but did not report it to the police. One informant from a national organisation noted that they focused on provision of psychosocial support for survivors and had not considered the importance of the clinical response:

"I think we are lacking in that, now only that you pointed it out".

Figure 4.8: Focus group discussion participants

Blurred to protect anonymity

Despite this, a few INGOs trained internal staff and provided comprehensive clinical care for rape survivors. Representatives from an INGO-run clinic reported that a handful of rape survivors presented each month after Nargis. These were either young children or women who had become pregnant after rape. Informants and focus groups discussion participants said that women in Myanmar were unaware as to why they should seek medical care after rape. Many communities were unaware that pharmaceuticals exist to prevent pregnancy and minimise HIV transmission. Further, community awareness of basic human rights was low, particularly related to violence against women. A Myanmerese director of a large INGO commented:

"Women [who have experienced violence] don't come forward. They don't know their rights."

Compounded by the intense social stigma of rape, lack of knowledge, and limited care, very few women sought medical services after surviving rape in the aftermath of Cyclone Nargis.

4.4.3.5 Planning for comprehensive RH services

One of the key activities in planning for comprehensive RH services is to identify training needs of staff. RH actors were exceptional in this regard, working together to identify training needs and establish training sessions in order to increase capacity to implement the MISP. (See Appendix A for list of trainings throughout Myanmar.) Data collection is also important to design more comprehensive services. Although agencies reported that the DoH was generally supportive of their work, they also could not conduct independent health and protection surveys or assessments without government interference. As such, reliable health data were not available in-country. This significantly hindered planning for more comprehensive services.

4.4.3.6 Additions to the MISP

Contraceptives were in high demand after the crisis, but many women reportedly had difficulty accessing them. Some women in the FGD reported that they could not access contraceptives for up to five months after the cyclone. A number of respondents reported an increase in children born after the cyclone, which were called “Nargis babies”. Antiretroviral therapy was also disrupted after the cyclone; transport to the few health facilities that provided ARV was a major issue. Informants reported that STIs were widespread but social barriers, such as shame and fear of ostracism, prevented them from seeking care. UNFPA distributed more than 50,000 hygiene kits, which included menstrual hygiene supplies, toothbrushes, and underwear, among other personal supplies.

Figure 4.9: UNFPA distribution of dignity kits after Cyclone Nargis

© UNFPA, 2008

4.4.4 Funding

Funding requests and funding received for the RH response after the cyclone were both unusually high. Indeed, the SPRINT Initiative offered financial support to UNFPA to coordinate implementation of the MISP, but UNFPA declined because it had secured adequate funds. Of the approximately USD 95 million in RH Flash Appeal funds to 18 crisis-affected countries in 2008, almost 30% was allocated to the Nargis response (Tanabe, Schaus, Tastogi, Krause, & Patel, in press; UNOCHA, 2011b).

Tables 4.4 and 4.5 below outline the total funding requested and received for RH-related activities from the Flash Appeal and CERF, respectively.[19] The total funding requested

[19] A Flash Appeal is instigated by the UN Humanitarian Coordinator and should be issued within the first week of an emergency. Appeals generally fund short-term, life-saving interventions, although they may fund early recovery programmes as well. The CERF is a pre-existing fund managed by the UN and includes windows for

amounted to almost USD 45 million, which reflects considerable attention to the issue by implementing agencies (CERF, 2008; UNOCHA, 2011b). As of January 2011, around USD 30 million, or 68%, had been received (CERF, 2008; UNOCHA, 2011b). This is significantly higher than other humanitarian RH appeals: between 2002 and 2013, on average, 43% of RH funding requests were met globally (Tanabe et al., in press).

Major donors for the Nargis RH-related response included Australia, Norway, Denmark, the Netherlands, and the UK, which have historically been among the top funders for RH in crises since 2002 (Patel et al., in press). UNICEF received almost 90% of Flash Appeal funding and 95% of CERF funding for RH-related activities with a primary focus on children. Although UNFPA and other INGOs such as MSI and Population Services International (PSI) did not directly receive substantial funds through the Flash Appeal and CERF, according to informants representing these agencies, they did secure funding through internal and external sources. For example, the Post-Nargis Recovery and Preparedness Plan, developed by the Tripartite Core Group, also provided some funding to implementing agencies for maternal health and family planning (Tripartite Core Group, 2009). Further, many national and INGOs and the DoH were implementing partners for UNICEF, and thus indirectly received Flash Appeal and CERF funds (Table 4.5).

When asked if funding was a barrier to the RH response, a UNFPA representative responded:

> *"I think not much. We've received a lot of funding".*

Only one of the informants, a country director from a small INGO, cited funding as a barrier to MISP implementation.

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rapid response and under-funded emergencies. CERF funding is only disbursed to UN agencies, although these agencies often sub-grant to implementing partners.

Table 4.4: Flash appeal funding for Cyclone Nargis response as of 1 Jan 2011*

Project	Agency	Amount requested (USD)	Funding received (USD)	% of funding request received
Provision of life saving sexual and reproductive health care in emergency	UNFPA	$4,247,900	$242,776	6%
Protection of vulnerable female survivors	UNFPA	$1,337,500	-	0%
Let's reduce HIV vulnerability together! A safe mobility program	IOM	$493,992	-	0%
Repair, rebuild, and rehabilitate PHC and capacity enhancement in Irrawaddy delta**	IOM	$1,937,828	$751,274	39%
Restoring and revitalising health care systems including TB/HIV control and HIV/AIDS	WHO	$3,392,264	$954,731	28%
Prevention of maternal and childhood illnesses and deaths in the cyclone affected areas	UNICEF	$15,515,000	$18,088,331	117%
Procurement and distribution of dignity kits to women, girls, boys and men	UNFPA	$1,776,200	$94,600	5%
Rehabilitation of health clinics and provision of community health education and info**	UNFPA	$700,000	-	0%
Mitigation and prevention of HIV impacts after cyclone Nargis	Int'l HIV/AIDS Alliance	$830,410	-	0%
Access to Commodities and Communications in Emergency for RH Services (ACCESS)	MSI	$485,299	-	0%
Provision of life-saving basic and reproductive health care services through the private sector in cyclone-affected areas	PSI	$297,186	-	0%
Protecting children and women affected by Cyclone Nargis	UNICEF	$10,700,000	$7,225,092	68%
Community based protection project for children and their families in Ayeyawaddy Delta	World Vision	$920,000	$892,433	97%
TOTAL		**$42,633,579**	**$28,249,237**	**66%**

Source: UNOCHA, 2011b
*All health Flash Appeal proposals for the Cyclone Nargis response were reviewed in detail on UNOCHA's Financial Tracking Service.
**Project titles in bold included components of RH in the proposal description, but were not focussed on RH specifically.

Table 4.5: CERF funding for Cyclone Nargis response (rapid response window)

Project	Agency	Funding received in USD	Implementing partners
Prevention of maternal morbidity, sustaining reproductive health	UNFPA	$99,510	Myanmar Medical Association
Prevention of child and maternal deaths and illnesses	UNICEF	$2,000,900	CESVI, Save The Children, Myanmar Medical Association, MSF-Holland, MSF-Switzerland, Ministry of Health
TOTAL		**$2,100,410**	

Source: CERF, 2008

UNFPA provided USD 500,000 worth of RH Kits to the 14 cyclone-affected townships through the DoH and the Myanmar Medical Association. Through its implementing partners, UNFPA also distributed USD 30,000 worth of clean delivery kits and USD 330,000 worth of 50,655 dignity (hygiene) kits. In addition, it provided birth spacing commodities and RH information materials to the mobile health services of NGOs. UNFPA, CERF, Australia, and Norway provided funding support for maternity waiting homes and mobile clinics.

4.4.5 Policies and protocols

National policies (or the lack thereof) related to RH and disasters played an important role in the efficacy of the RH response. According to informants, at the time of the cyclone, a national emergency response plan was in place, but RH had not been integrated into the health component; the National Reproductive Health Strategy also did not include emergency response at the time. Thus RH in emergencies was not integrated into any relevant national policy when the cyclone struck.

National protocols on the clinical components of the MISP varied. With regard to HIV transmission, national protocols were in existence. Protocols on safe blood handling and standard precautions were in place, and informants noted that most medical staff were familiar with them. The Myanmar National Strategic Plan on HIV and AIDS was developed in 2006 and outlined 13 strategies to respond to the needs of the affected population as well as prevention mechanism to prevent further transmission (Ministry of Health Myanmar,

2006).[20] The strategy has been recognised as reflecting international good practice, emphasising the most at-risk populations and developed in a participatory manner by an inclusive technical working group (PSI, Save the Children, & UN Joint Team on AIDS in Myanmar, 2008). Yet implementation was weak and prevention and response to HIV in emergencies was not included in the plan. This marked a significant gap that was reflected in the neglect of HIV during the cyclone response. One Myanmarese UN informant noted that prevention of HIV transmission was the least prioritised of all MISP objectives.

Many respondents noted that MDG 5a[21] was a new focus of the government, in part because of recent international pressure highlighting Myanmar's poor record on maternal health. Maternal mortality in Myanmar remains high, with 200 women dying per 100,000 live births as of 2010, although the ratio has significantly improved from 520 deaths per 100,000 births in 1990 (WHO & UNICEF, 2013). the time of the cyclone, the Five-Year Strategic Plan for Reproductive Health in Myanmar 2004-2008 was in place, partially initiated by the government's interest in MDG 5a (WHO, 2005). Although disaster response was not included, maternal health was a strong focus of the plan. RH informants reported working together to leverage the government's interest in maternal health to address the more sensitive elements of the MISP in the Nargis response. One of initial SPRINT trainees described the Technical Working Group's tactics:

> *"We can do for maternal health whatever we want to do. But for sexual violence the barrier is much bigger. The barriers are again the political and cultural situation. So we use maternal health as an entry point. We change the sequence of the five objectives. One is coordination and then maternal health".*

Other national policies and protocols noted by informants that affected implementation of the maternal and newborn health component of the MISP included inadequate training of midwives in emergency obstetric and newborn care and related policies that prevented midwives from providing this care. A Myanmarese UN official remarked:

> *"Our midwives are not capable of doing much on even basic emergency obstetric care: they cannot give assisted delivery, they cannot perform manual removal of the placenta*

[20] The 2011- 2015 Myanmar National Strategic Plan on HIV and AIDS has since been developed, two years after the cyclone.
[21] MDG 5 is comprised of two targets: 5a: Reduce by three quarters the maternal mortality ratio; and 5b: Achieve universal access to reproductive health

or retained products. And even for medicine—oxytocin, anticonvulsant, antibiotics—they are not allowed to use".

Lack of policies and protocols regarding sexual violence was a significant barrier to preventing rape and providing care for survivors after the cyclone. There was no standard national operating procedure on clinical management of rape. According to a UN representative, although forensic guidelines for post-care treatment were technically in place, the protocols only instructed medical practitioners to refer survivors to a government hospital for collection of evidence and not to provide care. Rape was understood as a criminal offense and providers were not allowed to interfere. At the same time, almost all of those interviewed did not know whether they themselves were legally mandated to report to police if a rape survivor presented at a clinic. A national UN official commented:

"Health service providers are very confused who is responsible".

Another informant from a different UN agency had explored this issue and reported that the guidelines were only relevant to public facilities. Reporting requirements for private health facilities were unclear. Informants said that some doctors provided care "under the table" without reporting it to authorities at the patient's request.

Additional national policies affecting implementation of the MISP include those relating to abortion. Abortion is only permitted in Myanmar when the mother's life is in danger (Center for Reproductive Rights, 2014). Although maternal mortality data related to unsafe abortion after Cyclone Nargis is not available, the highly restrictive national policy put women's lives at risk, particularly after the natural disaster when access to contraceptives was disrupted, sexual violence increased, emergency contraception was not available for survivors, and access to emergency obstetric care was limited. A Myanmarese representative from a UN agency commented that although abortion laws globally seem to be becoming less restrictive, she thought Myanmar would not follow suit given the deep-seated cultural and religious beliefs around abortion.

4.4.6 Access/humanitarian space

Humanitarian space refers to the establishment and preservation of a safe, productive environment in which humanitarian agencies can operate (UNOCHA, 2003). Humanitarian

space was limited in the post-Nargis response. Constraints included both political and physical factors. International humanitarian actors faced long delays in accessing the affected areas due to government resistance. As noted, visas were denied or delayed, boats with food and other supplies were not allowed to dock, and even when staff and supplies arrived in country, access to the Delta region was often limited (Human Rights Watch, 2010). Roadblocks were established and the military tried to take over the delivery of aid for their own purposes, to the chagrin of international humanitarian agencies (Hoge, 2008, May 15; Human Rights Watch, 2010). In some cases, national relief organisations and individual people trying to help were denied access to the affected areas by government officials, presumably to maintain government's image that it can solely manage the response (Human Rights Watch, 2010). According to Amnesty International, at least 22 local people were arrested for helping Cyclone victims, probably to quash any other local activism (Amnesty International, 2008b). Yet increased access was granted with time, particularly after the establishment of Tripartite Core Group.[22]

Physical access to the affected communities was also extremely challenging. The affected region spans 23,500 square kilometres—approximately the same size as Peru—and is comprised of swampy land divided into islands and peninsulas by rivers and smaller waterways (UN, 2008). The region's terrain was challenging to traverse under normal circumstances and relied heavily on boats, many of which were destroyed during the cyclone (UN, 2008). Roads were completely wiped out or obstructed by debris, and flooding and mudslides were widespread. The cyclone disrupted telecommunication lines, radio and the electrical power grid, thus significantly limiting communication (USAID, 2008). Total damage and losses to transport and communication were estimated at more than USD 185 million (Tripartite Core Group, 2008). The post-crisis clean up began almost immediately, largely initiated by the affected communities themselves in addition to some local security forces. Although many major roads were cleared and communication lines were restored in the first few months, reconstruction required years of effort and the area has yet to fully recover (Metta Development Foundation, 2011).

[22] Other areas of Myanmar, particularly the conflict affected minority states, remain highly inaccessible. However, these areas were not significantly affected by the cyclone.

As noted previously, the members of the RH/HIV Technical Working Group coordinated in innovative ways to address these challenges, including procuring boats to support delivery of supplies, such as clean delivery kits, and to transport women with obstetric emergencies.

Figure 4.10: Cyclone Nargis destruction in Dedaye

© George Pararas-Carayannis, 2008

4.4.7 Community involvement

To the extent possible, populations affected by crises should be involved in every phase of a humanitarian intervention, including programme design, implementation, and monitoring (Barry & Barham, 2012). The involvement of affected communities is often overlooked during the emergency response, although more attention has been given to this issue in recent years particularly through new accountability initiatives.[23] Involving affected communities in MISP implementation is essential for success. At the most basic level, it is important that affected communities are informed of the services available to them. For example, community members must know how and where to access care during pregnancy or after rape as well as why the benefits of seeking care. Other research on RH in

[23] Such as HAP, ALNAP, and People in Aid

emergencies has highlighted the importance of community engagement to address social-cultural barriers to accessing care (Casey et al., in press; Chynoweth, in press).

Directly after the cyclone, the affected communities themselves were involved in the immediate response. People helped and cared for each other. Yet, according to some informants, as more national and international agencies became involved, participation by the affected communities waned. Formal FGDs and participatory response appraisals by aid agencies were forbidden by the authorities (HAP, 2008b). However, informal engagement with the affected communities was allowed and some agencies reached out on an ad hoc basis (HAP, 2008b).

Assessments of the response overall noted that affected communities did not have many opportunities to feed into planning and decision-making ("Review of the RCRC Movement Response to Cyclone Nargis" in Alexander, 2009). There were some noteworthy exceptions such as one INGO's efforts to set up information centres at food distribution points as a way to provide affected communities the opportunity to feed back comments (Featherstone et al., 2009).

According to informants, engagement and involvement of affected communities in MISP implementation was generally positive, though key gaps remained. In the immediate aftermath of the crisis, many agencies worked with community-based health workers to raise awareness on the importance of giving birth in a facility and on danger signs during pregnancy. A few organisations worked together to launch community awareness programmes on condom usage. In some cases, community members helped raised awareness on services offered by mobile clinics and helped identify and link people in need of care, as well as worked to coordinate with local authorities (Featherstone, Hart, et al, 2009).

The established trainings and orientations on the MISP were developed specifically for humanitarian actors and policymakers. Yet some organisations in Myanmar, for the first time globally, worked together to adapt orientations for the community level as a way of raising awareness on the life-saving services of the MISP and to generate demand for this care. These workshops were exclusively geared towards women in the affected communities and informants said they were well received.

However, a major gap was the lack of community involvement in prevention of and response to sexual violence, which was largely ignored by implementing agencies. Women and girls' input was not sought regarding programming that directly affected their lives, such as about camp design and health care provision. Only a small number of clinics run by international agencies provided clinical care for rape survivors, and women did not know the benefits of seeking this care. Given the sensitive nature of sexual violence in Myanmar, agencies may have deliberately chosen to ignore these activities to avoid negative repercussions from the government.

4.5 Conclusion

The story of the RH response to Cyclone Nargis illuminates a number of subtle factors that are often lost in standard assessments. This is a story about people and relationships: the RH response was initiated by two exceptional Myanmarese UN officials and propelled forward by the strong relationships among representatives from international and local NGOs, UN agencies, and government ministries. Despite enormous physical, social, cultural, and political challenges, they worked together in one of the most effective RH coordination mechanisms documented at that time. As a result, they were able to advance a number of life-saving RH services, although significant gaps in addressing sexual violence and HIV remained.

The next chapter explores the implementation of the MISP after the 2010 earthquake in Haiti. Following that, Chapter 6 compares the findings from the two case studies, explores enablers and barriers to MISP implementation, and identifies emerging themes.

5. Chapter Five: Phase I – Implementation of the MISP after the 2010 Haiti earthquake

5.1 Introduction

The following case study examines how and to what extent the MISP was implemented after the 2010 Haiti earthquake. The seven factors of analysis introduced in the previous chapter are used to organise and explore the findings. The findings reveal a markedly different RH response to that in Myanmar in which cohesion among RH actors advanced MISP implementation; in Haiti the RH response was more fragmented and less effective. This is explored below and the two compared in Chapter 6.

5.2 Background

The Republic of Haiti is the third largest country in the Caribbean in terms of both population (estimated at 10 million people) and land mass (PAHO/WHO, 2010a). It shares the island of Hispaniola with the Dominican Republic (PAHO/WHO, 2010a). A former French colony, Haiti achieved independence in 1804 through the world's only successful slave revolt (Knight, 2000).

Haiti's rich and complex history has been marred by violence and political instability. These have contributed to Haiti being the poorest country in the Western Hemisphere and one of the poorest in the world (World Bank, 2014a). Haiti ranked 168 out of 187 countries in the 2014 Human Development Index as well as the 2014 Gender Inequality Index (UNDP, 2014a). Out of 178 countries, Haiti was ranked the tenth worst country in the world in which to give birth, according to the 2014 *State of the Word's Mothers* report (Save the Children, 2014). As of 2012, an estimated 59% of the population survive on less than USD 2 per day (World Bank, 2014a).

Population-based indicators remain grim (Table 5.1). For example, the under-five mortality rate and the maternal mortality ratio are five times the regional average (WHO, 2014d). As of 2012, the adult HIV prevalence was 2.1%, twice the generalised epidemic threshold of 1% (U.S. Central Intelligence Agency, 2014b).

Table 5.1: Basic health profile – Haiti

Selected indicators (2012)			
	Haiti (national)	**Regional average**	**Global average**
Total population (thousands)	10,174	--	--
Population living in urban areas (%)	55	80	53
Gross national income per capita (ppp - international dollar)[24]	1,220	27,457	12,018
Total fertility rate (per woman)	3.2	2.1	2.5
Life expectancy at birth for both sexes (years)	62	76	70
Under-five mortality rate (per 1000 live births)	76	15	48
Adult mortality rate (probability of dying between 15 and 60 years per 1000 population for males (M) and females (F))	M: 268 F: 227	M: 161 F: 89	M: 187 F: 124
Maternal mortality ratio* (per 100,000 live births)	350	68	210
Prevalence of HIV (per 100,000 population	1,435	315	499

** Data refer to 2013*

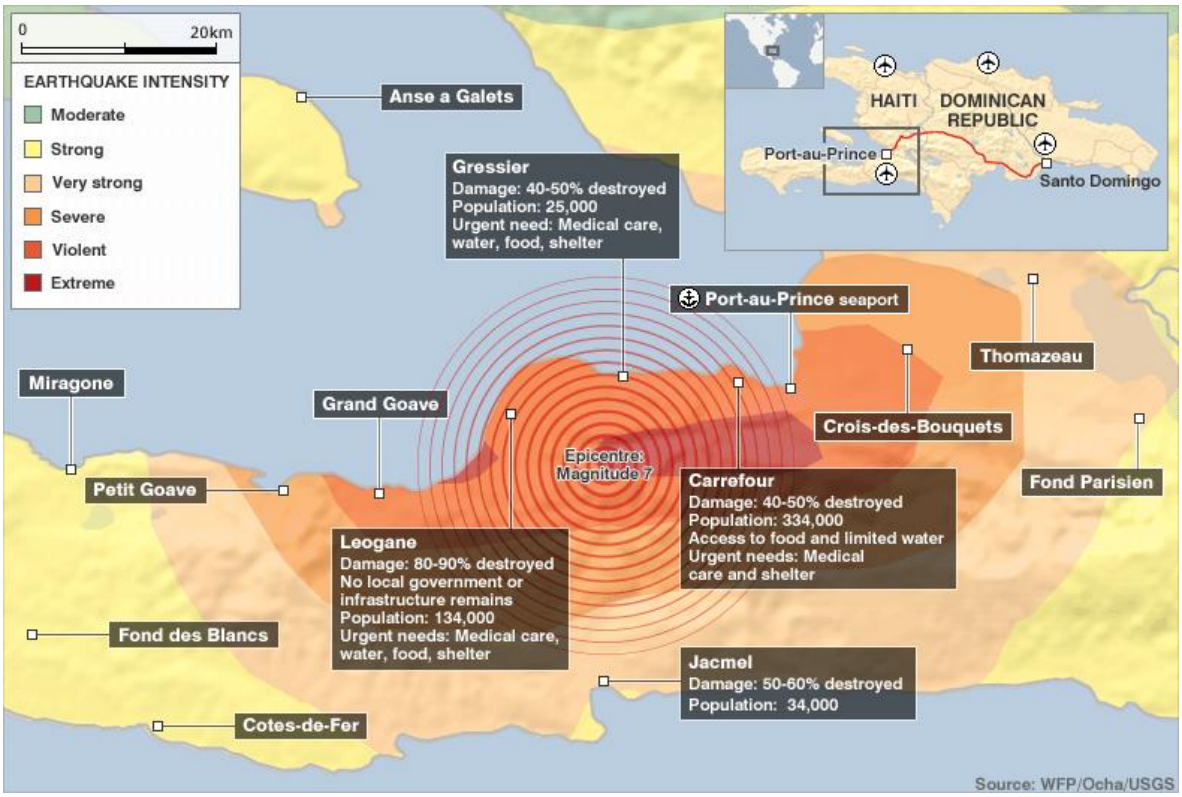
Source: (WHO, 2014d)

On 12 January 2010, a magnitude 7.0 M_W earthquake struck, approximately 25 kilometres from the capital of Port-au-Prince (Figure 5.1) (U.S. Geological Survey, 2010). Over three million people were affected, including 2.1 million displaced (UNOCHA, 2011c). Almost a quarter of a million people were killed (UNOCHA, 2011c) which, in terms of lives lost, was comparable to the impact of the 2004 Indian Ocean tsunami albeit in a much more contained area (Grünewald & Binder, 2010). One of the marked differences between the 2004 tsunami and the Haiti earthquake was the economic impact. In Indonesia, the country most heavily affected by the tsunami, the cost damage amounted to 2% of its GDP whereas

[24] "An international dollar has the same purchasing power as the U.S. dollar has in the United States. Costs in local currency units are converted to international dollars using purchasing power parity (ppp) exchange rates. A ppp exchange rate is the number of units of a country's currency required to buy the same amounts of goods and services in the domestic market as U.S. dollar would buy in the United States. An international dollar is, therefore, a hypothetical currency that is used as a means of translating and comparing costs from one country to the other using a common reference point, the US dollar". –World Health Organization

in Haiti, the disaster incurred costs of approximately USD 8 billion—117% of Haiti's GDP (Cavallo, Powell, & Becerra, 2010). The capital and surrounding towns were devastated: 60% of governmental, administrative, and economic infrastructure was demolished and 80% to 90% of the city of Léogâne was destroyed (Julmy, 2011; UN Office of the Special Envoy for Haiti, 2010). Further, ten months after the earthquake, Haiti suffered one of the worst outbreaks of cholera in recent history (CDC, 2011), with approximately 700,000 cases and more than 8,000 deaths from 2010 to 2013 (WHO, 2014b).

Figure 5.1: Haiti earthquake impact



Source: (World Food Programme, UNOCHA, & U.S. Geological Survey, 2010)

Well before the earthquake, Haiti struggled with chronic poverty and political instability. In 2009 Haiti ranked 145 out of 169 countries in the Human Development Index (UNDP, 2010) and 72% of the population survived on less than USD 2 per day (Rencoret, Stoddard, Haver, Taylor, & Harvey, 2010). An estimated 70% of the urban population lived in slums in 2009 (Inter-agency and Expert Group on MDG Indicators, 2012). While significant strides in economic, judicial, and governmental reform were in progress (USAID, 2010), the earthquake and subsequent cholera epidemic triggered significant setbacks from which the

country is still reeling. Indeed, four years after the disaster, approximately 147,000 internally displaced people remain in 271 camps, and countless others reside in non-camp settings (Brookings Institute and International Organisation for Migration, 2014). Nevertheless, the World Bank (2014a) suggests that Haiti is slowly recovering, at least economically, as reflected by economic growth from 2.8% in 2012 to 4.2% in 2013.

Similar to Cyclone Nargis in Myanmar, the destruction and loss of life caused by the earthquake was in large part due to the poor infrastructure, chronic poverty, and weak governance that left Haitians vulnerable to the impact of disasters. This was strikingly highlighted by the 2010 earthquake in Santiago, Chile—one of the strongest earthquakes ever recorded—just a few weeks after the Haiti quake. Although the Chilean earthquake was 500 times stronger than the Haitian earthquake, only a few hundred people were killed and damages were substantially lower at 18% of Chile's GDP (Kovac, 2010). This was in large part attributed to the nation's strict building codes and the government's investment in disaster preparedness (Kovac, 2010).

Figure 5.2: Port-au-Prince destruction four months after the earthquake

In relation to RH, the Haiti crisis response is informative as it was, at that time, reported as the most robust RH response ever in terms of funding and agency attention. Many of the

key IAWG leaders were directly involved in the response or provided remote support. The SPRINT Initiative had conducted a MISP training session in Port-au-Prince in May 2009, seven months prior to the earthquake.[25]

5.3 Methods

The research for this case sought to answer the question "How was the MISP implemented after the 2010 Haiti earthquake and what were the key enablers and barriers to MISP implementation?" Table 5.2 summarises the data collection by method and Table 5.3 cross-tabulates the data by organisation and nationality. In total, the assessment team interviewed 41 humanitarian responders from 22 organisations, including two UN agencies, 17 INGOs, two local NGOs, and one government agency (MoH).

Ten health facility assessments were undertaken: three hospitals and one mobile clinic in Port-au-Prince; two field hospitals and one camp clinic in Léogâne; and one mobile clinic, one referral hospital, and one dispensary in Jacmel.

Fourteen FGDs were held with 329 displaced men, women, and adolescent girls and boys: two groups of men (44 men total), six groups of women (191 total), three adolescent boys groups (51 total), and three adolescent girls groups (43 total). Six FGDs were held in Port-au-Prince (in Accru Sud and Martissant camps), five in Léogâne (in Mitton, Santo, and Pere Brigole camps), and three in Jacmel (Pinchina camp and two other unnamed settlements).

Chapter 2, section 2.3.3 provides further details on data collection methods for this case study.

[25] At the onset of the response, SPRINT staff systematically followed up with each trainee, but most did not respond by email or phone. The few who were reachable by phone said they and their families were too affected to be able to participate in the initial response. It is unclear to what extent the other participants were affected by the earthquake.

Table 5.2: Haiti case study: Phase I data collection by method

Sites	Semi-structured interviews	Facility assess-ments	Total no. of FGDs	FGD: no. of girls	FGD: no. of women	FGD: no. of boys	FGD: no. of men	Total FGD partici-pants
Port-au-Prince	22	4	6	16	47	26	18	107
Léogâne	8	3	5	18	59	25	26	128
Jacmel	11	3	3	9	85	--	--	104
Total	**41**	**10**	**14**	**43**	**191**	**51**	**44**	**329**

Figure 5.3: Team debriefing the last day of the assessment in Port-au-Prince

© SK Chynoweth, 2010

Table 5.3: Informants by agency and nationality

	UN	INGO	Local NGO	MoH	Total
Haitian staff	4	8	4	2	18
Expatriate staff	3	19	1	--	23
Total informants	**7**	**27**	**5**	**2**	**41**

5.4 Findings

The following explores the same seven areas of analysis outlined in the Myanmar case study: composition of the response (e.g., the range of national and international actors), coordination, the extent of MISP implementation, funding, policies, access/humanitarian space, and community involvement.

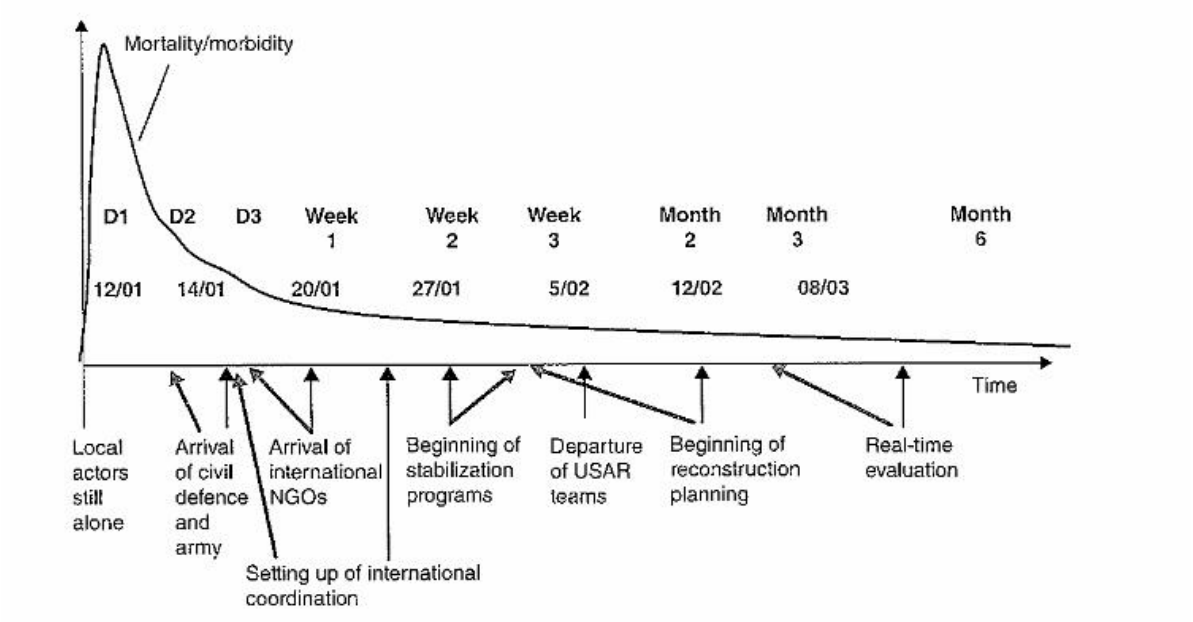
5.4.1 Composition of the response

The magnitude of the destruction is difficult to comprehend. Approximately one-third of government staff were killed (UNOCHA, 2011c), leaving the already weak governance system unable to effectively lead and coordinate the response. The UN lost 102 of its staff members, the greatest loss of life from one incident in UN history (UN News Centre, 2011). More than 250,000 homes were destroyed or damaged (Government of the Republic of Haiti, 2010b) as were 80% of schools in Port-au-Prince (UNOCHA, 2011c). The Ministry of Health (Ministère de la Santé Publique et de la Population – MPSS) lost more than 200 of its staff when its headquarters collapsed. MSF noted that their operation in Haiti was the largest in their 40-year history (MSF, 2010). Almost all aspects of Haitian society—its people, infrastructure, and political and economic systems—were overwhelmed and in many cases paralysed.

Figure 5.4: Severely damaged government building, Port-au-Prince

As with Cyclone Nargis, the first responders after the earthquake were primarily local women and men who came to the aid of those in need (Figure 5.5) (IASC, 2010c). Countless lives were saved as a result of their efforts (Grünewald & Binder, 2010). However, the survivors and surrounding communities themselves were significantly affected by the earthquake, which limited their capacity to respond. They struggled with the lack of electricity, lack of mobility, dearth of knowledge of first aid while also experiencing their own emotional traumas (Grünewald & Binder, 2010). Government, military and other traditional responders were generally not able to step in promptly as they too were significantly affected.

Figure 5.5: Humanitarian response to Haiti earthquake, 2010



**D = day*

Source: (Grünewald & De Geoffrey, 2014)

Nevertheless, many civil society groups, which have a long and vibrant history in Haiti, engaged after the crisis and provided assistance (IASC, 2010c). The government, despite sustaining heavy losses in both personnel and infrastructure, established the Council of Ministers in Port-au-Prince as a coordinating body to interface with the international humanitarian actors the day after the earthquake (IASC, 2010c). Many UN and international development agencies were already operational in Haiti before the crisis; headquarters and regional offices quickly mobilised additional personnel and support. The UN Disaster Assessment and Coordination (UNDAC) team arrived within 24 hours, and six international search and rescue teams were operational within 48 hours (IASC, 2010c). The UN

Stabilization Mission in Haiti (MINUSTAH), which had been operating in Haiti since 2004, was severely affected and lost more than 100 staff, including its head and deputy head (IASC, 2010c). Due to these significant losses and lack of clarity regarding its mandate, MINUSTAH initially did not provide support to UNDAC, although over time support was made available (Grünewald & Binder, 2010).

The U.S. military also played a key role and U.S. Army, Marine, and Navy troops arrived within 24 hours (IASC, 2010c). Within the first few weeks, over 22,000 newly deployed U.S. troops were on the ground (IASC, 2010c). Twenty-five other countries, such as the Dominican Republic, Canada, and France, provided military support as well, primarily in relation to field hospitals, troops, and logistic support including aircraft (IASC, 2010c, p.10).

Finally, numerous INGOs rushed into Haiti to provide aid, triggering the largest international humanitarian response since the Pakistan earthquake of 2005 (IASC, 2010c). Around 400 agencies were operational within three weeks after the earthquake. The Disasters Emergency Committee, a group of 14 UK charities, reported more than 1,000 organisations were involved at varying points in the response, while the Inter-agency Real-Time Evaluation estimated around 2,000 agencies (IASC, 2010c). Many of the organisations that inundated Haiti were smaller NGOs with little humanitarian experience. National or international mechanisms to monitor and manage the influx of aid agencies were not in place. The proliferation of novice organisations severely affected the quality and speed of the response as many of the staff and volunteers were not familiar with humanitarian standards and ethics and lacked relevant skills (Bhattacharjee & Lossi, 2011; Grünewald & Binder, 2010; Rencoret et al., 2010). During an interview with a seasoned doctor working with an INGO, he remarked:

> *"Haiti is unique…I have worked in several emergencies, and there is nothing like this. There are so many NGOs…more than needed and we just aren't seeing results. Some of the NGOs aren't familiar with coordination and they don't use protocols".*

Another INGO informant reported that volunteers competed with the affected communities for scarce resources such as water, food, and shelter. Furthermore, the responding agencies focused almost entirely on the capital rather than peripheral rural areas, which also had significant needs (Oxfam, 2010).

The resulting quagmire of NGOs, civil society organisations, UN, and government agencies as well as military troops in Port-au-Prince undermined state capacity and significantly obstructed coordination and response (Edmonds, 2012; Grünewald & Binder, 2010; Merlin,

2011; Oxfam, 2010). Almost five years after the earthquake numerous evaluations and studies of the international response have highlighted poor coordination, mismanaged funds, and limited involvement of national and local actors (Bhattacharjee & Lossi, 2011; Cunningham, 2012; Edmonds, 2012; Grünewald & Binder, 2010; Human Rights Watch, 2011; Merlin, 2011; Oxfam, 2010; Refugees International, 2010a, 2010b; Rencoret et al., 2010; Stedman, 2011). Bilateral and multilateral donors provided a total of USD 6 billion in humanitarian aid to the support the earthquake response (UN Office of the Special Envoy for Haiti, 2012). The majority of the funds were distributed to UN agencies and INGOs; less than 10% of these funds went to the Haitian government and less than 1% to local organisations (UN Office of the Special Envoy for Haiti, 2012).

One year after the earthquake 40 Haitian organisations jointly issued a public criticism regarding the failure to engagement national and local actors in response and recovery processes: “Our analysis and evidence leads us to conclude that Haitian society continues to be locked into the same traps of exclusion, dependency, and ignorance of our strengths, our resources, our identity … The structures of domination and dependence have been reproduced and reinforced by the constellation of agencies including MINUSTAH, the IHRC [Interim Haiti Reconstruction Committee] and large international NGOs” (Edmonds, 2012, p. 440).

5.4.2 Coordination

An Onsite Operations Coordination Centre (OSOCC) was established in Port-au-Prince by UNDAC to support civil military relations (Grünewald & Binder, 2010), and an NGO Coordination Support Office was also set up at OSOCC (Rencoret et al., 2010). These and other humanitarian coordination mechanisms were established with surprising ease given the chaos of the crisis and the wide variety of actors. Yet coordination itself was riddled with challenges due to the large number of inexperienced NGOs, high staff turnover, lack of strategic leadership, lack of engagement with Haitian civil society, and an over-emphasis on Port-au-Prince to the detriment of rural areas (Grünewald & Binder, 2010; IASC, 2010a, 2010c; Oxfam, 2010; Refugees International, 2010a; Rencoret et al., 2010; USAID, 2010).

The Cluster Approach, which had been dormant since its original implementation in Haiti in response to hurricanes and tropical storms in 2008, was reactivated three days after the earthquake (Grünewald & Binder, 2010). The government worked to appoint national

counterparts for the Clusters, but was slow to take a leading role, at least initially (IASC, 2010c; Oxfam, 2010).

The Health Cluster was initially led by the Pan American Health Organization (PAHO), WHO's regional office, and subsequently jointly with the MoH. Health Cluster meetings were held daily for the first six weeks, and then three times a week after mid-February (PAHO/WHO, 2010b). The Health Cluster was particularly burdened by the influx of NGOs. Indeed, up to 400 agencies participated in the Cluster, resulting in huge, unwieldy meetings (IASC, 2010a). In an effort to improve efficiency, a smaller (or "mini") Health Cluster was established, mainly made up of key UN agencies and large international health NGOs and focussed on strategic planning. The informants who participated in these mini meetings found them valuable. One expatriate doctor with an INGO commented:

> *"This [the mini-Health Cluster meetings] is productive and useful. We are observers in the Health Cluster from time to time. There are a lot of people, a lot of talking…but there is no 'who, what, when, where' strategising".*

Figure 5.6: Crowded Health Cluster meeting at UN Log Base in Port-au-Prince

© WHO, 2010

Informants recognised the challenging conditions of coordinating the health response. At the same time, some respondents criticised the lack of respect for national and local authorities. National protocols, such as the MoH's protocol on clinical management of rape, were initially ignored, and the mini-Health Cluster meetings were entirely comprised of INGOs and UN agencies, excluding local organisations. A Haitian health coordinator working with a UN agency remarked:

> *"There was a bit of arrogance with the INGOs because they assumed that the MoH is not capable and there wasn't an effort to recover national protocols…[But] we need to build capacity and not make Haitians dependent on assistance. We have to listen and empower people".*

Although the internationally dominated response may have been warranted at the onset of the crisis due to compromised national capacity, the assumption that national actors were too weak to participate did not change over time, although their capacity to respond did. Merlin, an INGO, reported that 95% of state-employed nurses were working within one week of the earthquake (Merlin, 2011, p. 6). The report asserted that international agencies "took over" the health response, undermining national capacities and systems (p. 3).

WHO/PAHO, as the Health Cluster lead, focused primarily on the capital city, although informal health coordination meetings were held by Save the Children, the MoH, and the Haitian Red Cross in the nearby, heavily affected towns of Jacmel and Léogâne (Bolles & Lewis, 2010). Communication between the main Health Cluster in Port-au-Prince and the sub-national mechanisms was initially weak; this improved with time and sub-national Clusters were subsequently established (Bolles & Lewis, 2010).

The Health Cluster prioritised trauma and controlling potential infectious disease outbreaks during the acute phase. Although the establishment of emergency obstetric and newborn care referral systems was discussed in some of the meetings, informants noted that key opportunities to integrate RH were not capitalised upon. For example, the Health Cluster's Initial Rapid Assessment overlooked RH questions and thus a separate RH assessment had to be conducted at a later date, duplicating efforts and failing to highlight RH needs to Cluster partners. The reasons for this omission were unclear.

One of the leading experts on RH in emergencies, a doctor working with a UN agency, was deployed to Haiti for one month to act as the Focal Point for the initial RH response. She arrived five days after the earthquake and immediately announced in a Health Cluster meeting that an RH Working Group was to be established and invited interested parties to attend. The first meeting was held one week after the earthquake and were subsequently held weekly. Few agencies participated in the beginning but after the second meeting, momentum gathered. Most meetings focused on demonstrating and disseminating RH supplies as well as information updates regarding which agencies were working where. UNFPA led these meetings and later co-facilitated with the MoH.

The leadership, membership, and activities of the RH Working Group changed significantly during its first six months of operation. Almost all agreed that the initial RH coordination efforts were positive. With approximately 25 agencies participating regularly, the Working Group was relatively small and specifically focused on RH and was thus more effective and targeted than the Health Cluster. Participants found it helpful to know what other agencies were doing and how to procure RH supplies. Further, it was important for NGOs to be able to interact and coordinate with the MoH. One midwife from an INGO who had worked in Haiti for three years noted:

> *"It was tremendous to have NGOs, UN, and government reps all in the same room. For the first time ever! [The RH Working Group] is important for our relationship with the government; we've never sat around the table before with the Ministry of Health".*

The RH Working Group facilitated UN and NGO access to the MoH and provided an unprecedented opportunity to advocate for opening access to a range of services, including access to safe abortion care and the community-based distribution of injectable contraceptives. Others commented that it strengthened their partnership with UNFPA, which helped facilitate the ordering of RH Kits. One expatriate INGO informant remarked that the Working Group was established far more quickly in Haiti than in other emergencies, and many noted the importance of the leadership qualities of the RH Focal Point. An expatriate nurse working with an INGO commented:

> *"There were strong advocates, like [the first Focal Point] who got the [RH] Working Group up and running. That was very important. She also got the GBV [Gender-based Violence] Working Group started".*

Despite this progress, numerous challenges to RH coordination were present. Some limitations were structural, such as obstructed roads, traffic congestion, and lack of gasoline, which prevented people from attending the initial meetings. Other issues highlighted the complexity of the international response. For example, the initial RH Working Group meetings were held in either French or English on an ad hoc basis; later translation into French, Creole and English was made available, but significantly slowed discussion. This real-time translation process was, in one expatriate participant's words, "painful".

All informants emphasised the detrimental effect of high staff turnover on coordination, particularly of the RH Focal Point. By the time the data collection took place four months after the earthquake, the Working Group was being led by its fifth Focal Point. Working Group members themselves rotated out at a similar rate. I observed an RH Working Group meeting during the field mission in May 2010, and only two participants had been there since the onset of the crisis in January. This is not atypical of international humanitarian response, in which UN agencies and INGOs frequently send in staff for four to eight weeks in an effort to reinforce in-country "surge capacity" (Houghton & Emmens, 2007).

Another challenge related to the process of coordination itself. Collaboration and cooperation among Working Group members, beyond sharing programmatic updates, were weak. UNFPA and MoH representatives remarked that it was difficult to obtain basic data from RH partners in order to inform programming. Focal Points requested information on services, such as the number of condoms distributed and the number of women referred for emergency obstetric care, through checklists, forms, and surveys, yet only a few agencies responded.

Even with a strong leader in place, Working Group members were focussed on their own programming. The first Focal Point remarked that:

> *"One of the hardest things that I had to do—and I only convinced two people to do it—is to give information as to what they are doing [and] where".*

The fifth Focal Point, who was a member of the Working Group from the beginning of the response, described an individualistic culture among members:

"Having information was like having money. I'll give you this if you give me that. So nobody wanted to share because they wanted to be important enough".

Many participants were overwhelmed by their workloads and commented that there were simply too many meetings, which detracted energy and resources from addressing the extensive, life-threatening needs of the affected communities. A Haitian gynaecologist remarked:

"Frankly, some of the meetings are unnecessary. It feels like we are losing time talking about these issues".

A senior RH adviser with more than 20 years experience in humanitarian settings similarly questioned the emphasis on coordination meetings at the onset of the response:

"It wasn't appropriate to pull [the RH Working Group] together at the beginning—too much emphasis was placed on coordination when there were so many needs".

Coordination between the RH Working Group and the Health Cluster was also challenging. Despite numerous requests by the RH Focal Point, the Health Cluster did not post the minutes from the RH Working Group meetings on the primary coordination website[26], and thus this valuable information on the efforts and gaps in the RH response was not made widely available. The RH Working Group was not included in the Health Cluster's list of sub-working groups, despite regular announcements at Health Cluster meetings that it was up and running. The first Focal Point attributed these issues to poor organisation:

"It's the problem of the Health Cluster. They need to centralise all this information so people can go and click and see what services are available…on the WHO website. WHO needs to do that…It needs to be integrated, especially now that they are saying that we [the RH Working Group] work under the Health Cluster, then it's their responsibility".

It was unclear to Working Group members whether the Focal Point fed information back into the Health Cluster, as per the guidelines set forth in the IASC Health Cluster Guide (WHO, 2009a). An expatriate doctor working as an INGO health coordinator stated that the

[26] http://www.humanitarianresponse.info/operations/haiti/health

lack of communication between UNFPA and WHO regarding RH and health had a detrimental effect on coordination in all settings, not just Haiti. He said:

> *"Health and reproductive health don't communicate. One driven by WHO and the other by UNFPA… that is the worst set-up for coordination and it is like that in all countries. These organisations don't coordinate internally".*

Two other issues that affected the coordination of the RH response included access barriers to the meetings as well as the lack of RH Working Groups at the sub-national level. The RH Working Group meetings were held on the UN Log Base, which was in an inconvenient and isolated location. Further, the UN restricted access to the Log Base and many Haitians were turned away, thus preventing national actors from participating in coordination meetings. This was highlighted as an issue with the response overall, and some Clusters started holding their meetings elsewhere in Port-au-Prince to facilitate access for national and other agencies (Bhattacharjee & Lossi, 2011). Nevertheless, four months into the crisis, the RH Working Group was still meeting at the UN Log Base, which prevented the participation of local and national actors given the UN access restrictions. Further, RH coordination was focused exclusively on Port-au-Prince. At the time of the Phase I data collection, sub-national RH Working Groups had still not been established in Léogâne or Jacmel, despite the high RH needs.

5.4.3 MISP implementation

Haitians had poor access to basic health services before the earthquake. In 2009 Haiti averaged four health care professionals (physicians, nurses, and midwives) per 10,000 people—well below the WHO's recommended minimum threshold of 23 per 10,000 for basic coverage (WHO, 2009b). Nearly half of the population lacked access to basic health care and medicines (PAHO/WHO, 2010a).

The earthquake further devastated an already fragile health system. According to the MoH, the earthquake damaged or destroyed 30 out of 49 hospitals (61%) in the affected areas including the only national referral hospital (IASC, 2010c; UNOCHA, 2011c). UNFPA Haiti reported that they lost 90% of their partners when the Ministry of Women's Affairs' building collapsed (UNFPA, 2010a). As such, despite the robust response, implementation of the five components of the MISP was challenging.

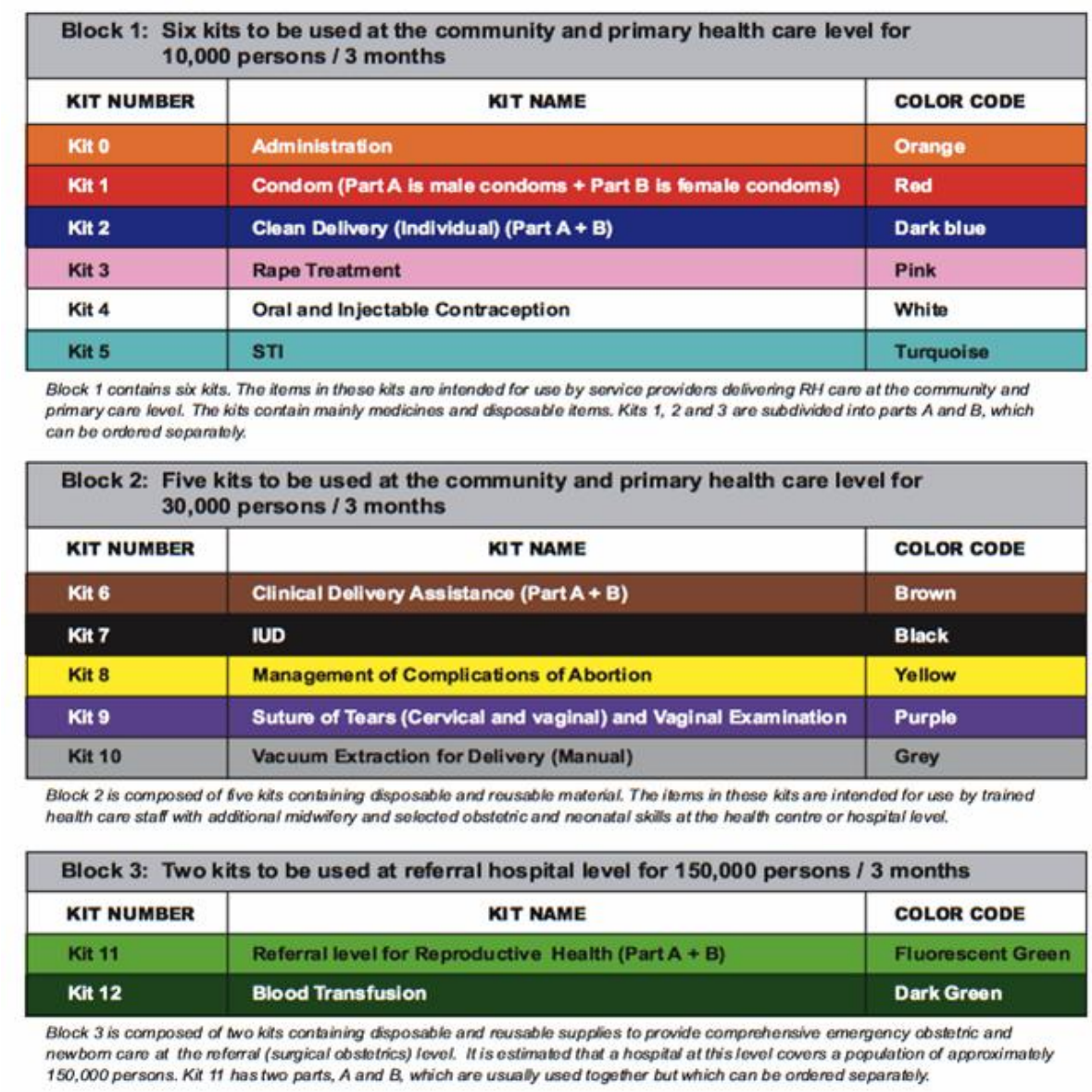
5.4.3.1 Supplies

Upon her arrival, the RH Focal Point ordered a small batch of the 12 Inter-agency RH Kits to support MISP implementation. These arrived within one week of the crisis response. However, the RH Focal Point had no logistical support and tried to manage the ordering and distribution of the Kits alone in addition to overseeing the coordination of the RH response, which proved extremely challenging. She explained:

> *"There was no logistician for about two weeks and I was screaming at everybody because I was doing all the logistics of the Kits. Which is, you know, great but hard. I'm not made for logistics. These guys earn their money I tell you".*

Many agencies did not understand that different Kits were designed for different populations. For example, Kit 12 is designed to manage obstetric emergencies at a referral level hospital serving 150,000 people, while Kit 5 contains supplies for STI management at the primary health care level for 10,000 people (Figure 5.7) (IAWG, 2011). Significant interaction was required with agencies requesting Kits to ensure they were ordering appropriate items and amounts. The actual distribution of the RH Kits was through PROMESS (Programme on Essential Medicine and Supplies), the national procurement and warehousing system for medical supplies managed by PAHO. Agencies requesting RH Kits needed to fill out a specific form by PROMESS that had to be signed by the RH Focal Point before the order could be filled. Due to the overwhelming demand for Kits, the RH Focal Point made her signature available electronically, which sped up the process and reflected a level of trust amongst actors. A pharmacist was put in place after three weeks to support the RH Kit distribution process, which greatly eased the burden on the Focal Point and helped expedite procurement and distribution of the Kits.

Figure 5.7: Inter-agency RH Kits



Block 1: Six kits to be used at the community and primary health care level for 10,000 persons / 3 months

KIT NUMBER	KIT NAME	COLOR CODE
Kit 0	Administration	Orange
Kit 1	Condom (Part A is male condoms + Part B is female condoms)	Red
Kit 2	Clean Delivery (Individual) (Part A + B)	Dark blue
Kit 3	Rape Treatment	Pink
Kit 4	Oral and Injectable Contraception	White
Kit 5	STI	Turquoise

Block 1 contains six kits. The items in these kits are intended for use by service providers delivering RH care at the community and primary care level. The kits contain mainly medicines and disposable items. Kits 1, 2 and 3 are subdivided into parts A and B, which can be ordered separately.

Block 2: Five kits to be used at the community and primary health care level for 30,000 persons / 3 months

KIT NUMBER	KIT NAME	COLOR CODE
Kit 6	Clinical Delivery Assistance (Part A + B)	Brown
Kit 7	IUD	Black
Kit 8	Management of Complications of Abortion	Yellow
Kit 9	Suture of Tears (Cervical and vaginal) and Vaginal Examination	Purple
Kit 10	Vacuum Extraction for Delivery (Manual)	Grey

Block 2 is composed of five kits containing disposable and reusable material. The items in these kits are intended for use by trained health care staff with additional midwifery and selected obstetric and neonatal skills at the health centre or hospital level.

Block 3: Two kits to be used at referral hospital level for 150,000 persons / 3 months

KIT NUMBER	KIT NAME	COLOR CODE
Kit 11	Referral level for Reproductive Health (Part A + B)	Fluorescent Green
Kit 12	Blood Transfusion	Dark Green

Block 3 is composed of two kits containing disposable and reusable supplies to provide comprehensive emergency obstetric and newborn care at the referral (surgical obstetrics) level. It is estimated that a hospital at this level covers a population of approximately 150,000 persons. Kit 11 has two parts, A and B, which are usually used together but which can be ordered separately.

Source: (Matthews, Krause, & Chynoweth, 2011)

After the initial batch of RH Kits was ordered and it became evident that the demand for more Kits was high, UNFPA put in much larger orders totalling USD 1 million. The Kits were provided for free and served approximately one million people. Yet the shipping costs to Haiti were exorbitant. According to the first RH Focal Point, one shipment from UNFPA's warehouse in Denmark to Haiti was estimated to be USD 100,000. As such, UNFPA as well as many other agencies had their supplies shipped to the Dominican Republic and then

sent overland to Haiti. This delayed the process and it wasn't until after the second week of the crisis that the first big shipment of RH Kits arrived.

Many informants noted that the RH Kits were abundant in the first few months and that this was a significant contribution to the RH response. An expatriate health advisor employed by a large INGO reported:

> *"UNFPA made RH Kits available within days… Supplies were good at first… But a shortage of supplies hit about one month after. I put in an order to UNFPA but they had run out".*

Further, the majority of the health facilities in the affected areas were damaged or destroyed; identifying clinics (tent, mobile, or otherwise) where the Kits could be put to use was challenging. The scale of the disaster and the sheer number of those affected soon overwhelmed the actual supplies. By the time data collection took place four months after the disaster, a number of stock-outs were reported, particularly of clean delivery kits. UNFPA did not want to order additional supplies; instead, it pushed agencies to procure RH supplies internally as per international guidance, yet a number of agencies were just setting up operations and would have benefited from the Kits. An expatriate midwife working with a small INGO reported:

> *"Our agency is just starting in some settings and UNFPA does not have any kits. They suggest we make them ourselves because they are not distributing anymore but we don't have time now".*

5.4.3.2 Emergency obstetric and newborn care

At the time of the earthquake in 2010, maternal mortality in Haiti was very high with 420 women dying per 100,000 live births (WHO, 2014c). After the earthquake, maternal and newborn needs were numerous: approximately 63,000 women and girls were pregnant in Port-au-Prince alone, of whom an estimated 9,450 would experience a life-threatening complication and require emergency care (RHRC, 2010).

The response to address these needs was patchy. During the first two weeks, emergency obstetric and newborn care was not prioritised as the health response concentrated on physical trauma. Indeed, one national obstetrician/gynaecologist reported that his agency

had funding to rebuild the maternity ward at Haiti's main referral hospital. Yet an unnamed foreign organisation obstructed them and declared maternal health a secondary concern. He recalled:

> *"We didn't prioritise women's health at the beginning of the response. None of the big international agencies who came in for the health response had Ob/Gyns. We tried to set up a maternity ward in the General Hospital…we were pushed out by an international agency because they wanted to use the area to treat trauma victims. They said we didn't need this now and stopped us".*

Other agencies also witnessed the need for maternal services and tried to address it accordingly. One INGO representative reported:

> *"...There were few health facilities, the highest maternal mortality rate in the Western Hemisphere Region, and the facilities that were available were primarily trauma oriented. That was a real crisis for pregnant women. Agencies recognised this".*

Figure 5.8: Women focus group participants in Léogâne

© Women's Refugee Commission/Lauren Heller, 2010

Referral for emergency obstetric and newborn care was discussed at a Health Cluster meeting, and despite WHO/PAHO mapping health facilities that included availability of emergency obstetric and newborn care, this did not translate into implementation of emergency obstetric and newborn care.

Referral systems were weak. Participants in FGDs described women giving birth in abandoned buildings, cars, tents, and on the streets. Particularly problematic was the main referral hospital, which did not inform health partners that the maternity ward had collapsed and supplies were scarce. Thus the hospital continued to receive referrals, which then had to be referred out again. The majority of sites visited by the assessment team had not established a referral system to a health facility. In those that did, the system was limited. For example, transport was not available at night due to curfews, the community was not always aware of the system and thus did not access it, and transport was costly. Although a number of clinics offered free services, participants from FGDs often commented that they had to pay for health services and that this was a significant deterrent in seeking care.

The majority of women in Haiti give birth at home with 75% to 80% of deliveries taking place outside of a medical setting (Arie, 2011). Although clean delivery kits were widely distributed at the beginning of the crisis and were included with the non-food item distribution, they rapidly ran out due to high demand. Ordering had been based on a population of one million rather than the three million affected.

Health facilities were also severely compromised, with many reporting lack of basic systems such as running water. At the time of the assessment the staff of the main referral hospital were on strike as they had not been paid for months. As noted previously, almost all efforts to address emergency obstetric and newborn care were concentrated in the capital: four months after the earthquake there were remarkably few emergency obstetric and newborn services in Jacmel and Léogâne. Indeed, in one FGD in Jacmel, women were desperate for services and said that the only health services they had received since the earthquake were from two mobile clinics:

"They were here and then never came again. We need a clinic".

Lack of qualified midwives was also an issue. Haiti faced a dearth of midwives before January 2010. The earthquake damaged beyond repair the country's only midwifery school,

which had 78 students and graduated roughly 35 per year (UNFPA, 2010a). Almost all informants commented that recruiting national midwives was very challenging. Some noted that MSF, in an effort to secure midwives, paid far more than the local market rate and, in the words of one expatriate health adviser, “MSF bought all the local midwives”. A physician with an INGO remarked:

> *“If I get good midwives, after a few weeks I hear that she is leaving because she is getting better pay with MSF”.*

A respondent from the organisation in question exclaimed:

> *“It’s no problem to get midwives here! They are easy to recruit”.*

Informants commented that they did not know how to address the issue.

All interviewees reported a significant increase in unsafe abortion, which accounted for 10% of maternal deaths before the earthquake (UNICEF, 2012). Informants were unsure as to cause of the alleged increase, whether it was due to a lack of family planning, rape, or other issues. The medical director of the state gynaecological and obstetric hospital was interviewed by Human Rights Watch (2011) and reported a “marked increase” in young women seeking care for pregnancy complications, including unsafe abortion (p.33). Data on abortion in the aftermath of the earthquake have not been identified.

Finally, informants reported that newborn care was non-existent in Port-au-Prince. None of the agencies interviewed had an incubator, and one NGO representative stated that there were no neonatology services in the entire city. One informant with an INGO providing maternal health services reported that up to 25% of newborns born in their field hospital were less than 2.5 kg. A medical team leader working with an INGO that had a long history in Haiti said:

> *“There is a need for neonatology services—we don’t have incubators—but there is nothing even in Port-au-Prince… [There are] no referrals to other facilities. We are the end of [the] referral system”.*

5.4.3.3 HIV prevention

At the time of the earthquake, Haiti had a generalised HIV epidemic with a pre-earthquake adult prevalence of 2.2%, which accounted for 47% of all HIV positive people in the Caribbean (UNAIDS, 2010, p. 4). Significant efforts to address HIV, particularly the provision of ARVs and prevention of mother-to-child transmission of HIV (PMTCT), were introduced in the few years before the earthquake, with ARV coverage almost doubling from 2007 to 2009 (UNAIDS, 2010).

In the immediate aftermath of the earthquake, safe blood for transfusions and supplies for standard precautions to prevent infections and disease transmission were widely lacking. This improved with time and most informants reported compliance with standard precautions, although one noted that many national staff were not familiar with them.

USAID and the Red Cross shipped in large amounts of safe blood in the first few weeks, although shortages were not uncommon and the blood bank system had just started running again at the time of the data collection four months later. WHO had ordered health providers to only use pre-tested blood and strongly discouraged blood screening on-site. One RH Focal Point recounted the following story, highlighting the tension between maintaining rigorous standards and medical needs on the ground:

> *"I was at PROMESS once and this army guy comes running in with a tube of blood and said, "Can we test this somewhere because I have a patient who is dying", and the rep of WHO said, "No, you've got to go there and there and get blood". And he says, "Yeah, but we need to blood proof this". So I said, "Well, we have supplies here to test it", and the rep said NO. So the guy had to go off with his test tube of blood trying to find somewhere to test it".*

Waste management was also a significant issue and was taken up by the Health Cluster. Trucks were sent to the largest health facilities to collect their waste, and corpse management was also prioritised. A health advisor for an INGO noted that waste management was still problematic four months later, although most said that systems were in place.

Approximately seven million condoms were distributed for free in the first few months of the crisis. Informants positively noted that condoms "were everywhere", and focus group participants welcomed them. Indeed, the widespread and visible distribution of condoms was noted as having a significant impact on the cultural acceptance of condom usage, which had been low before the earthquake. Prevalence of condom use among adult (aged15-49) men and women during higher-risk sex was 34% and 21%, respectively (WHO, 2009b). One Haitia UN representative reported,

> *"Culturally Haiti has not been open to condoms historically. And I think this wide distribution UNFPA was doing—including in camps for expats and at [the UN] Log Base—condoms became like no big deal. That is one of the things I think about, I feel good about—we are cool with condoms now in Haiti! The proof and result is in the little focus groups and hearing that the boys are using condoms—that is huge!"*

Yet, like the other RH supplies, sustainability became an issue and at the time of the assessment free condoms were in short supply and high demand. Condoms were available in stores to buy, but focus group participants complained that they could not afford them. Some clinics provided condoms after HIV testing, and girls in one FGD reported undergoing weekly HIV tests to obtain them. Further, at the time of the data collection, communities were distressed because used condoms were strewn about the camps since disposal systems were not in place.

5.4.3.4 Prevention and response to sexual violence

Sexual violence against women and girls in Haiti was commonplace before the disaster, particularly during periods of unrest (Human Rights Watch, 2011). Up to 50% of women and girls in conflict-affected areas of Port-au-Prince experienced some form of sexual violence during political turmoil from 2004 to 2006 (Human Rights Watch, 2011). A Lancet paper on human rights abuses in greater Port-au-Prince estimated that 35,000 women and girls, more than half of them under 18, were raped between February 2004 and December 2005[27] (Kolbe & Hutson, 2006). Further, a 2009 study found that rape was a significant contributor to pregnancy among urban Haitian adolescent girls (Gomez, Speizer, & Beauvais, 2009). In

[27] Reliable data on population numbers were not available; thus, calculating probability proportion to size cluster sampling was unfeasible.

2008 one MSF clinic in the capital reported that 20% of sexual violence survivors who came to seek care were pregnant as a result of the rape (MSF, 2008a).

Health workers as well as displaced communities reported a dramatic increase in sexual violence after the disaster (Human Rights Watch, 2011; Institute for Justice & Democracy in Haiti & MADRE, 2010; INURED, 2010; Stedman, 2011). One local women's group documented 230 incidences of rape in 15 camps in the two months following the earthquake (Institute for Justice & Democracy in Haiti & MADRE, 2010, p. 8). A randomised study of four camps found that 9% of respondents reported one or more members of their household had been "raped or forced to have sex when they did not want to" in the year after the earthquake (Satterthwaite & Opgenhaffen, 2011). MSF reported treating 212 cases of sexual violence in the first five months of the crisis (MSF, 2010). A Haitian health coordinator with a large INGO said:

> *"We are very concerned about [sexual violence]. It has been drastically increasing because of the situation. I just heard of a case of gang rape with 7 men".*

All focus group participants, including men and boys, described pervasive rape, including gang-rape and kidnappings for rape. They expressed distress, anger, and helplessness. A woman in a FGD in Léogâne said:

> *"Rape has gotten worse since the earthquake. Everything that you could possibly think of has gotten worse, especially for us women".*

A midwife working with a local organisation reported that displaced women had asked if a centre could be built so they "could be washed out after rape" because many of them were becoming pregnant as a result. In a FGD with adolescent boys, one young man said:

> *"They [men and boys] go around and rip up the tents with their blades [to rape young women]".*

A few months after the earthquake, informants reported a rise in sexual exploitation resulting from the discontinuation of free access to services, particularly food, since the acute emergency phase had ended. Yet access to employment remained severely inadequate and the displaced were desperate for income to support themselves and their families. A 2011 report by UNHCR confirmed that food insecurity strongly contributed to the increase in sexual exploitation. The study, which involved 15 FGDs with 124 displaced

women and 50 displaced men, reported that 100% of the participants had been directly involved in or witnessed transactional sex; for the women interviewed, transactional sex was described as a new post-earthquake coping mechanism to help provide for their families (UNHCR, 2011). Similarly, for this research, adolescent girls in all FGDs reported that exchanging sex for food and basic goods was common, including with soldiers. “You gotta do what you gotta do”, explained one young girl in a Léogâne focus group. Some adolescent boys in a different focus group in Léogâne admitted to buying sex for small amounts of money.

Prevention measures were minimal. Humanitarian staff reported awareness of sexual violence, including violence by aid workers and Peacekeepers, and a Gender-based Violence Sub-Cluster was established. Nonetheless, prevention efforts were not prioritised. One senior RH advisor working with an INGO reflected:

> *“Everyone is aware of [sexual violence]. It has been talked about but in terms of practice, more could have been done.”*

For example, six months after the earthquake, only 15.5% of all camps had a management committee in place, leaving more than three-quarters of the settlements “lawless” (UNOCHA, 2010b). A Haitian health coordinator with an INGO commented:

> *“Prevention was not as prioritized by the GBV group [Gender-based Violence Sub-Cluster] …Some camps have a security committee, but they are not trained or monitored”.*

Further, in some settings the camp management structure was not necessarily a prevention measure but actually put women and girls at risk: in one of the camps visited for this research, the camp management was made up of aggressive young men who intimidated our assessment team and the participants of a FGD.

Figure 5.9: Aerial view of crowded displacement camps in Port-au-Prince

© SK Chynoweth, 2010

Protection interventions known to be effective, such as sufficient lighting and separation of latrines, were not sufficiently implemented. According to UNOCHA's *Multi-Cluster Rapid Initial Situational Assessment for Haiti* (2010c) conducted in the first month after the quake, only 3% of camps and 6% of non-camp settings had adequate lighting. Moreover, most latrines were not separated, thus increasing women and girls' vulnerability to sexual violence (UNOCHA, 2010c). Limited resources, inadequate law enforcement, overwhelming needs, failure to engage women in relief programming, and lack of prioritisation of the issue have been cited as key causes for the significant protection failures (Institute for Justice & Democracy in Haiti & MADRE, 2010; Stedman, 2011).

Some displaced communities organised their own security patrols in an effort to address sexual violence. However, focus group participants reported that some of the members of the security patrols themselves took advantage of their power and sexually assaulted the women and girls they were tasked with keeping safe.

The medical response to rape survivors was more robust than prevention efforts, but these were still woefully inadequate. Only a few of the hundreds of health agencies provided

clinical treatment of rape. Those that did so included MSF, Médecins du Monde (MDM), International Rescue Committee, CARE, Save the Children, and local NGOs such as GHESKIO (Haitian Group for the Study of Kaposi's Sarcoma and Opportunistic Infections), KOFAVIV (Commission of Women Victims for Victims), and SOFA (Solidarité Fanm Ayisyen). One expatriate RH adviser with an INGO reported that, in the beginning of the crisis response, her organisation had ordered a number of post-rape care RH Kits, but they were not able to distribute them because health facilities did not have the capacity or interest to provide the care. She explained:

> *"You know, at the beginning, clinical care wasn't really in place. We had a difficult time finding providers… We had to hold off on giving out Kit 3 [for clinical management of rape] until we could give an orientation first… Some clinics argued that women weren't asking for it [treatment after rape], so why should they provide it".*

Mobile clinics were reluctant to make care for survivors available because it meant creating a private space in which confidential consultations could take place and this was seen as a burden. Further, there were discrepancies between the MoH and WHO protocols on clinical management of rape. For example, the national protocol's window for emergency contraception was three days whereas international guidance was five. The medication used to treat STIs was also different in the RH Kits from that in the national protocol. These issues were eventually reconciled but earlier created barriers.

Efforts were made to inform the community of where and why to receive care after rape, including through radio programmes and a widely distributed post-card with hotline numbers. However, most of the numbers on the card either did not work or no one answered, which discouraged women from coming forward. It was not clear why this was the case. Further, the cards did not include information about local NGOs providing treatment after rape. Representatives from the Gender-based Violence Sub-Cluster claimed that the organisations were not included on the cards because they were not listed in the 2008-2009 National Dialogue Resource Directory, which specified agencies approved to provide emergency services (Institute for Justice & Democracy in Haiti & MADRE, 2010, p. 23). Yet another UN representative asserted that internal members of the Gender-based Violence Sub-Cluster decided to exclude local organisations in order to pander to wealthier, higher-status Haitian women's groups, although again, the reasons for this were unclear (Institute for Justice & Democracy in Haiti & MADRE, 2010, p. 23).

Almost all FGD participants did not know where to go for medical treatment after rape. They also noted that they would not come forward if they had been raped due to shame, fear of retaliation including "being killed", and lack of confidentiality of services. Teen girls in Léogâne said they would report a problem like rape "in their hearts".

Even when survivors did access care, systems to guarantee their safety post-treatment were limited. For example, a Medical Team Leader with an INGO lamented:

> *"We had two orphans who were raped and after treatment they had to return to the orphanage [where they were raped] because there was no other place for them to go"!*

5.4.3.5 Planning for comprehensive RH

Objective five of the MISP—planning for comprehensive RH services—was difficult to initiate, in part because of the large number of uncoordinated and competing health actors. As noted above, data collection proved very challenging: despite requests for feedback through surveys and forms, agencies generally did not share information. It is unclear whether they deliberately chose not to share information, or were simply too overwhelmed at the time. The RH Focal Point also struggled with a high workload and was unable to spend the time following up with agencies for the information.

Training needs were identified from the outset, with STI management and clinical management of rape identified amongst those most required. Many health actors sought to strengthen the national system rather than provide emergency care, and plans were made for integration of RH into primary care. A number of agencies had identified sites for providing comprehensive RH, including in Léogâne and Jacmel. Some key efforts were begun, but more work needed to be done, particularly in the area of data collection.

5.4.3.6 Additions to the MISP

Before the crisis, approximately 38% of Haitian women aged 15-49 in a stable relationship expressed desire to limit or discontinue from having more children, yet did not have access to family planning (John Snow International, 2009). Efforts were made to ensure contraceptives were made available after the crisis and informants noted that MoH commitment had a significant impact. An expatriate RH adviser with a large INGO remarked:

"The Ministry of Health prioritised family planning, and it was included in mobile clinics. This made a huge difference. The [Ministry of Health] rep said family planning was a priority at the reproductive health meeting... Women wanted it".

Nevertheless, many women in FGDs complained that they did not have access to contraception. Health workers commented on the high number of unwanted pregnancies, as well as reports of infanticide and maternal suicide. One UNFPA survey of 2,391 women of reproductive age displaced by the earthquake showed that 12% were pregnant; two-thirds of these reported their pregnancies were unwanted (UNFPA, 2011).

Regarding ARVs, the destruction of health facilities disrupted ARV therapy for thousands of people with HIV. At the time of the assessment, the MoH and development NGO Partners in Health engaged health volunteers to go camp-to-camp to identify those in need of treatment. At least three health facilities in Port-au-Prince provided ARVs, including Hopital de la Paix, the Haitian Community Hospital, and the GHESKIO centre. Other health service providers referred patients accordingly. Yet focus group participants generally did not know that ARVs were available. ARVs were reportedly not available in Léogâne. One INGO representative thought certain agencies were inflating the number of people on ARVs in order to receive more funding, although this could not be substantiated. When questioned about the lack of knowledge about ARVs among the displaced community, an expatriate HIV focal point employed by an INGO reported:

"Some people are still in the 80s and don't know about services while funds have also diminished in HIV for IEC [information, education, and communication materials]. For example, you don't see advertising on HIV in Haiti—you don't see billboards about where to get tested, you don't hear about it on the radio".

Regarding syndromic treatment of STIs, informants' responses were inconsistent. While all reported high rates of STIs among the displaced community, some reported that it was not prioritised whereas others said that services were being provided.

Finally, provision of menstrual hygiene supplies was sporadic. Some women and girls reported receiving hygiene kits with menstrual supplies and other personal items, but said supplies were not adequate and that they wanted pads to manage their menses. A woman in a FGD near Jacmel reported:

"Most women have to go to Jacmel to buy them but it is difficult since they don't have money".

5.4.4 Funding for RH response

Funding requests for the RH response to the Haiti earthquake was unprecedented: more than 50% of the health projects under the Flash Appeal[28] included some component of RH (Table 5.4) (UNOCHA, 2011a). The total revised health amount requested was USD 140 million (UNOCHA, 2011a). Of this, almost USD 98 million included some aspects of RH, of which USD 36 million specifically targeted for RH (UNOCHA, 2011a). Eighty-eight percent of the appeals specifically for RH were funded, higher than the health appeal overall, of which 74% was funded as of 12 September 2011 (UNOCHA, 2011a). According to the Women's Refugee Commission, which has monitored funding for RH in emergencies for over a decade, this marked a record level of commitment (Krause et al., 2011). Further, 26 out of the 54 protection appeals included components specifically addressing gender-based violence (UNOCHA, 2011a).

Table 5.4 below lists the health projects in the Flash Appeal that included RH. All health Flash Appeals for the Haiti response were reviewed in detail on UNOCHA's Financial Tracking Service (UNOCHA, 2011a).

Despite overall strong funding, nine out of the 28 proposals were never funded, perhaps because seven of the nine appealing agencies were less well-known NGOs. UNICEF received the largest amount of funding: more than USD 21 million, 12% more than requested. UNFPA received a total of USD 2.3 million and, on average, 41.8% of its proposals were funded. Funding was fairly well distributed among large, reputable INGOs, with International Medical Corps, Médecins du Monde-France, Merlin, Partners in Health, Save the Children, and World Vision each receiving multi-million dollar grants.

[28] A Flash Appeal is instigated by the UN Humanitarian Coordinator and should be issued within the first week of an emergency. Appeals generally fund short-term, life-saving interventions, although they may fund early recovery programmes as well.

Table 5.4: List of all health projects that include some component of RH for the Haiti earthquake Flash Appeal*

Title	Appealing agency	Original request (USD)	Revised request (USD)	Funding received (USD)	% Funding received
Primary health services and health promotion	AMI	0	211,546	0	0%
Protect the health of residents and IDPs in Lower Artibonite	Hospital A. Schweitzer	0	390,000	10,000	3%
Supporting health care provision - IDPs	HWA	0	1,128,000	0	0%
Health care for earthquake-affected populations in Haiti	IMC	2,200,000	3,700,000	4,295,098	116%
Emergency health referrals – vulnerable populations	IOM	1,500,000	1,500,000	700,000	47%
Restoring basic health services	IRC	0	451,000	451,000	100%
Strengthening reproductive health services and HIV	MARCH	0	480,080	0	0%
Mobile clinics for Cité Soleil	MDM Canada	0	1,183,000	973,710	82%
Provision of free PHC, psycho-social support services	MDM France	0	4,661,965	2,621,232	56%
Provision of primary health care	MDM Greece	0	500,000	0	0%
Emergency health response in CHOSCAL and Cite Soleil	MDM Greece	400,000	400,000	0	0%
Re-establishing access - health services	MDM Suisse	0	652,750	652,750	100%
Support to public health and health care services	MERLIN	500,000	8,287,200	8,287,200	100%
Re-activate basic health care services in PHC	PIH	0	10,000,000	11,968,147	120%
Health for children and families in Haiti	SC	1,000,000	6,212,520	6,212,520	100%
Prevention of occupational HIV, PMTCT, blood safety	UNAIDS	0	24,331	24,331	100%
Rebuilding the HIV response	UNAIDS	500,000	593,250	0	0%

Title	Appealing agency	Original request (USD)	Revised request (USD)	Funding received (USD)	% Funding received
RH & mental health services	UNFPA	0	418,370	303,666	73%
Providing girls- and women- friendly health services	UNFPA	500,000	5,236,262	1,296,400	25%
Providing emergency Reproductive Health Kits	UNFPA	1,000,000	1,000,000	693,651	69%
Assessing RH needs	UNFPA	300,000	300,000	0	0%
Essential health and nutrition needs for women and children	UNICEF	0	2,251,500	2,251,500	100%
Essential health services for women and children	UNICEF	8,500,000	19,000,000	21,245,295	112%
Enhancing local health resources in Haiti	WCC	0	94,133	0	0%
Public health response	WHO	0	4,080,001	4,116,900	101%
Reactivation of basic health services	WHO	3,500,000	20,784,000	7,050,574	34%
Provide PHC with emphasis on women and children	World Hope International	0	796,000	0	0%
Primary health care and outbreak prevention	WVI	2,000,000	3,542,967	3,542,967	100%
TOTAL		**21,900,000**	**97,878,875**	**76,696,941**	**78%**

*Bold projects are specifically targeted to RH; other appeals address RH as a component of the overall project.
Source: (UNOCHA, 2011a)

Through CERF,[29] UNFPA received an additional USD 306,000 for the RH response (CERF, 2011). WHO received USD 5 million for the health response overall through CERF (CERF, 2011). More than USD 35 million of CERF funding was allocated to Haiti, the most ever given to a single emergency at the time (CERF, 2011).

Two representatives from INGOs noted that they used their own agency's unrestricted funds for the Haiti response, rather than applying for funds through the Flash Appeal. As a

[29] The CERF is a pre-existing fund managed by the UN and includes windows for rapid response and under-funded emergencies. CERF funding is only disbursed to UN agencies, although these agencies often sub-grant to implementing partners.

result, they had to advocate internally for the funding to be allotted towards RH. A senior RH adviser with a large INGO remarked:

> *"It was a challenge to make the case for RH internally. It just wasn't seen as a priority…We had to frame RH in the context of [our agency's] broader gender mainstreaming work to get funding for it".*

The health coordinator from a major INGO commented that the rapid inflow of funding may have undermined quality programming:

> *"There is a lot of money—this makes people lazy about considering the best option".*

The initial high level of funding and support for RH was short-lived and not sustained given the extensive needs. For example, only 20% of displacement camps had any sort of health facility on-site almost nine months after the earthquake, despite generous funding at the beginning and many competent agencies active in the health response (Human Rights Watch, 2011, p. 21).

5.4.5 Policies and protocols

Efforts to advance policies to improve RH in Haiti were underway before the earthquake. The government's 2007 *Growth and Poverty Reduction Strategy* included maternal health as a priority, and the 2005 *National Strategic Plan for the Reform of the Health Sector* included integrating RH into the primary health care system (Human Rights Watch, 2011).

Nonetheless, RH was not well integrated into Haiti's emergency plans. For example, Haiti's *National Disaster Risk Management Plan*, which had been in place since 2001, did not include the MISP (Global Facility for Disaster Reduction and Recovery, 2009). Within two months after the earthquake, the government released the *Action Plan for the National Reconstruction and Development of Haiti,* which outlined short- and long-term plans to revive key sectors such as agriculture, housing, and education (Government of the Republic of Haiti, 2010a). The plan did not include RH under the health component, although did mention the importance of strengthening rule of law and violence prevention strategies particularly for women and displaced persons (p. 45).

National policies and protocols regarding RH played an important role in the response. Informants reported that MoH protocols on safe blood transfusion, STI management, care for rape survivors, emergency obstetric care, and other areas of the MISP were in place. However, these protocols were primarily available in hard-copy. The destruction of the MoH building destroyed many of the printed treatment guidelines, and electronic versions were not available. The RH Focal Point tried to reprint and distribute as many national protocols related to RH as she could find. She remarked that a colleague found a hard copy of the national STI management protocols, which the colleague photographed and then emailed to partners.

As highlighted previously, some of these national protocols, such as protocols on the clinical management of STIs and rape, were in conflict with guidance stipulated by WHO. In addition, the lack of accessibility to national treatment protocols and the wide-variety of uncoordinated agencies resulted in vertical health programming guided by different protocols. The RH Focal Point noted that agencies were using their own internal protocols, which may not have aligned with international or national protocols. A health coordinator from a UN agency commented that the disregard of national protocols by some “arrogant” INGOs was perceived badly by the MoH.

National laws, specifically regarding rape and abortion, also affected the access by displaced women and girls to life-saving RH care. Rape was not officially a punishable crime in Haiti until the modification of the penal code in 2005 (Human Rights Watch, 2011). At the time of the earthquake, a framework for implementation had not been developed, and Haiti was one of the few countries in the Western Hemisphere without specific legislation protecting women and girls against sexual violence (Amnesty International, 2008a). Further, marital rape was not covered under the law, despite evidence that forced sex in marriage was not uncommon (Amnesty International, 2008a; Smith Fawzi et al., 2005). Indeed, a 2006 MoH survey of 10,757 women of reproductive age found 10.8% had experienced sexual violence by an intimate partner (IASC, 2010b).

On a positive note, the *National Plan to Fight Violence Done Against Women* was instituted in 2005 and special police units for women and child victims of domestic violence were established (Amnesty International, 2008a; Human Rights Watch, 2011). Haiti is also signatory to the Inter-American Convention on Violence Against Women as well as to

Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (UN Office of the Special Envoy for Haiti, 2010). In general, however, legislation to protect women and girls against sexual violence and to support survivors was extremely weak (OHCHR Haiti, 2012). Women and girls in focus discussions noted that they would not go to the police if they were raped because of their lack of faith in the system and fears of revictimisation. The *Ministre à la Condition Féminine et aux Droits des Femmes*, or Ministry of Women's Affairs, oversees policies on violence against women and is among the least funded government ministries, receiving 1.4% of the 2011-2012 national budget (OHCHR Haiti, 2012).

Emergency contraception is legal in Haiti and is part of the standard protocol for post-rape treatment. However, informants reported that national health workers were uncomfortable dispensing emergency contraception in part due to conflict with personal religious beliefs. Focus group discussions revealed low awareness of emergency contraception among the displaced population.

Abortion is permitted when the mother's life is in danger but not under any other circumstances. As of 2007, unsafe abortion was widespread and accounted for approximately 13% of maternal deaths in Haiti (PAHO/WHO, 2007). Unsafe abortion increased after the earthquake as a result of unwanted pregnancies with UNFPA reporting up to 66% of pregnancies among displaced women and girls were unplanned (Human Rights Watch, 2011, p. 32). Health providers interviewed reported alarming rates of unsafe abortion, primarily induced by misuse of misoprostol. Other methods mentioned by focus group participants included vaginal douching with icy Coke and salt water. Under Haitian law, women who seek out unsafe abortions could be prosecuted (Amnesty International, 2008a).

5.4.6 Access/humanitarian space

The significant challenges in physical access plus security concerns severely hampered the response. Roads throughout the city and the countryside were blocked with debris and rendered impassable. With 85% of aid supplies normally transported via the road network, the destruction of the roads alone had a colossal impact on the capacity to respond effectively (IASC, 2010c, p. 16). Due to these access difficulties, agencies concentrated

their efforts in the Port-au-Prince, even though the needs in the rural areas were high. UNOCHA's Rapid Initial Situational Assessment found that 53% of health facilities outside of Port-au-Prince had severely compromised access compared with 18% in the capital (UNOCHA, 2010c, p. 7).

The road from Port-au-Prince to Jacmel, for example, was obstructed for ten days after the earthquake, preventing life-saving supplies from reaching those in need (IASC, 2010c). Lack of fuel and vehicles compounded the situation further. In the beginning it could take three to four hours to reach the UN Log Base, which was ten kilometres from the centre of the city, greatly affecting participation in coordination meetings. One of the RH Focal Points commented:

> *"I did see that people couldn't come to the [RH Working Group] meetings. They said that they really wanted to come but that they didn't have time, that it was too far and it would cost them half the day to come to Log Base".*

At the time of the data collection—four months after the earthquake—many of roads were still barely functional and congestion made travel painstakingly slow.

Figure 5.10: Destroyed apartment building in Port-au-Prince four months after the earthquake

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Haiti's main airport and seaports were also severely affected. Only one airstrip was functional at Toussaint Louverture International Airport and the control tower was damaged, creating a dangerous situation as a wide range of actors tied to send in much needed supplies (IASC, 2010c). The U.S. Army commandeered the airport, and although criticised for prioritising their planes over other incoming flights carrying relief supplies, their role was recognised as essential to averting a potential catastrophe (Grünewald & Binder, 2010; IASC, 2010c). The seaports were not operational for the first ten days after the earthquake, and storage capacity for incoming supplies was severely limited (Grünewald & Binder, 2010; IASC, 2010c).

Communication was disrupted as Haiti's only submarine telecommunications cable was damaged (IASC, 2010c, p. 5). The mobile phone system crashed, although the internet, including Skype, worked sporadically (Grünewald & Renaudi, 2010). In addition, informants noted that many people had lost their phones, which further disrupted communication even after the telecommunications systems were restored. This affected the RH response specifically, for example, in that it was difficult to reach the local SPRINT trainees to mobilise them for the response.

Logistics were further frustrated by the sheer number of relief agencies working in the urban setting. Humanitarian organisations have historically operated in rural settings where space and population density have not been an issue. The urban context required a steep learning curve even for seasoned relief workers. One expatriate INGO medical director reported:

> *"The situation was chaotic. There were a lot of NGOs—coordination was not good… The urban versus rural areas was challenging… Working in war torn areas is easier than this".*

Insecurity was also a barrier to respond effectively. Haiti was classified as UN Security Phase 3 (UNOCHA, 2010a), which meant aid workers experienced occasional, multiple threats (UN Department of Safety and Security, 2010). In contrast, development actors who had worked in the country in the years prior to the earthquake described it as a "relatively calm posting" (Grünewald & Binder, 2010, p. 24). Humanitarian agencies' security concerns were exacerbated by the destruction of the main prison, which allowed 4,000 criminals to escape (UNOCHA, 2010a).

Adherence to stringent security protocols was often prioritised over needs. Curfews were imposed as early as 4 p.m. and, in conjunction with the travel challenges, this significantly limited the amount of work that could be accomplished in one day. Escorts were often mandatory or staff had to travel with a minimum of two vehicles. Many UN and INGO staff were prohibited by their agencies to travel to particularly insecure areas—so-called Red Zones—such as Cité Soleil, despite urgent needs. Desperation and frustration with the painfully slow response soon mounted among the displaced population and looting, assault and the violent demonstrations were not uncommon in the months after the earthquake, although the UN reports that these were exaggerated by the media (Rencoret et al., 2010, p. 22). Whether the conservative approach of humanitarian organisations toward security was unfounded is difficult to ascertain. Regardless, the real or perceived insecurity of the situation compromised the response.

5.4.7 Community involvement

Although some efforts to engage with the affected populations were undertaken, community outreach broadly was poor. Many new technologies were employed to assist with the response and help communicate with affected communities. Agencies disseminated vital health information through SMS, located missing persons through interactive online maps, and announced food and water availability through radio messages (Nelson & Siga, 2010). Innovative inter-agency initiatives were launched, such as Communicating with Disaster-Affected Communities (CDAC) Haiti, a cross-cluster collaboration designed to improve the feedback loop between responding agencies and affected communities (CDAC, 2010). Individual organisations made efforts to engage the general population, such as the Haitian Red Cross' radio programme, which included live call-ins and text messages from affected communities with questions regarding health and service provision (IFRC, 2011).

Yet many of these efforts were limited to sharing information with the affected communities, rather than meaningful engagement in programme design and evaluation. Efforts were often ad hoc and, due to ease of access, focused almost entirely on Port-au-Prince to the detriment of the outlying areas. Numerous reports criticised the lack of participation of the affected communities in the response (Grünewald & Binder, 2010; Haver, 2011; IASC, 2010c; Refugees International, 2010b). An inter-agency evaluation asserted that "…overall the earthquake response has been highly exclusive. The affected population was not

consulted, informed or included in the design, planning and implementation of the humanitarian response" (Grünewald & Binder, 2010, p. 42). An assessment by Refugees International (2010b) concluded that the communication gap between humanitarian agencies and affected communities contributed to the deteriorating security situation. The *Haiti Earthquake Post-Disaster Needs Assessment*, which provided a framework for the reconstruction process and was led by the government and UN, was criticised for not sufficiently consulting women specifically (Rebuilding Haiti Initiative & g+dsr, 2010).

Community participation is a fundamental principle of RH programming in humanitarian settings (IAWG, 2010c). The informants noted that many programmes were designed with women in mind, but that communities—particularly women—were not consulted in the process. A number of health staff commented that women were prioritised in condom and food distribution as well as service provision generally. Efforts were made to inform women about where and why to receive care post-rape and there was community awareness-raising on STIs including HIV. Yet upon further questioning, informants acknowledged that affected women (and others) were often not engaged or asked to provide input in programme design. One senior RH advisor for an INGO commented:

> *"We tried to consult with women, but it was not easy. When we visited a camp, the 'leaders' would come forward, but we weren't always talking to the right people".*

The majority of informants acknowledged that even the efforts to inform the community were not successful. An expatriate INGO health coordinator remarked:

> *"Most women don't know care [after rape] is available. The radio messages help, but many health facilities don't provide the services, so the messages basically backfired".*

Focus group discussions with women, men, and young people confirmed that displaced communities were generally not consulted and that they often did not know where to receive basic RH services. For example, women in a FGD in Jacmel described a woman who gave birth unattended in a camp because she was unaware of a free referral system to the local hospital.

5.5 Conclusion

The RH response to the Haiti earthquake marked one of the most significant inter-agency efforts to implement the MISP in an emergency to date. Unprecedented awareness and prioritisation of the MISP by a variety of actors contributed to the groundswell of support for its implementation. This is a marked departure from previous emergencies in which knowledge of the MISP was invariably low, RH Working Groups were often not established, and qualified RH staff are lacking (Women's Refugee Commission, 2005, 2007, 2008; Women's Refugee Commission & UNFPA, 2004). While all the right pieces seemed to be in place: strong RH leadership, an RH coordination mechanism, robust RH funding, and high awareness of the MISP among health actors, numerous problems and challenges were evident.

Despite many humanitarian staff working tirelessly to implement RH services, considerable gaps in MISP implementation prevailed. Though some of the barriers were beyond the control of the RH actors—such as the scale of the disaster—the fragmented RH response revealed a major paradox that raised further questions. Why didn't well-seasoned RH actors, who knew the value and benefit of coordination and cooperation, engage more with stakeholders, particularly other RH agencies, local community based organisations and affected communities themselves? Why was coordination so poor, sharing of information limited, and efficiency low? Why was inequity of provision left without an effective solution?

Why did RH responders in Myanmar coordinate far better than in Haiti, despite the latter having more RH experts and actors on the ground? The following chapter synthesises and compares the findings from the Haiti and Myanmar responses to explore in detail the barriers and enablers to MISP implementation.

6. Chapter Six: Phase I synthesis

6.1 Introduction

The RH responses to the disasters in Myanmar and Haiti revealed important similarities but also marked differences. In this chapter I compare, contrast, and analyse these in an effort to identify key enablers and barriers to MISP implementation in these settings. Additional Phase I data are presented to clarify issues and inform the next stage. This is followed by a constructivist grounded theory approach to identify and draw out relevant themes.

6.2 Overview

The two crises examined shared a number of features. Both Myanmar and Haiti experienced massive, sudden onset natural disasters. This occurred against a backdrop of exceptionally weak governance capacity and structures that were ill-prepared for catastrophes of this magnitude (Stover & Vinck, 2008; Turner et al., 2008; UNDP, 2013; World Bank, 2014a). Basic disaster risk reduction strategies—such as early warning systems, disaster management capacity building, vulnerability mapping, emergency services, and standby arrangements—had not earlier been adopted in either setting.

The population impact was staggering with more than 120,000 lives lost in each setting (Human Rights Watch, 2010; UNOCHA, 2011c) and 75% and 61% of health facilitates in the affected areas damaged or destroyed in Myanmar and Haiti, respectively (Tripartite Core Group, 2008; UNOCHA, 2011c).

Apart from maternal health, both governments held a conservative stance on RH, reflected by the limited funding and attention to the issue (John Snow International, 2009; UNFPA, 2010b). At the time of the crises, RH was not integrated into key emergency preparedness and response policies in either setting (Global Facility for Disaster Reduction and Recovery, 2009; Government of the Republic of Haiti, 2010a).

At the community level, although Haitians were, broadly speaking, more comfortable about openly discussing some sexual topics, certain RH issues such as rape and abortion were

culturally sensitive in both settings; and knowledge about SRH in the general population was limited (UN, 2013; UNFPA, 2010b). In both countries, most women gave birth at home rather than in a health facility and midwives were relatively scarce (Arie, 2011; Human Rights Watch, 2010).

Despite this challenging background, the RH responses were, in many respects, strong after both crises. UNFPA initiated an RH Working Group, led by effective Focal Points, under the Health Cluster within the first two weeks after both disasters. Funding for RH service provision was considerable: approximately USD 30 million was allocated to Myanmar and USD 77 million to Haiti through CERF and Flash Appeals (CERF, 2008, 2011; UNOCHA, 2011a, 2011b). Nevertheless, MISP implementation was uneven in both settings.

Marked differences both in relation to the crises and their impacts and the responses were also noted. In Haiti, the earthquake decimated the capital and surrounding areas, including key infrastructure and government buildings, paralysing the country. In Myanmar, the cyclone struck a massive rural area, leaving Yangon and Napitaw, the former and current capitals, relatively unscathed and operational.

Haiti has traditionally been dependent on foreign aid. Net official development assistance was more than the government's total internal revenue in 2009, the year before the crisis (UN Office of the Special Envoy for Haiti, 2011). With Haitian governance incapacitated after the earthquake, military forces and relief agencies poured in from around the world. In contrast, the Myanmar government has historically resisted external interference and been particularly suspicious of Western governments; it initially clamped down quickly and refused international assistance after the cyclone (Stover & Vinck, 2008). As a result, in Haiti, the humanitarian response was almost exclusively led by international agencies, to the exclusion of local groups, whereas in Myanmar in-country actors spearheaded the initial relief effort with much more limited external engagement at the onset of the response.

6.3 Human resources

The leaders of the respective RH responses—the RH Focal Points in Haiti and Myanmar and the two SPRINT trainees in Myanmar—were important in advancing the MISP in both

settings. Competent leadership is essential for an effective humanitarian response (Buchanan-Smith & Scriven, 2011; Featherstone, 2010). A literature review on cross-sectoral leadership suggested that effective inter-agency leaders require "formal and informal authority, vision, long-term commitment to the collaboration, integrity, and relational and political skills" (Bryson, Crosby, & Stone, 2006, p. 47). I identified five key qualities—the "five Cs"—in the RH leaders that enabled the RH responses: commitment, creativity, competence, collaborativeness, and "chutzpah" (a bold or audacious form of assertiveness.)

The leaders' *commitment* to the issue was important: they were willing to put in the long and often difficult hours necessary to help ensure RH was addressed and they were enthusiastic about their work. One of the SPRINT trainees in Myanmar, for example, made herself available by phone and email to assist other agencies, even those that did not participate in the RH Working Group, and she responded immediately, despite this being beyond her purview. They were personally committed to the issue and exuded enthusiasm. "I was excited to implement the MISP", noted one Focal Point in Haiti.

They were *creative* and flexible in their approaches, which aided in developing innovative solutions to problems that arose. In Haiti, for instance, one Focal Point supported the establishment of birthing tents, staffed by local midwives, in camps with night curfews; thus pregnant women had access to care at all times. Another made her signature electronically available to speed up the processing of RH Kits.

They were *competent*, familiar with the MISP, and able to guide the RH response in prioritising the MISP objectives. One of the SPRINT trainees from Myanmar explained how she guided UNFPA to lead the RH response:

> *"We were in the KL [Kuala Lumpur] airport [after the SPRINT MISP training] when the cyclone struck Myanmar. We understood that the MISP is not aware by many people so it will be very difficult to initiate RH responses. We discussed and planned to initiate first with the UNFPA office—even with the office people haven't taken the [SPRINT MISP] course—so we predicted the challenges… I explained to [the UNFPA] Assistant Representative our future activities on MISP... She was supportive".*

The leaders understood the value of *collaboration* and did not solely focus on their own agencies. They facilitated coordination meetings, shared information, and tried to support the RH efforts of other agencies. A SPRINT trainee from Myanmar recalled:

> *"We try to contact our partners to respond because many organisations are going to the Delta so we want to explain how to prepare for RH responses. Many organisations have interest in maternal health care and MDM [Médecins du Monde] are not our partner but they request through the Health Cluster meeting that they are interested people and they contact us by e-mail and they requested training for their new staff. So I organised a five-day training for all MDM staff. And they request commodities and technical support, trainings... We provide".*

Finally, they had *chutzpah*: they initiated an RH response even without the support of the Health Cluster and advocated to colleagues to include the MISP in their programming. The first RH Focal Point in Haiti said:

> *"I walked into the Health Cluster meeting and just said right, we are going to coordinate reproductive health…. I didn't ask permission".*

In addition to effective leadership, there were other human resource-related enablers. Specifically, the RH Working Groups had a number of members representing various agencies who were designated to implement RH. This contrasted with an earlier lack of RH-specific actors in previous emergency settings (IAWG, 2004b; Vann, 2012).

Human resources challenges also frustrated RH implementation in both crises. The rapid turnover of the RH Focal Points in Haiti—five in four months—combined with a lack of handover processes undermined RH efforts. Research by People in Aid and the Emergency Capacity Building Project, two initiatives addressing human resources in humanitarian settings, indicated that staff turnover in emergencies undercuts not only learning and efficiency but can also sometimes compromise the continuation of existing programmes (Loquercio, Hammersley, & Emmens, 2006, p. 1). Furthermore, despite the relatively large number of RH actors, capacity to implement key elements of the MISP was limited in both settings, particularly clinical management of rape, which has historically been neglected in humanitarian responses (IAWG, 2004b).

6.4 Stakeholder engagement

Engaging with key stakeholders, specifically other RH actors and affected communities, was a clear enabler in Myanmar. The RH/HIV Technical Working Group provided a mechanism to share information, problem-solve, provide support, and link with other agencies. Assessments in other settings have also highlighted the importance of RH coordination in effectively advancing MISP (Women's Refugee Commission, 2005, 2008). Outreach to affected communities, particularly through community-based trainings on the MISP, also helped raise awareness and encourage health-seeking behaviour.

The development alone of an RH Working Group in Myanmar was remarkable. Before 2008, the year of the cyclone, the establishment of RH coordination mechanisms in humanitarian emergencies was ad hoc at best. Yet not only was a national RH Working Group created immediately after Cyclone Nargis, but sub-national coordination mechanisms, which fed back to the national group, were also set up at the field level. This was established even though only two people in-country had been trained in international humanitarian RH standards. In Haiti, however, despite a plethora of RH experts, sub-national coordination had not been set up even four months after the earthquake.

Further, the RH Working Group in Myanmar coordinated exceptionally well, whereas in Haiti coordination was fragmented. This contrast can, in part, be explained by the composition of the Working Groups. In Myanmar, the Working Group comprised long-term, Myanmarese staff with pre-existing relationships while the Haiti Working Group was predominately made up of transient, external humanitarian workers from diverse organisations who were unfamiliar with the context and language. Indeed, a 2013 public health emergency study on Cyclone Nargis found that the successful aspects of the health response could be attributed to, among other things, pre-existing, in-country networks among skilled national staff, often working for different agencies (Shwe, Zwi, & Graham, 2013).

For example, a Myanmarese UN officer described how she and her local colleague were able to advocate to government officials to support RH Kit distribution to damaged hospitals. Her relationship and rapport with government authorities, understanding of local cultural and political sensitivities, and continuity in her job facilitated this success. She said:

"The RH Kits arrive and we wanted to distribute them to their hospitals… We loaded the RH Kits onto a truck and at that time, the deputy minister came and was angry with us. Even [though] I had discussed properly with the directors—they denied, they said they didn't know—and they have to unload it. In next time I went directly to the Deputy Minister and he said that they still want to give back the commodities to UN and they are also angry with WHO. Very complicated. And he said that if the commodities go to anti-[government] groups, then they are afraid. I explain that we plan to distribute them to their [government] hospitals, a prearrangement with the directors… Later we [another local UN representative and me] met with the Deputy Minister again and finally a few months later, distributed to cyclone-hit townships… So I'm very happy. I plan to give the training for the BHS [national Basic Health Staff] and my [government] counterpart programme manager was thanking me".

Although the RH response in Myanmar remained largely locally-driven, the Health Cluster became dominated by international agencies after the visa ban was lifted. A Myanmarese UN representative described the difficulty of participating in a mixed (international and national) Health Cluster meeting:

"Actually at the Health Cluster at the beginning was quite small and then got very big. Many of them are expatriates. And very few local people and in our office only the rep is a foreigner… At our office is only local people and during the [Health Cluster] meeting to have a voice is very difficult… We announce that we want to present about our activities—our RH kits and our training and our RH responses—and we try to be on the agenda but they postponed and it is several months later [before RH got on the Health Cluster agenda]".

Informants in Myanmar also reported that speaking the same language was an important element in effective coordination. This not only supported clearer communication but fostered a sense of a unified, national approach.

In Haiti, the lack of a common language undermined coordination efforts and group cohesion. RH Working Group meetings rotated among French, English, and Creole, requiring significant translation that slowed the meetings. The RH Focal Point said:

"There's a lady that came up to me just yesterday who said she felt insulted because she felt like she was being discriminated against in the meetings [because she only

spoke English]. I think before it was much easier for English but yesterday we were going jab jab jab in French… We were not discriminating. We said to her you can sit here [with someone who can translate], but she did not want that… It just takes more time repeating the same thing".

Moreover, despite strong participation in the Haiti Working Group by international agencies and an effective initial RH Focal Point, collaboration and information-sharing was lacking. Requests for even basic feedback on programming, such as which agencies were providing emergency obstetric care and how many condoms agencies had distributed, were largely unmet. Overwhelming workloads and high staff turnover undermined the development of interpersonal relationships and contributed to a "culture of individualism" among agencies, resulting in lack of engagement and coordination with relevant stakeholders. The individual-mindedness of agencies was evident in the "poaching" of local midwives by paying them above local market rates, thus contributing to the brain-drain of local health workers from the national health system to INGOs (Merlin, 2011). The most damaging aspect of this "individualism" was the lack of engagement with national RH actors and affected communities, both of which are essential to an effective response.

Successful coordination was enabled by national actors who shared language, understood the cultural context, had connections with government and other key actors, and were familiar with relevant laws and policies. This reinforces research evidence that tacit local knowledge and shared understandings facilitate coordination (Powell, 1990).

Furthermore, nationally-led responses can be constructive because civil society organisations and affected communities themselves are the first responders in emergencies and provide some of the most critical initial assistance (IFRC, 2004). These local actors are familiar with local capacities and dynamics and remain throughout the recovery phase, thus strengthening sustainability. The more robust and resilient civil society is before a crisis, in this case regarding gender and RH, the more effective the response (WHO, 2012c). As such, utilising in-country capacity to respond to emergencies can potentially augment the effectiveness and efficiency of the response in addition to other benefits, such as strengthening the health systems. Indeed, a study commissioned by Oxfam and partners also revealed that national and local actors enhance both the relevance as well as the positive impact of humanitarian action (Ramalingam, Gray, & Cerruti, 2013).

A 2012 global survey among aid workers on their experiences with emergency preparedness found that recurring problems in humanitarian responses were in part due to limited prior knowledge or contextual understanding by international agencies responding to emergencies (RedR UK, 2012). International and national humanitarian survey respondents agreed that supporting local implementing agencies, specifically through disaster risk reduction initiatives, is of value to successful programming. Respondents noted that disregarding national stakeholders and affected communities not only undermines a response but can put expatriate staff at risk.

6.5 Organisational and financial support for RH implementation

UNFPA's support greatly enhanced RH implementation in both settings. UNFPA volunteered to lead the RH responses, providing internal funding and establishing a Focal Point to oversee coordination. UNFPA-Myanmar in particular supported and empowered their staff to lead the RH response, and, in Haiti, the head of the UNFPA Humanitarian Response Branch flew to Port-au-Prince to champion the efforts.

Financial support was an important enabler in both settings. As noted earlier, the Nargis RH response received roughly USD 30 million and the Haiti earthquake USD 77 million through CERF and Flash Appeals (CERF, 2008, 2011; UNOCHA, 2011a, 2011b). Yet the windfall of funding for the Nargis and Haiti responses were anomalies rather than the norm. Although funding for RH in emergencies through the Flash Appeal process has steadily increased since 2002, the field remains underfunded (Tanabe et al., in press; Vann, 2012). Other research suggests that gains in global funding for RH in crises through official development assistance are due to an upsurge in funding for HIV alone (Patel, Roberts, Guy, Lee-Jones, & Conteh, 2009).

It is notable that UNFPA, relative to other agencies addressing RH, was not itself well funded for RH service implementation in the two crises. In Haiti, UNFPA received 41.8% (USD 2.3 million) of its requested funds whereas UNICEF received 112% (USD 21 million) for similar RH programming (UNOCHA, 2011a). The differentials in funding for UNFPA for the Cyclone Nargis response were more striking: for the RH response, UNFPA received a total of USD 337,376, or only 4% of requested funds, whereas UNICEF received USD 25.3 million, or 97% of requested funds (UNOCHA, 2011b). Indeed, WHO, IOM, and UNICEF all

received significantly more funding tha UNFPA to address RH, although RH is not their main area of expertise. This may be due to their more established track record of working in humanitarian emergencies. UNICEF and IOM, for example, were established after the Second World War specifically to address the needs of conflict-affected populations (IOM, n.d.; UNICEF, 2013). WHO, which had worked in crises since its inception in 1948, formally established an emergency unit in 1974 (WHO, 1993).

In contrast, UNFPA is a comparatively small agency and did not establish a humanitarian response branch until 2002 (UNFPA, 2002). Although it has made significant strides, UNFPA's internal humanitarian response systems still require considerable strengthening and the agency struggles with its internal capacity to respond to emergencies. A 2010 evaluation revealed a number of weaknesses. For example, eight years after the establishment of the humanitarian unit, standard operating procedures for emergencies and a comprehensive humanitarian programming manual were not yet finalised (UNFPA, 2010c). In its first decade of working in emergencies, UNFPA did not have the capacity or was unwilling to lead the RH response in a number of settings. Indeed, the 2010 evaluation made no reference to UNFPA's role in RH coordination and only discussed its role as co-lead of the Gender-based Violence Sub-Cluster (UNFPA, 2010c).

Against this backdrop, the case study findings demonstrate that UNFPA's organisational support at country level were essential to the RH response and may reflect UNFPA's maturation as a humanitarian actor. It further highlights the need for an organisation, not just individuals, to take responsibility for overseeing the RH response and to have adequate funding to support the response. Financial support for multiple actors to implement RH services is also important.

6.6 Awareness

Knowledge of the MISP among humanitarian actors was an important facilitating factor. Before Cyclone Nargis knowledge of the MISP was very low in Myanmar. Upon return to Yangon just a few days after Nargis, two recently SPRINT-trained personnel immediately spearheaded rapid trainings and awareness-raising among responders, helping to build momentum for the RH response. The UNFPA Myanmar senior management were very supportive and provided funding and institutional support. Within the first six months after

the cyclone, UNFPA facilitated 38 training sessions and orientations on MISP and gender-based violence reaching a total 2,019 personnel, including 1,295 government staff.[30]

The training sessions had a dual effect of both raising awareness on the importance of the MISP as well as helping to facilitate coordination by bringing together the agencies working on RH and highlighting RH activities to prioritise. A Myanmarese UN representative commented:

> *"After the cyclone we had different kinds of trainings. In the beginning they were not aware. But after receiving many trainings, health staff were aware of many more things. And I think it [awareness of MISP] is better than before [the cyclone]".*

The training sessions were also offered an opportunity for advocacy to government officials and raised awareness at community level. They had an impact on improving RH service delivery. A Myanmarese doctor working with the UN said:

> *"Through the MISP training many organisations became aware of the importance of the referral mechanism [for emergency obstetric care]. Some organisations trained volunteers and included referring maternal emergencies. So the referral mechanism is better than before [the cyclone] because there are many health organisations working on it in the Delta".*

At a later point she continued:

> *"For our partners through our training they became aware that they also need to focus on universal precautions especially during mobile services. Because at the very beginning [of the crisis response] they only bring the medicine without safety box or other things, but many of them became aware [through the trainings]".*

In Haiti, many international actors, particularly IAWG experts, were familiar with the MISP before the earthquake. Informants commented that awareness of MISP among the humanitarian responders was exceptionally high. An expatriate midwife employed by an INGO remarked:

> *"This is some of the best awareness and communication I've seen on the MISP... That really helped move things forward".*

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[30] See Appendix A for training/orientation breakdown.

A Haitian manager with a small INGO commented that the RH Working Group raised awareness about RH during the crisis independent of the Health Cluster. She said:

> *"I think that people were much more aware and there was a much bigger deal about RH, but I think the RH Working Group did that—I didn't think the Health Cluster in general helped. And I stopped going [to Health Cluster meetings] in the beginning".*

External support played a role as well. In Haiti, the RHRC's (2010) statement on Haiti was used as an advocacy tool by a number of agencies to gain internal and inter-agency buy-in for the RH response. The IAWG's MISP Sub-Working Group convened emergency teleconferences and provided remote support to agencies on the ground. In Myanmar, SPRINT Initiative staff provided remote support and guidance.

Yet the lack of support for RH by the respective Health Clusters affected the RH response. Although this did not hinder the establishment of RH Working Groups, it did contribute to the fragmentation of RH within primary health care. RH was not systematically integrated into health assessments and agencies that did not participate in the RH Working Groups generally prioritised RH less than those that participated.

The Health Cluster's relationship to RH was different in the two countries. In Myanmar, the Health Cluster initially appeared to dismiss RH. A representative with UNFPA recalled:

> *"The Health Cluster in the first meeting did not invite UNFPA. But when we had the second Health Cluster meeting we attended. We try to include MISP but at that time it was very difficult. We continually attended all the Health Cluster meetings…and we tried [to] put in the agenda [issues] about the RH response. And when the other people take all the time in the last minutes they said they will postpone that agenda. We prepared a lot but we can't present anything but gradually RH is in the agenda".*

In Haiti, the Health Cluster also neglected RH, although not to the same degree. For instance, it did not announce the RH Working Group meetings and failed to upload the Working Group meeting notes to their website. Yet informants suggested this was not necessarily due to a conscious neglect of RH but may have been more a reflection of the chaotic health operating environment as a whole. One of the RH Focal Points explained:

> *"I actually sent the [RH Working Group] minutes to the Health Cluster but they never posted them… And I also try to send invitations through the Health Cluster email list but*

also didn't happen. The whole Health Cluster was a bit chaotic. It was a huge emergency— they had like 80 people in a Health Cluster meeting".

The RH Focal Point in Haiti also reported that the Health Cluster failed to request RH data, such as the number of patients requiring post-rape treatment, which it should have been collecting Other aspects of RH were discussed and taken more seriously by the Health Cluster, however, such as emergency obstetric and newborn care.

The two case studies reflect the ambiguous relationship between the Health Cluster and RH. On the one hand, the Health Cluster in Myanmar did not designate RH a priority in the health response. In Haiti, however, the Health Cluster did not discount RH, but its actions reflect the fragmented nature of RH with the Cluster. As mentioned, emergency obstetric and newborn care alone received attention, and RH generally was not integrated into the Cluster's scope of work. During the development of the Cluster Approach, the Health Cluster resisted the establishment of a separate RH Sub-Cluster, arguing that "reproductive health is health", but the findings suggest that it has yet to take full responsibility for the field. An RH Focal Point in Haiti commented:

"…[RH data] is the problem of the Health Cluster. They need to centralise all [RH] information [online] so people can go and click and see what services are available…WHO needs to do that. It needs to be integrated, especially now that they are saying that [RH] is under the Health Cluster, then it's their responsibility".

Some agencies, most notably MSF, have consistently integrated the clinical components of the MISP into their essential health services. Provision of emergency obstetric and newborn care, post-rape treatment, and HIV prevention are part of their core health services. They provided these services in Haiti and other settings as well. Interestingly, interviews with MSF staff in Haiti found that many were not aware of the MISP per se. This is not problematic, however; indeed, one of the goals of the IAWG is to systematically integrate RH into primary health care and not split it off as a "special" field. As such, awareness of the MISP per se, as opposed to operationalising its key components, is not essential to its implementation.

At the community level, however, lack of awareness about RH was a significant barrier. Focus group discussion participants in both settings remarked that they did not know where

to access many life-saving RH services, such as post-rape care and emergency obstetric and newborn care, despite the availability of these services nearby. As a result, women and girls gave birth in unsanitary and dangerous conditions, had unwanted pregnancies, and contracted HIV and other STIs through rape or lack of access to condoms. In regards to sexual violence, many of the displaced in both settings were unaware of the existence of medication to prevent pregnancy and minimise HIV transmission. While some efforts were made—such as the distribution of postcards with information for rape victims in Haiti—these were insufficient to cope with the enormity of the need.

6.7 Socio-cultural norms

In many settings around the world, RH remains a sensitive and deeply personal issue, and Myanmar and Haiti are not exception. Although Haitians tend to be more open about sex generally, issues such as sexual violence and abortion were not openly discussed in either setting. These norms proved to be stumbling blocks to advancing certain components of RH after the respective disasters. Indeed, a 2012 literature review and a 2014 three-country study found that socio-cultural barriers were a major challenge to accessing RH care (Casey et al., in press; Vann, 2012).

In Myanmar, abortion was regarded as taboo. It is only permitted when the woman's life is in danger (Center for Reproductive Rights, 2014), and acknowledgement and discussion of abortion was socially unacceptable. As a result, some women and girls were forced to resort to unsafe abortion after the cyclone. A Myanmarese UN representative explained that this policy reflects Myanmar's deeply held Buddhist beliefs, specifically the first of its five fundamental ethical tenants: do not kill (Epstein, 2002). She said:

> *"Now I am aware that abortion is legal in many countries and it is somewhat helpful to solving the problem of unwanted pregnancy, but I think in the near future, in 10 or 20 years, it will not be legal here. There is a strong religious beliefs and also cultural".*

Fortunately, she noted that post-abortion care was accepted in Myanmar and was often provided, although its provision depended on the skill and sensitivity of the attending medical provider.

In Haiti, emergency contraception was similarly sensitive. Although provision of emergency contraception is legal, knowledge and usage were low. A 2006 survey found that only 0.3% of Haitian women had ever used emergency contraception, although 13.2% knew about it (International Consortium for Emergency Contraception, 2014). The lack of provider knowledge and willingness to dispense emergency contraception beyond post-rape treatment has thwarted more widespread use (Lathrop et al., 2013). An expatriate midwife who had worked in Haiti for three years reported:

> *"People aren't comfortable with EC [emergency contraception] even though it is legal, including the providers. Although it has been sanctioned by the MoH, it hasn't been fully embraced by the health system. I had a lot of problems with Haitian staff, saying that [EC] is something available to all women, and people were uncomfortable with that. At the [staff] meetings it would come up and people would nod yes, but I could tell people had issues with it. Abortion is illegal but a lot of abortion happens in Haiti. I never had a patient with a septic abortion in Haiti. Cytotech[31] is widely available. Lots of private physicians do abortion. But the institutionalisation of EC in Haiti is still quite controversial".*

Given the significance of this barrier, the findings from the case studies demonstrate the need to engage with social norms on a number of levels. They highlight how provider knowledge, skill, and cultural sensitivity are important determinants of availability and use of RH services. National staff may have more understanding of cultural sensitivities than expatriate personnel and thus may be able to guide the development and implementation of culturally appropriate RH interventions. At the same time, local staff themselves may feel uncomfortable or unwilling to provide certain services, and thus expatriate staff play an important role in addressing their reservations and ensuring services are available in the setting.

Further, even when appropriate and accessible RH services are in place, social norms or misinformation may impede health-seeking behaviour. Culturally appropriate engagement with the affected communities, such as in relation to condom campaigns or awareness-raising on sexual violence, is important to ensure people receive needed care.

[31] Generic: misoprostol, an abortifacient

In some ways the crises themselves proved to be an enabler for RH advancement. They provided a window to address some of these conservative norms. In both settings awareness-raising about condoms by international and national actors appeared to have made some impact. Informants provided anecdotal examples of tangible shifts in perception and usage of condoms. An RH Focal Point in Haiti recounted:

> *"There was such a mass distribution of condoms—now it's cool to say I use condoms all the time. It's no longer taboo to see a condom and to hold it. I wonder if it changed culturally the younger generations to be surrounded by every single one person using or at least walking around with condoms in their pocket… Before in health centres years ago someone did a study on condoms in Haiti. Haitians were always very awkward, would be shy to go the health centre to ask for it. So culturally Haiti has not been open to condoms historically. And I think this wide distribution [UNFPA] was doing—that is one of the things I think about, I feel good about. We are cool with condoms now in Haiti! The proof and result of what you've done is in the little focus group and hearing that the boys are using condoms. That is huge! That is the biggest thing of a simple gesture—to make it so visible you can't be embarrassed because we are all seeing it and you can't deny it. That's huge".*

A medical doctor in Myanmar said:

> *"Before [my organisation] arrived, people were shy of condoms. But we did a big campaign and gave them to trishaw drivers, teashop owners, everyone. And they gave them out to people. It really worked…people use them now".*

Other informants in Myanmar noted that, prior to the cyclone, discussing catastrophes was considered a bad omen by many communities; this hindered preparedness. Yet many noted that attitudes were changing because the cyclone had made people acutely aware of their own vulnerabilities.

6.8 Policy and protocols

Legal barriers and inadequate medical treatment guidelines also impeded MISP implementation in both settings. In particular, lack of alignment between the international standard of the MISP and national policies were problematic in both countries, particularly regarding the legality of abortion and clinical management of rape.

National guidelines for medical providers in Myanmar instructed them to refer rape survivors to a government hospital for forensic evidence collection and to report the crime to the police. One of the original SPRINT trainees described:

> *"I attended the rape survivor training with [other Myanmarese] medical doctors and I think all did not know the guidelines. And I want to organise multiplier trainings. And I sound out with my partners and they say no way. The [national] forensic guidelines are different. That is where the barrier is. According to our forensic guideline, they have to report [to the police] and not [provide] medicine at all… During training there was a lot of argument. Many medical doctors share their previous experience of the rape cases. Bitter experiences".*

The lack of protocols in conjunction with the mandatory reporting guidelines for medical providers added an additional layer of difficulty and further deterred women who did not want to file a police report from coming forward for care.

In Haiti, as discussed previously, treatment protocols for post-rape care were in place, but they were not aligned with WHO guidelines. Furthermore, the government-recommended therapy for emergency contraception differed from that supplied in the RH Kits. The first RH Focal Point explained:

> *"There is a discrepancy between the post-rape protocol of the government and what we have in the [RH] Kits. So we've been supplying the Kits and the EC is different from what the government is recommending. We have progestin only and they are using hormonal contraceptive pill. So I have been trying to discuss with several people to say that this needs to change, but again, that is going to be a long process. Yes, the government protocol needs to change. There is a more effective EC and you can give it up to five days, and the government still has three days. It's good for women to come in three days—it's important—but you can give EC even later than that".*

It is notable that despite these challenges, this informant and others were successful in changing the protocol. Indeed, the findings demonstrate the ways in which crises offer opportunities for accelerated policy change in addition to socio-cultural change. These large-scale disasters initiated the reorganisation of relationships and shifts in behaviours. Government authorities were forced to collaborate with national and expatriate actors during the crisis response, and these actors had the opportunity to advocate for reform. The

disasters also revealed policy and protocol barriers to RH care against the backdrop of extreme need. In both settings, the objectives of the MISP were more readily accepted during the crisis as humanitarian responders were eager to do what they could for the affected population. In Myanmar, many informants noted that, post-Nargis, RH was seen as a real need in an emergency, including by government authorities. One national UN representative reported:

> *"Cyclone Nargis is very unfortunate but without it I cannot initiate anything. We cannot include MISP in our national strategy plan. And now we can".*

Perhaps the most radical shift in both settings was the window of opportunity for addressing sexual violence. In Myanmar, the government's increasing attention to MDG 5, and its corresponding concern with international criticism on the issue, was strategically exploited by humanitarian actors seeking to address sexual violence in the high profile emergency. By leveraging the maternal health aspect of the MISP, RH actors were able to gain a toehold in the cyclone response. One UN official noted:

> *"We can do for maternal health whatever we want to do. But for sexual violence the barrier is much bigger… So we use maternal health as an entry point.*

Thus, during the recovery phase, the MoH allowed the UN to hire an expatriate expert to establish a national referral pathway for rape survivors. The government also allowed trainings of health care workers on prevention and response to sexual violence for the first time in Myanmar's history.

In Haiti, the widespread sexual violence after the earthquake received considerable international attention, which helped catalyse political reform (MADRE, KOFAVIV, International Women's Human Rights Clinic, Center for Gender and Refugee Studies, & Center for Human Rights and Global Justice, 2012). Indeed, significant amendments to Haiti's penal code are, at the time of this writing, in progress to enable rape survivors to prosecute their attackers and align the definition of sexual assault with international law (Herz, 2013). Marital rape would also be criminalised (Herz, 2013).

While evidence on if and how disasters can create "windows for change" is currently limited (Birkmann et al., 2010), the findings from these case studies provide some insights into this question.

6.9 Emergent themes

This research takes a constructivist grounded theory approach, which entails engaging in reflexive processes through which new themes are identified over time. The approach allows and supports space for new thinking and ideas to surface. Emergent themes are not ends unto themselves, but are further analysed to support understanding and theorising. As Charmaz (2006) notes, “The content of theorising cuts to the core of studied life and poses new questions about it” (p. 135).

Through engaging with the data from Myanmar and Haiti while coding, memo-writing, reflection and analysis, and further reading, an emerging theme was identified: *the intersection of accountability, coordination, and interpersonal relationships* (Figure 6.1)

Figure 6.1: Phase I barriers, enablers, and emerging themes

The data from Haiti demonstrated a lack of processes through which to hold humanitarian actors accountable for their actions and decisions. Particularly striking was the widely acknowledged sexual abuse and exploitation of displaced girls and women, including by some humanitarian responders and UN Peacekeepers. While this indicates profound failure on multiple levels, especially shocking to me was the disturbing behaviour of Peacekeepers "partying" with young Haitian women at my hotel, as noted in the first chapter. Although the legality of these actions was ambiguous, they were alarming given the relative power differentials, previous reports of sexual exploitation by Peacekeepers in Haiti (Bri Kouri Nouvèl Gaye et al., 2011), and the fact that some of the women appeared younger than 18. The hotel was filled with other expatriate aid workers. Why did it seem that people were averting their eyes? Why weren't others speaking up and asking what was going on? That is, why weren't people holding each other accountable— on a very basic human level, formal mechanisms aside—by questioning such behaviour?

It was uncertain whether the actions observed were unlawful. Yet this example reflected a broader culture of impunity, or at the very least individualism, among the humanitarian actors. Other clearly problematic and damaging, albeit non-criminal, decisions and actions were taken by different humanitarian agencies in Haiti. One well-known organisation—with a member on the IAWG Steering Committee—failed to separate latrines for women and men despite the known risks of sexual violence when latrines are combined and that such separation is a minimum standard in gender-based violence prevention (Global Protection Cluster, 2008). MSF hired a large percentage of the local midwives at a higher market rate, thus disrupting the local economy and thwarting efforts by other organisations that needed local midwives to implement RH programming. Other agencies did not question these occurrences. Some informants expressed their lack of clarity on what actions to take to address the situations and were overwhelmed with their own commitments needing follow through. Others reported that the RH actors had a sense of responsibility to each other, but chose to focus on their own programming.

The lack of cohesion among RH personnel in Haiti appeared to encourage the erosion of accountability processes. A senior RH adviser with an INGO recalled:

> *"In the [RH Working Group] meetings, they [the participants] listened but there was not a lot of constructive criticism in the group. They wouldn't voice their opinion. If they*

heard something they didn't like or they didn't agree with, they would just go ahead and did their own thing rather than question or challenge something".

These findings were particularly striking given the high number of international RH and gender-based violence experts engaged in the earthquake. These individuals were familiar with the international humanitarian system and were well-versed in internationally agreed minimum standards. Indeed, a number of them had led the development of the very standards that were being overtly ignored in the Haiti crisis. Although an RH coordination mechanism led by a strong Focal Point had been established, the RH response appeared fragmented and individualistic, with actors primarily focused on their own programming to the detriment of the wider response. What was really going on in this space between what was espoused and what was tolerated?

In contrast, the response to Cyclone Nargis differed markedly. The coordination efforts in Myanmar were exceptional in that actors engaged beyond traditional pragmatic working group parameters and reframed their relationships in innovative and unprecedented ways. As discussed, agencies pooled funding, itself unusual to address emergency obstetric and newborn care. They worked together to brainstorm a creative transportation system to enable women to access referral hospitals using boats. Informants reported progress with the notoriously intractable government; the National Natural Disaster Preparedness Central Committee considered the integration of RH into disaster-related policies. In another example, a local doctor working in the affected area recounted how inter-agency collaboration helped prosecute a perpetrator of sexual violence:

"Survivors don't come in time. There was one case of father-daughter rape and the mother took her to the clinic because she was pregnant. And now the father is now in prison for rape… Coordination between the agencies working together helped the successful prosecution".

The coordinated efforts to hold a perpetrator of sexual violence accountable juxtaposed with the dearth of accountability for perpetrators in Haiti was striking. Indeed, the inter-agency collaboration in Myanmar helped guide others who were unclear of what actions to take. For instance, a local doctor working with an international RH NGO recalled:

"When I attended the [RH/HIV] Technical Working Group Meeting, I hadn't realised until then how many agencies were working on RH. I realised we needed to work more with

them to make sure we were on the same page. I didn't know if what we were doing was right… With the training [organised by the RH Working Group] we realised that RH is important [in emergencies] and that there was another facet to RH [beyond family planning] that we hadn't touched before".

In this way, the Myanmar coordination efforts appeared to facilitate a culture of peer-to-peer accountability that encouraged agencies to understand and embrace their responsibilities to RH. Informants engaged in the Myanmar RH Working Group said that coordinating with partners was one of the most important enablers for the RH response. In contrast, the RH Working Group in Haiti, while useful for information-sharing, was otherwise fragmented.

These findings raise new questions about the *possibilities for accountability* offered by effective collaboration. Can coordination and collaboration foster a kind of peer accountability for RH implementation in emergencies? Can this informal accountability compensate for the dearth of formal accountability mechanisms that are commonly lacking in humanitarian settings? Does fragmentation among RH actors undermine accountability processes? These questions stimulated me to explore more deeply an emerging idea: that of *socialising accountability*.

To take this forward, the second phase of this research explores whether the notion of socialising accountability offers a useful framework through which to examine the experiences and realities of the RH response in Haiti and Myanmar. It seeks to answer the second research question "How did socialising accountability manifest and what was its impact during the RH responses in the two case studies?"

The next chapter bridges the first and second phases of this research. It reviews the literature on accountability and humanitarian response and brings to the fore the concept of socialising accountability.

7. Chapter Seven: Bridging Phase I and Phase II - Literature review on humanitarian accountability

7.1 Introduction

Accountability regarding humanitarian action has become increasingly salient over the past two decades. The failures and short-comings of the international humanitarian system, highlighted during and following high-profile crises such as the Rwandan genocide, the 2004 Asian tsunami, and the 2010 earthquake in Haiti, have fuelled the drive for increased accountability. This push has come not just from donors and the public, but from humanitarian actors themselves. Janice Gross Stein (2009), a Canadian political scientist and international relations expert, argues that the humanitarian community may be averse to addressing the issue because of an underlying belief that the sector transcends the need for accountability given its moral roots in principled action. However, the literature shows that humanitarian actors are indeed spearheading the discourse on accountability in their field and have made numerous efforts to address it (cf. Buchanan-Smith, 2002; Davis, 2007; Grünewald et al., 2001; HAP et al., 2013; Steets et al., 2010; Zarnegar Deloffre, 2010; among others).

Humanitarian action involves a labyrinth of assorted actors with diverse interests and agendas and often unclear or poorly specified roles. Humanitarian agencies and their staff are often accountable to an array of stakeholders, including crisis-affected communities, donors, national authorities, coordination bodies, the general public, and their own boards. These stakeholders may have conflicting agendas and different means of assessing performance and impact. Humanitarian workers are also accountable to internationally agreed standards, ethics, codes of conduct, and national and international law.

Below I review of the literature on accountability in humanitarian action. This is divided into four sections. The first introduces the concept of accountability and explores efforts to define it. The second examines accountability and humanitarian action and outlines the chronology of accountability as it has appeared on the humanitarian agenda. Third, current tensions and trends are identified, including debates around minimum standards, competing accountabilities, enforcement, and the roles of donors and affected communities.

I highlight the linkages and disconnect between the field of RH in emergencies and the broader discourse on humanitarian accountability. Finally, the theme of socialising accountability, which emerged from the first phase of the research, is explored in more detail.

7.2 Understanding accountability

7.2.1 Definition impossible?

Accountability is a slippery notion: everyone knows what you mean—generally—but defining it precisely remains challenging. It is impossible to translate succinctly, having no equivalent word in German, Hebrew, Japanese, Russian, or many of the Romance languages (Dubnick, 1998). The English word "accountability" has its roots in the Latin *accomptare* (to account) (Weber, 2009), derived from *computare* (to calculate), which means both "to tell" and "to count" (Liberman, 2006). As such, accountability marries two separate concepts: story-telling and financial bookkeeping (Liberman, 2006). Accountability originally emerged to describe financial recordkeeping, but has broadened over the centuries and is now applied to political, legal, administrative, professional, and social contexts.

Sociologist Harold Garfinkel (1967) writes about accountability in terms of transparency and sense-making of people's actions: "visibly-rational-and-reportable-for-all-practical purposes, i.e., 'accountable'" (p. vii). Similarly, famed British sociologist Anthony Giddens (1979) discusses accountability in terms of "the rationalisation of action" (p. 244). Robert Gray, one of the world's pre-eminent authorities on accountability, articulates the concept as "the duty to provide an account (by no means necessarily a financial account) or reckoning of those actions for which one is held responsible" (in Raynard, 2000, p. 5). He suggests that accountability has two key aspects: to be responsible to take (or refuse) specific actions and to be responsible to provide an account of said actions. Embedded in these definitions are notions of responsibility, answerability, and transparency.

Yet these definitions do not fully capture an important aspect of accountability. Simply explaining one's actions (i.e., providing an account) does not fully constitute accountability; there must be a suitable response to the account, whether that is positive (reward),

negative (sanction), and/or neutral (change or refined understanding of an issue). In an Overseas Development Institute (ODI) Briefing Paper, Paulo de Renzio and Sarah Mulley (2006) note that accountability has two key components: answerability and enforceability. While they define enforceability in terms of sanctions for poor performance or abuse of power, other scholars such as Austen Davis agree that the concept of enforceability—not necessarily punitively defined—is an important component of the concept (Davis, 2007).

More nuanced and dynamic definitions of accountability continue to emerge. For example, in the 2004 World Development Report, the key annual World Bank document publication, accountability is articulated as a cycle, rather than a linear process. In this model, the relationships between the account giver(s) and the account taker(s) are emphasised, demonstrating an iterative process (World Bank, 2004). In a sense, accountability is a process that is "performed" by all the actors, or constituents, involved (World Bank, 2004). Others have made the distinction between accountability *tools*, such as donor reports and logframes, and *processes*, such as self-regulation (Ebrahim, 2003). Avina (1993), Najam (1996), and Kearns (1996) distinguish between short-term *practical* or *functional* accountability, which includes accounting for finances and reporting on activities, and long-term *strategic* accountability, such as accounting for broader structural impact.

Among the more expansive definitions, Gross Stein (2008) posits accountability "as a question rather than a clear and unequivocal goal". Hugh Willmott (1996), who founded three peer-reviewed journals on accountability, describes it as "rendering intelligible some aspect of our lives or our selves" (p. 23). Amanda Sinclair, a scholar at the University of Melbourne, asserts that accountability remains "chameleon-like", fragmented, and is continuously being reconstructed (1995).

7.2.2 Humanitarian sector efforts to define accountability

Humanitarian actors have struggled to develop an agreed definition of accountability, which has become a key stumbling block to the development of effective accountability mechanisms. For example, in the mid-90s, during the drafting of People in Aid's *Code of Best Practice in the Management and Support of Aid Personnel* which set out the principles for managing relief staff, agencies failed to reach consensus on a definition of accountability. As a result, agreement on a standard that elaborated staff accountability to

various stakeholders, such as communities and donors, ended in a stalemate. Thus the final standard was dropped from the draft *Code* and the reference to accountability was excluded (Raynard, 2000).

More than 15 years later, although the discourse has made great strides, an agreed definition or understanding remains elusive. The Humanitarian Accountability Project (HAP) International's *Humanitarian Accountability Report 2008* and the 2010 Steering Committee for Humanitarian Response's (SCHR) *Peer Review on Accountability to Disaster-Affected Populations* highlighted the challenges in developing a coherent definition and found that, although surveys demonstrated that aid staff desired a more precise and unified definition of accountability, HAP and SCHR members could not come to consensus on the issue (HAP, 2009a; Steering Committee for Humanitarian Response, 2010). Further, accountability is, in general, still narrowly understood in fiscal terms within the humanitarian sector: a 2012 survey of 152 transnational NGOs—21% of which identified as humanitarian agencies—found that 63.8% of the total defined accountability in terms of financial management (Schmitz et al., 2012).

A range of accountability initiatives in the humanitarian sector, including the Sphere Project, HAP, and the Active Learning Network for Accountability and Performance in Humanitarian Action (ALNAP), each offer slightly different definitions of accountability. ALNAP (2005) employs Edward and Hulme's (1995) definition: "Accountability is the means by which individuals and organisations report to a recognised authority, or authorities, and are held responsible for their actions" (p. 11). This is a classic definition of accountability, entailing reporting, authority, and responsibility. HAP, on the other hand, defines accountability within the context of the responsible use of power, particularly in regards to affected populations: "[Accountability] involves taking account of the needs, concerns, capacities and disposition of affected parties, and explaining the meaning of, and reasons for, actions and decisions. Accountability is therefore also about the right to be heard and the duty to respond" (HAP, 2009b, p. 47). By explicitly situating accountability in terms of the power differentials between humanitarian actors and the people they seek to serve, HAP tries to directly address the long-standing gap in improving accountability to crisis-affected populations. Such "downward" accountability seeks to balance the perceived over-emphasis on "upward" accountability to donors.

Contextualising accountability fundamentally as a power dynamic makes sense in the humanitarian sector, as power differentials among, for example, donors, aid staff, and affected communities, need to be negotiated and addressed. Indeed, it is the problems stemming from these tensions in power that brought accountability to the fore in the humanitarian sector. Yet this framing has limits. Accounting scholar John Roberts (2001) suggests a more expansive definition and notes that "[a]ccountability is not just a necessary corrective in relation to the powerful", which presumes an opportunistic, self-seeking motive on behalf of those in power (p. 1549). He proposes a more complex notion of accountability as an ongoing, inter-personal process, rooted in dialogue and interaction, with instrumental and moral dimensions.

Tilley and Watson (2004), in their work on nursing and accountability, note that accounts that are given freely, that is, without obligation or duty, allow space for transformation and ultimately what Alnoor Ebrahim (2003) labels *internal accountability*. Ebrahim, a professor at Harvard University's Business School, draws an important distinction between "being held responsible" (external accountability) and "taking responsibility" (internal accountability) (2003, p. 814). The definitions by HAP and ALNAP are narrow in that their focus is on external, structural accountability and neglect internal accountability, or an individual's personal feeling of commitment and responsibility. Accounts freely given—i.e., internal responsibility—offer innovative thinking on what accountability means, how it manifests, and if and how it can be improved, including in the humanitarian sector.

Due to the shifting nature of concepts and approaches to accountability, it is in some ways more useful to move beyond definitions and explore its history, how it is understood and manifests, that is, accountability to whom, what, and how, in relation to the contexts with which we are concerned.

7.3 Accountability and humanitarian action

7.3.1 Overview

Attempts to systematically address accountability in the humanitarian sector began in the 1980s when individual aid agencies began developing standards to enhance and systematise their programming. By the early 1990s, aid organisations had started

discussing industry-wide standards in an attempt to increase accountability, coordination, and quality. In 1992 the Red Cross Code of Conduct was drafted as one of the first ethical frameworks for agencies responding to emergencies. However, it was the 1994 Rwanda genocide and subsequent humanitarian response that proved to be a watershed in terms of catalysing aid agencies, donors, and the general public to deeply scrutinise their performance, objectives, and principles.

Maryam Zarnegar Deloffre, a U.S.-based scholar in international ethics and humanitarianism, examines how accountability was understood during and after the Rwandan conflict (2010). She notes that the humanitarian response to the genocide marked an important departure from previous forms of aid delivery, describing the shift from "good enough" aid, where relief interventions are charity-based with a primary goal of easing suffering, to "humanitarian plus", where humanitarian agencies are expected to provide not only appropriate services but also address the underlying issues that caused the crisis in the first place (p. 181). The previous charity-based model of humanitarian assistance became unsustainable and even grossly absurd when Hutu *genocidaires* infiltrated refugee camps and ended up not only receiving aid, but diverting it and using the camps as bases to launch raids back into Rwanda (p. 187). As a result, a number of agencies withdrew, citing it untenable to potentially contribute to the ongoing conflict, while others felt a duty to stay to assist civilians (Terry, 2002).

These decisions caused a deep rift in the humanitarian community and birthed two fundamentally different approaches to accountability. The organisations that decided to stay in Rwanda saw their primary failures as performance-based. To address these failures, they helped spearhead an accountability initiative known as the Sphere Project in 1997 (Buchanan-Smith, 2003; Zarnegar Deloffre, 2010). The agencies that left Rwanda, on the other hand, claimed that humanitarian action must be politically contextualised, and launched what was later to become the COMPAS Qualité initiative as a direct challenge to Sphere (Zarnegar Deloffre, 2010).

The Sphere Project marked the first time relief actors worked together to establish standards for humanitarian response and to monitor their activities in emergencies (Ouyang et al., 2009). The resulting Sphere Handbook, *Humanitarian Charter and Minimum Standards in Humanitarian Response*, first published in 2000, consists of a humanitarian

charter, which outlines its ethical and legal framework, as well as a list of minimum standards for each of the major sectors, including water, sanitation and hygiene, food security and nutrition, shelter, settlement and non-food items, and health (Sphere Project, 2011). The handbook is an impressive accomplishment: it sets forth internationally agreed minimum standards across multiple sectors and articulates the provision of humanitarian assistance within a human rights framework rather than a needs-based approach.

Sphere has also been criticised. For example, scholars from Harvard University (Ouyang et al., 2009) have argued that Sphere's commitment to rights is limited as it does not outline *how* to operationalise the rights-based approach, while other commentators from MSF (Stobbaerts & de Torrenté, 2008) have voiced concerns that the rights-based approach is rendered irrelevant since affected communities cannot claim these rights given their compromised status. Other criticisms of Sphere include its failure to address protection issues and the possibility of donors using the standards to control implementing agencies (cf. Grünewald et al., 2001; Tong, 2004). Perhaps the main criticism—which is still a salient, unresolved issue today and is further discussed below—is the linking of accountability to technical standards rather than more expansive interpretations (cf. Grünewald et al., 2001; Tong, 2004). Despite shortcomings, Sphere has evolved over the years and is widely recognised as the industry standard. A revised third edition was launched in 2011, which integrated Protection Principles and Core Standards to the Humanitarian Charter, reflecting a more people-centred approach (Nadig, 2012).

In 1999, two years after the launch of Sphere, an inter-agency initiative, COMPAS Qualité, was launched primarily by French NGOs and led by Groupe URD. It was designed to counter what they perceived to be the "mechanisation" of aid and "bull-dozer approach" of Sphere (Grünewald et al., 2001, p. 35). COMPAS works to improve quality and learning, rather than accountability per se, and developed a variety of field tools to support this process, most notably the COMPAS Method. The Method helps aid workers contextualise their programming, rather than offer technical guidance, through asking questions such as, "Do you have sufficient knowledge about the social and political context to ensure that your intervention does not have negative impacts?" (Groupe URD, 2009, p. 20). Although COMPAS seeks to fill an important gap in humanitarian action—by explicitly taking into account the broader political, cultural and social elements—it has not gained as much traction as Sphere; critiques of COMPAS could not be found in peer-reviewed literature.

This partitioning of humanitarian agencies can be seen as differences in ideological underpinnings of U.S. (Sphere) versus European agencies (COMPAS). Abby Stoddard (2003) of New York University situates this division within a philosophical and political framework. She suggests that American NGOs are grounded in a Wilsonian tradition, which emphasises pragmatic, technical forms of aid often linked with national foreign policy interests. European organisations, such as MSF, use a Dunantist approach, which emphasises advocacy, humanitarian ideals, and independence from state interests.

Other initiatives were developed to address the various accountability gaps in the field. A common concern amongst humanitarian actors was (and continues to be) the lack of meaningful accountability to affected communities (cf. Davis, 2007; Dempsey, 2007; Hilhorst, 2002; Krause, 2014; O'Dwyer & Unerman, 2010; Stockton, 2006; Taylor, Tharapos, & Sidaway, 2014). One commentator noted that the "accountability revolution" after Rwanda benefited donors whereas there were no significant changes in accountability to crisis-affected communities (Lawday, 2006, p.40). This is a somewhat cynical viewpoint: while donors and other stakeholders are often prioritised over affected communities (Dempsey, 2007; Ebrahim, 2005), the accountability movement did, at the very least, put the discussion of accountability to affected communities on the humanitarian agenda. Indeed, a 2006 survey of relief workers showed that 57% found it essential to engage affected communities in project evaluations (Keystone, 2006).

The Humanitarian Ombudsman Project was launched in 1999 as an initial attempt to develop a feedback mechanism for affected communities; this later evolved into HAP, the Humanitarian Accountability Partnership-International. HAP marked an important development as the first major initiative concentrated on accountability to crisis-affected communities. HAP works with humanitarian agencies to develop policies and processes to ensure effective and appropriate quality and accountability to affected populations (HAP, 2010). HAP is, to a large degree, an accreditation body, providing certification of humanitarian agencies and monitoring compliance. It sets forth seven principles that go beyond conventional understandings of accountability and include, for example, communication with affected communities and ensuring their participation in programme design (HAP, 2008a). However, HAP has also been criticised for being too technically focused and bureaucratic (Grünewald et al., 2001; Krause, 2014).

ALNAP is another key accountability initiative that was established soon after the Rwanda crisis and comprises a network of members focused on research, evaluation, and learning. ALNAP has helped redefine accountability more broadly by linking it with learning and participation (Gross Stein, 2009). ALNAP emphasises innovation and flexibility and is among the more forward thinking of the current accountability undertakings.

Other initiatives were introduced to address specific issues, such as People in Aid (human resources), the Emergency Capacity Building Project (capacity building), One World Trust (good governance), and Good Humanitarian Donorship (donor accountability). Individual agencies, such as CARE, Oxfam, and Islamic Relief, began to institutionalise internal accountability mechanisms, and this has continued to pick up speed (Lawday, 2006; Lloyd et al., 2008).

Since mid-2000, new accountability-focused initiatives have been launched, often with an emphasis on linking to existing efforts to enhance synergies, align standards, clarify differences, and develop a shared vision. As described in Chapter 1, a sea change in the humanitarian accountability trajectory occurred with the development of the Humanitarian Reform Process in 2005. In 2008 the Quality and Accountability Initiatives Complementarities Group was launched to enhance coherence in humanitarian accountability; members included HAP, People In Aid, Sphere, ALNAP, Groupe URD, Coordination Sud, and the Emergency Capacity Building Project. In 2012 HAP, People In Aid, and the Sphere Project created the Joint Standards Initiative to increase consistency in standards. They conducted a mapping exercise and identified 71 distinct accountability initiatives, which they organised into seven categories (Table 7.1). The majority of accountability initiatives were related to the development of resources to help improve implementation and adherence to standards.

Table 7.1: Types of accountability initiatives

Type: Definition	Number*
Donor standards: Criteria or standards applied by donors in order to allocate funding	2
Charter/Code/Standards: A statement of principles and/or standards with various assessment and compliance mechanism	36
Network/Working Group: A formal or informal gathering and/or an on-line community	14
Reporting framework: A defined format for presenting information on results	5
Award: Some type of recognition of good practice	3
Training/capacity building: Courses, bespoke training, on-line training, training materials	5
Implementation/practice guidance: Publications and other resources that seek to improve practice	51

Source: (HAP et al., 2013)
*Some of the initiatives were allocated two types because it was impossible to distinguish a primary one.

At the time of writing, the Joint Standards Initiative was in the process of developing the Core Humanitarian Standard, an updated, unified standard to replace the 2010 HAP Standard and the People In Aid Code of Good Practice in an effort to harmonise standards (HAP International, 2014). In November 2013, however, Sphere decided to disengage from the Core Humanitarian Standard process due to difficulties in achieving consensus. The initiative aims to finalise the Core Humanitarian Standard the end of 2014.

7.3.2 The accountability diamond

Key questions that arise in the literature concern who and what are accountable to whom, for what, and how?

Who or what is a “humanitarian actor”? Humanitarian actor refers to international and national humanitarian agencies, such as UN bodies or NGOs, although sometime may refer to an individual working for one of these agencies. Government agencies, the military, peacekeeping forces, and donors are also humanitarian actors in that they may have an

active role in a humanitarian response (HAP, 2001), although these actors are not usually included in the working definition.

To whom are humanitarian actors accountable? Many commentators note the proliferating accountabilities in the humanitarian sector and the subsequent struggles that aid agencies and their staff face (cf. Cosgrave, 2013; Davis, 2007; Everett & Friesen, 2010; Featherstone, 2013; Gross Stein, 2009; Raynard, 2000). National Red Cross Societies, for example, are accountable to the affected communities they are serving, to the donors that fund their programming, to their internal boards, to the International Federation of the Red Cross (of which they are a member), to humanitarian coordination bodies (such as the Health Cluster), to the national host government as well as to the general public, among others. Raynard (2000) writes that "looking at accountability in terms of an organisation's relations with 'all' of its stakeholders is a daunting task at best and impossible at worst" (p. 21).

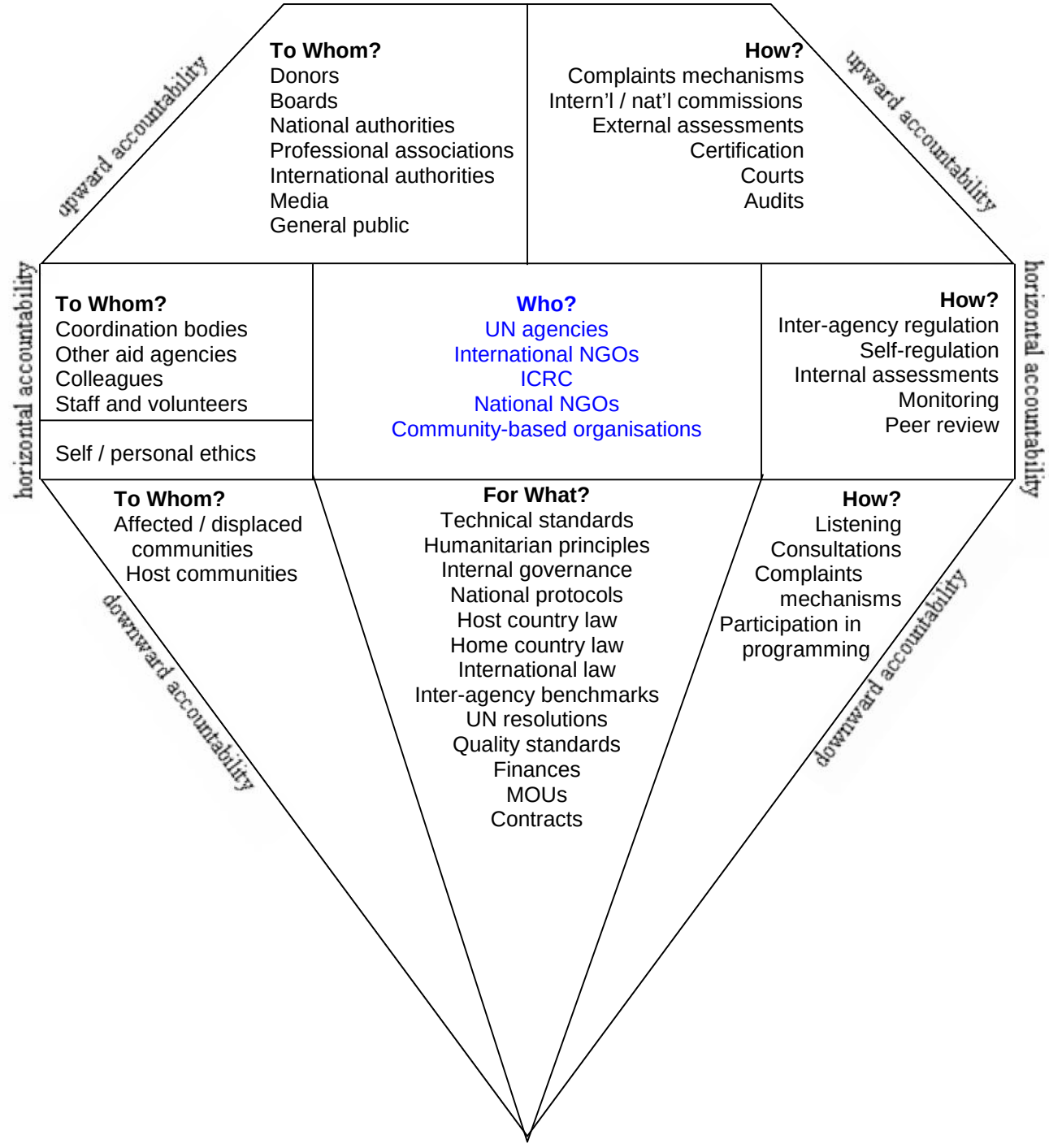
To whom and for what are humanitarian actors accountable? Relief agencies and their staff must comply with the national laws of the country of operation, as well as international law, and any contractual agreements with donors or other agencies. They also have obligations to humanitarian principles, ethical frameworks (both internal/personal and external, such as the Code of Conduct), technical standards, national protocols, and organisational benchmarks.

In what ways are humanitarian actors held accountable? Common examples are evaluations (external and internal), complaints mechanisms, reporting to stakeholders, accreditation, and self-regulatory bodies (Buchanan-Smith, 2002; HAP, 2001; HAP et al., 2013; Slim, 2002a). Buchanan-Smith (2002) remarks that many humanitarian agencies' efforts to improve accountability have actually been focused on quality and performance rather than accountability. She argues that mechanisms for enforceability— which are essential components of accountability—are often lacking.

Some organisations have categorised the rise of humanitarian accountability into strands or themes. ALNAP outlines three: the first relates to a rights-based approach to affected populations, the second to technical standards and impact indicators, and the third to humanitarian principles and codes of conduct (Mitchell, 2003). MSF groups these slightly differently. It maintains ALNAP's first theme—the downward, rights-based approach to

affected communities—but also includes upwards accountability to donors, and a third mutual accountability as related to internal governance (Stobbaerts & de Torrenté, 2008, p. 46). MSF acknowledges that there may be other areas as well, but maintain these are the three primary themes. However, in my view, these strands neglect other important, less formal forms of accountability, such as socialising accountability and personal accountability. Accountability in humanitarian action is more complex than the categories set forth by ALNAP and MSF. Here I conceptualise it as a diamond: multifaceted and continuously refracting the tensions and possibilities of humanitarian action (Figure 7.1).

Figure 7.1: The accountability diamond



Source: Diamond developed by author and informed by *Humanitarian Accountability: Key Elements and Operational Framework* (HAP, 2001) and *Concerning Accountability of Humanitarian Action* (Davis, 2007).

The categories within the diamond are not exhaustive but seek to illustrate the various tensions with which humanitarian agencies and their staff grapple on a daily basis. Indeed, simply identifying the various accountabilities is often the first challenge. For example, a newly hired aid worker would need to familiarise herself with the policies and protocols of her organisation, the donor requirements of her project, the laws of the country of operation, international and regional legal standards, any contracts with other agencies, relevant Sphere and other inter-agency guidelines, UN Resolutions, cluster/sector requirements, national protocols as well as appropriate ways of engaging with the affected communities. She would also have to explore cultural, language, and security challenges. Further, these accountabilities may not, and often do not, align. National laws and protocols on abortion may conflict with international law and standards of care; these may further conflict with organisational or donor policies or personal ethics. This can lead to an opposing and frenetic sense of responsibilities, leading one commentator to coin the term MAD or multiple accountability disorder (Koppel, 2005), that can ultimately undermine the objectives of humanitarian efforts.

7.4 Tensions and trends

The current challenges regarding humanitarian accountability are not dissimilar to those articulated in the mid-90s. While significant strides have been made, many of the tensions of the original tensions remain unresolved as new issues have emerged.

7.4.1 Minimum standards debate

The original debate over whether or not to “reject” the Sphere (and other) minimum standards is somewhat irrelevant given their now wide acceptance. Nonetheless, the issue of a “one-size fits all” approach to aid is an ongoing and legitimate concern. A number of commentators, including Davis (2007), Featherstone (2013), Terry (2002), Tong (2004) and Stobbaerts & de Torrenté (2008) from MSF as well as Grünewald, Pirotte, & de Geoffrey (2001) from Groupe URD, expressed misgivings about a de-contextualised, generic approach. As briefly touched upon above, their unease can be summarised into three specific concerns. The first relates to the linking of quality and accountability with technical standards. They argue that effective aid must be politically and socially contextualised, that it must be appropriate, flexible, and unique, and that universal standards undermine this.

Key elements of an effective response include aid workers who listen and show empathy towards the people they are serving, which are not captured in the logframes or checklists. As Grunewald et al. (2001) note, “How do you quantify compassion and solidarity?” (p. 35).

A second concern relates to the potential of technical standards, such as those set forth in Sphere, to undermine the independence of a humanitarian organisation. It leaves the door open for donors, particularly governments, to exert influence over funding recipients if they do not comply with certain norms and criteria; this creates a slippery slope of aid funding being tied to political agendas rather than the realities and needs of the people on the ground. It may also exclude certain humanitarian groups, particularly from the Global South, from receiving aid if they are not able to meet the pre-established requirements (Hilhorst, 2002).

The last issue concerns engagement with crisis-affected communities. Tong (2004) criticises what she sees as Sphere’s generic benchmark of “beneficiary participation”, noting the complexity of such participation: a few people cannot “represent” a community, particularly ones that are deeply divided as is often the case in displaced settings (p. 183). Stobbaerts and de Torrenté (2008) highlight the importance of engaging with affected communities in a nuanced manner, but also voice concern over the “rights-based approach” to affected communities. Displaced communities may not have the internal or structural capacities to hold aid agencies accountable for their “rights” (Stobbaerts & de Torrenté, 2008). Further, a technocratic approach to beneficiary accountability could lead to superficial efforts, such as mundanely ticking “community engagement” off a checklist (Dempsey, 2007; Everett & Friesen, 2010). Tong (2004) also argues that a rights-based approach may not always be appropriate as it is the responsibility of the State, not voluntary agencies such as NGOs, to fulfil the rights of affected communities, and it can be dangerous to place these responsibilities and expectations on humanitarian agencies.

Humanitarian action does need contextualisation, nuance, and flexibility, and these should be fostered by agencies, donors, and the field broadly. At the same time, the value of agreed standards cannot be underestimated. Particularly with RH, minimum standards are essential. RH issues are sensitive and often taboo, yet every population has RH needs. Providing RH services is a life-saving intervention, and should not be optional. If we relied on aid workers to continuously “contextualise” the health response without standards, it is

likely that the life-saving services of the MISP would not be implemented since communities often do not voice these needs and health workers may be unaware of them.

7.4.2 Humanitarian dilemma(s)

Scholars and commentators of the humanitarian sector have repeatedly complained that many of the same criticisms of the field twenty years ago still hold true today: international aid efforts are questionable at best, destructive at worst, and are often uncoordinated, undermining local and national capacities (Davis, 2007). Harsh analyses of humanitarian aid have been put forth by well-known critics such as Dambisa Moyo, Linda Polman, David Rieff, and William Easterly. A 2010 *Lancet* editorial summarised an underlying claim of these authors by accusing aid agencies after the 2010 Haiti earthquake of "jostling for positions" and prioritising their own interests over those of the displaced (Anonymous, 2010, p. 253). Ben Ramalingam (ALNAP) and Michael Barnett (George Washington University) (2010) contend that while there may be truth in this accusation, the reality is more complex: humanitarian organisations may hold genuine objectives to provide assistance and support to communities in need, but the incentives to stay true to their ethical frameworks are eroded by the broader realities and pressures that emerge during crises, such as competition for funding and visibility. They term the tension between agencies' moral obligations and short-term financial and political interests as the "humanitarian dilemma".

Ramalingam and Barnett frame their argument in terms of incentives: agencies are not incentivised to prioritise their primary moral objective—to avert and alleviate suffering—over strategic interests. Reframing the humanitarian dilemma through an accountability lens also highlights humanitarian actors' competing accountabilities. In an increasingly competitive industry with limited funding, "horizontal" and "downward" accountabilities, as well as accountability to the primary moral objective, may be at odds with an agency's "upward" donor requirements, reputation, and political interests. Indeed, using an accountability lens to understand the humanitarian dilemma brings further tensions—such as legal, administrative, and social—to the fore, beyond the "moral vs strategic" frame. Rather than solely an issue of incentives, the lack of alignment of accountabilities and interests also contributes to the humanitarian dilemma.

Indeed, humanitarian agencies and their staff routinely face contradictions in their accountabilities. A classic case of misaligned accountabilities can be found in the birth of MSF: doctors working in the Biafra crisis were faced with the tension of staying “neutral” (accountability to humanitarian principles) or speaking out against the atrocities they were witnessing (accountability to moral duty and personal ethics). Unable to honour both commitments, they were forced to decide which accountability to prioritise and chose the latter.

Agencies and their staff dealing with sexual violence also often face alignment challenges. In Darfur, for example, rape survivors were previously required file a police report before they could receive medical care, thus not only significantly thwarting survivors from coming forward, but also putting their lives at risk as many decided to forgo treatment for life-threatening issues (Fricke & Khair, 2007). National Sudanese law was in conflict with international law, inter-agency standards, medical ethics, and the needs of the affected community. The humanitarian actors’ struggled with an “alignment dilemma:” to whom should they be accountable? Does prioritising the needs of the people undermine local authorities and the national legal system, for which aid interventions are so often criticised? Should they provide the care and risk having their entire operation kicked out of the country? Who decides—the individual or the organisation? What if accountabilities of the staff member and the organisation do not align? And how is compliance to all these accountabilities enforced?

7.4.3 Enforcement

Perhaps the least resolved area of humanitarian accountability is the issue of enforcement. Despite the proliferation of standards, policies, and norms, mechanisms to enforce compliance are limited. Although it may be beneficial to move away from punitive notions of accountability, it is also important to establish consequences for negative or problematic behaviour, including appropriate sanctions for “transgressions”. Transgressions range from failure to meet standards, such as not making condoms available, to violent crime, such as sexual exploitation and abuse.

As seen in the accountability diamond above, humanitarian actors and their staff are bound by the various legal bodies, including the laws and policies of the host country and regional

and international law. However, in practice, humanitarian agencies and staff rarely face legal consequences for failure to fulfil responsibilities or deliberate wrongdoing. Further, studies have found that although accountability mechanisms such as assessments and consultations are commonplace among aid agencies, the resulting recommendations are often not acted upon or institutionalised (HAP, 2001; Olin & von Schreen, 2014).

The West Africa sex scandal that shocked the humanitarian world is a classic example. In 2002 a UNHCR and Save the Children study found widespread sexual exploitation and abuse of refugee children involving 42 aid agencies in Guinea, Liberia, and Sierra Leone (UNHCR & Save the Children-UK, 2002). Despite significant international attention, the response was dismal: only one UN staff was fired, one UN Peacekeeper sent home, and three Save the Children staff disciplined (Naik, 2003, p. 14). No one was criminally prosecuted and no senior personnel were held responsible (Naik, 2003, p. 14). Even when reporting mechanisms are in place and affected communities come forward to complain—a rare combination of events—the likelihood of punitive action is low. In one multi-country study on sexual exploitation in displaced settings, the authors found only a "handful" of cases over a two to three year period where a staff member had been fired for misconduct (Lattu, 2008, p. 50). This was despite findings that sexual exploitation and abuse were widespread and well-known in all the settings studied.

While the accountability gaps for violent crime are disturbing and require immediate action, few consequences are in place for agencies that do not meet standards as well. During the development of Sphere, the issue of enforcement was widely discussed, but strongly diverging opinions on the matter threatened to upset the process, and the issue was tabled until after the field-testing process (Walker & Purdin, 2004, p.109). Ultimately, the issue was never resolved, and, as a result, Sphere does not have an enforcement or accreditation mechanism (Zarnegar Deloffre, 2010).

Sphere's paralysis may have set the tone for humanitarian aid generally, as little progress has been made in clarifying roles and responsibilities and developing enforcement mechanisms. For example, during the 2012 refugee crisis in Maban County, South Sudan, crude mortality rates were above the emergency threshold and were exacerbated by a Hepatitis E outbreak caused by poor water and sanitation. Although the operational humanitarian agencies knew of the critical shortages in water supply, it took them nine

months after this realisation to reach Sphere standards—during which thousands contracted Hepatitis E. Although MSF complained to UN agencies in Geneva about the inadequate and slow response, no one—agencies or individuals—was fired or otherwise held accountable for this significant failure, which resulted in widespread loss of life (MSF, 2014; Tiller & Healy, 2013).

Who exactly is responsible to meet all the standards that have been developed and what mechanisms exist to enforce that? Advocacy groups—such as the Women's Refugee Commission—often criticise humanitarian actors broadly for not complying with standards, but, for the most part, do not identify the specific agencies that should be held accountable. During the joint field mission with the Women's Refugee Commission to Haiti, for example, we found many agencies had not complied with basic standards regarding separating latrines, which made displaced women and girls more vulnerable to sexual violence. However, these agencies were not held accountable for their lack of compliance with an established standard—there was simply no established mechanism to do this. Some affected communities have tried to take legal action against the UN—such as for the 2011 cholera outbreak in Haiti that lead to the death of more than 8,000 people—but, due to the UN's sweeping legal immunity, successful litigation is all but impossible (Schecter, September 26, 2013).

7.4.4 Donors

The relationship between relief agencies and their donors has received significant attention in the discourse on humanitarian accountability. In the literature, "donors" often refers to donor *governments*, although donors can also refer to individuals, organisations, foundations, and other funding sources. The reference to donor governments is relevant as they provide the largest amount of funding for humanitarian agencies, topping USD16.4 billion in 2013, while private, voluntary contributions amounted to approximately one-third of this (Global Humanitarian Assistance, 2014).[32]

The initial (and current) push from donors for increased financial and programmatic accountability on the part of their grantees stemmed largely from the pressure they faced

[32] These figures do not include contributions from crisis-affected countries themselves (government or private donors).

themselves. As the failings of humanitarian aid became more public with high profile media critiques, governments were criticised. Were millions of tax dollars being poured into humanitarian agencies, with no real accountability or oversight? Donors, in turn, transferred this pressure to aid agencies to strengthen their processes and procedures through increased financial and administrative mechanisms (Mitchell, 2003).

Many commentators on accountability and humanitarian aid criticise what Ebrahim (2005) terms the "accountability myopia" towards donors: aid agencies often prioritise their responsibilities to donors to the detriment of their accountabilities to their primary stakeholders (affected communities) as well as humanitarian principles (cf. Christensen & Ebrahim, 2006; Dempsey, 2007; Ebrahim, 2005; Hoffstaedter & Roche, 2011; Najam, 1996; Schmitz et al., 2012; Unerman & O'Dwyer, 2006). The resulting "mission drift" away from humanitarian goals and moral duties as a result of donor control has been well documented in the literature (Dempsey, 2007, p. 314) and has been highlighted throughout this review. Humanitarian agencies are not entirely to blame for their "upward" emphasis: donors themselves have shirked their responsibilities and have failed to reflect and account for their role in this process, although more efforts have been made in recent years (explored below).

The reality is that humanitarian organisations must vie for limited funding in an increasingly competitive industry. For example, only 65% of the UN's total appeal request of USD13.2 billion was met in 2013 (Global Humanitarian Assistance, 2014). Funding is not guaranteed, causing performance anxiety and increasing competition among aid agencies. While the criticisms of upward accountability abound, few commentators note the positive aspects resulting from donor demands, such as the benefits of systematic monitoring and evaluation, better tracking and use of funding, and the clarification of roles. Many of these demands are legitimate and rational means to hold humanitarian agencies to account (Ebrahim, 2005).

Although initial accountability efforts were focused on improving humanitarian agencies' performance, in recent years the role of the donors themselves has been examined. A primary concern related to donor governments is the use of humanitarian funding as a vehicle for foreign policy, compromising the fundamental humanitarian principle of neutrality (Mitchell, 2003). This politicisation of aid has led to increased insecurity for humanitarian staff, with one study showing a 208% increase in politically motivated attacks against aid

workers between 1997 and 2005 (Stoddard, Harmer, & Haver, 2006). Related concerns include inequitable funding flows based on political agendas rather than need (Mitchell, 2003), the disconnect between the donors and the needs of affected communities (Davis, 2007), dearth of donor monitoring and feedback mechanisms (De Renzio & Mulley, 2006), and lack of clearly defined roles and responsibilities to which to hold donors accountable (Buchanan-Smith & Collinson, 2002). Financial support from individual donors has its own set of challenges, such as the influence of the media on the general public's funding decisions (Ramalingam & Barnett, 2010) as well as the misconception that the proportion of administrative to programming costs reflects programmatic effectiveness (Wenar, 2006).

Efforts to improve donor accountability have multiplied. The first significant endeavour took place in 2003 when a group of donor governments established the Good Humanitarian Donorship (GHD) initiative to improve the coherence and strategy of donor governments for humanitarian relief. A few years later in 2005, the Paris Declaration for Aid Effectiveness was drafted, marking the first time indicators, targets, and partnership commitments were established for donors and recipient governments. This differed from the GHD in that it sought to harmonise the relationship and efforts of international donors with national development efforts, whereas the GHD was an informal initiative focused on coordinating the agenda of donor governments alone (Harmer & Ray, 2009). Related efforts to improve donor accountability include the Cotonou Agreement regarding aid between the EU and specific African, Caribbean, and Pacific countries, the World Bank and IMF's monitoring framework of donor commitments, and the Africa Partnership Forum, which works to improve partnerships between African governments and the G8 (De Renzio & Mulley, 2006, p. 3). Despite this important progress, donors continue to be criticised for not respecting their accountability commitments (Gulrajani, 2014; Steering Committee for Humanitarian Response, 2010).

A variety of suggestions have been put forth to reform donor policies and behaviour. For example, commentators have suggested institutionalising independent donor evaluations (Buchanan-Smith & Collinson, 2002), engaging in an honest, rigorous debate on foreign policy influences on funding flows (Bendell & Cox, 2006), supporting the capacity building of recipient governments (De Renzio & Mulley, 2006), advocating for increased political commitment within the donor government (Gulrajani, 2014), requiring donors to account for their use of funds (e.g., to support highly paid international consultants) (Bendell & Cox,

2006) and developing incentives to support, rather than punish or dissuade, innovation and risk-taking by grantees (Jordan, 2004).

7.4.5 Affected communities

One salient discussion concerns accountability to affected communities. Key questions include: What does it mean to be accountable to displaced communities? How is meaningful accountability achieved and promoted? Which accountability mechanisms are effective? In 2003 HAP set forth seven principles of accountability for humanitarian actors, four of them explicitly concerning affected communities. These principles include: 1. Commitment to humanitarian standards and rights, 2. Setting organisational standards of accountability and building staff capacity, 3. Communicating and consulting with stakeholders, particularly affected communities and staff, about the organisational standards, the project to be implemented and the mechanism for addressing concerns, 4. Involving affected communities in planning, implementation, monitoring, and evaluation of programmes, 5. Monitoring and reporting on compliance with standards in consultation with affected communities, 6. Addressing complaints by enabling affected communities and staff to report complaints and seek redress safely, and 7. Maintaining a commitment to the principles when working through implementing partners (HAP, 2003).

HAP has also been criticised for introducing corporate language in its approach, using terms such as “customer”, “target market”, and “re-branding” (HAP, 2008a). Some commentators have questioned whether this bottom-line approach may undermine the ethical underpinnings that are fundamental to humanitarian work (Everett & Friesen, 2010, p. 476).

ALNAP has also led efforts on the issue. In 2003, ALNAP and Groupe URD published *Participation by Crisis-Affected Populations in Humanitarian Action: A Handbook for Practitioners* (Groupe URD & ALNAP, 2003). Since then, it has developed a number of related reports and guidance (ALNAP, 2014) and focused its 2014 Annual Meeting in Addis Abba, Ethiopia on engagement of crisis-affected people in humanitarian action.

More and more humanitarian agencies have developed innovative ways to engage the communities they serve, with some organisations, such as Tearfund, publishing agency-

specific manuals to guide staff on accountability to affected communities (Bainbridge, Tuck, & Bowen, 2008). A section of ALNAP's website is specifically dedicated to resources on accountability and participation of affected communities and, as of November 2014, almost 800 publications on the issue (developed not only by ALNAP) were included (ALNAP, 2014). The discussion has reached the highest levels of the UN. In 2011, the IASC Sub-Group on Accountability to Affected Populations, part of the IASC Task Team on the Cluster Approach, developed five Commitments to Accountability to Affected Populations (CAAP), which included commitments to effective leadership and governance, transparency, feedback and complaints, participation, and design, monitoring, and evaluation (IASC, 2012d). The IASC Principals adopted these commitments and developed an operational framework for implementation (IASC, 2012d). A number of major donors—including AusAID (now incorporated into Department of Foreign Affairs and Trade), CIDA, DFID, ECHO, SIDA, and USAID—have also developed policy statements that ensure grantees integrate accountability mechanisms to affected communities into proposals (Barry & Barham, 2012). A 2012 review on participation of disaster-affected communities in humanitarian aid operations found that agencies are increasingly adopting participatory approaches (Barry & Barham, 2012). However, HAP has noted that many new initiatives are ad hoc and do not build on existing knowledge or coordinate with other relevant efforts (HAP, 2011).

Despite this progress, translating rhetoric into reality has been slow. The 2012 *State of the Humanitarian System Report* reported that "the weakest progress and performance [is] in the areas of recipient consultation and engagement of local actors, despite the rhetorical emphasis given to these issues" (Taylor, Stoddard, Harmer, Haver, & Harvey, 2012, p. 49). The second comprehensive evaluation of the Cluster Approach, which covered six countries, found that the Clusters continued to neglect engaging with affected communities and did not use participatory approaches, despite previous criticisms for this neglect (Steets et al., 2010, p. 57). A 2014 survey of 244 humanitarian field staff found that just 17% of the respondents agreed or strongly agreed that systematic communication with affected communities occurs throughout the programme cycle (International Council of Voluntary Agencies, 2014). A literature review on feedback mechanisms with affected communities demonstrated that affected communities may be too fearful to voice their true feelings due to fears of losing aid, insecurity, and lack of confidentiality (Bonino & Warner, 2014).

Efforts to address downward accountability have tended to focus on soliciting feedback on programming and establishing complaints mechanisms. Increased “participation” and “engagement” with affected communities—such as consulting with displaced communities regarding appropriate programme design—has now become a proxy for accountability. Yet some actors are recognising that participation alone does not constitute accountability. Guidance, such as by HAP and the SCHR, include elements that go beyond participation, such as the need for organisations to foster and support accountability efforts through shared values and strong leadership (HAP, 2011; Steering Committee for Humanitarian Response, 2010).

Other commentators, such as the author of the 2004 tsunami response assessment report, argue that humanitarian actors need a complete reorientation to aid: that participation and “accountability” are not enough; affected communities must be empowered to own the response (Cosgrave, 2007). Others approach the issue with more scepticism. Dempsey (2007) is concerned that increased accountability could produce the opposite effect of undermining communities by reifying local hierarchies, obstructing autonomy, and interfering with established social norms by, for example, trying to impose democratic or feminist values (p. 315). Davis (2007) questions whether accountability to affected communities is a possibility given that aid agencies are voluntary and can chose to withdraw at any point. Effective accountability requires affected communities to be able to affect desired change or sever the relationship with the organisation; however, communities receiving assistance do not wield such power (Hilhorst, 2002, p.368). Indeed, broadening the discourse beyond participatory approaches and technocratic understandings of accountability requires uncomfortable discussions on devolving power and relinquishing decision making on behalf of aid agencies, which they may not be prepared to confront (Ramalingam & Barnett, 2010, p. 8).

7.4.6 Reproductive health

As of 2014, the primary actors within the sub-field of RH, i.e., IAWG members, have had limited engagement with the broader discourse on accountability in the humanitarian sector. Yet significant efforts have been made to address accountability, although it has usually not been labelled as such. IAWG members have worked tirelessly to advance the MISP and other standards of care to ensure their mainstreaming throughout the health and other relevant humanitarian sectors. They have monitored RH implementation in a number of

crises and undertaken assessments and real-time evaluations to highlight gaps and provide recommendations (Chynoweth, in press; Doedens et al., 2013; IAWG, 2004b; Krause et al., 2011; Marie Stopes International & Women's Refugee Commission, 2003; Women's Refugee Commission, 2008). Further, when a new crisis strikes, they share information and brainstorm ways to help agencies implement the minimum standards of the MISP. All of these can be seen as advancing elements of accountability. Through the influence of HAP and the increasing interest of IAWG members in accountability, for the first time a section on accountability was included in the revised 2010 IAWG Field Manual (IAWG, 2010c). It uses the seven principles of accountability developed by HAP to guide RH implementation (p. 12-13).

As described in Chapter 3, within the Cluster Approach, RH ultimately falls under WHO's jurisdiction, but to date WHO does not appear to have fully taken on the responsibility for ensuring that the standards are met. The reasons for this are unclear, although it may result from WHO's legacy of prioritising infectious disease and trauma. UNFPA is a natural fit as the lead agency on RH—and has increasingly taken up this role—but it has not systematically embraced this responsibility primarily due to lack of capacity, resources, and institutional buy-in. RH therefore falls between the cracks, without a clear actor responsible to hold accountable. Informal, inter-agency accountability mechanisms fill the structural gap in the Cluster system: the members of IAWG—a loose, informal network of aid agencies—have tried to hold WHO and others accountable for ensuring RH is included in the health response through joint advocacy. My research explores one form of informal accountability—socialising accountability—as related to RH, particularly given the gap within the Cluster system.

7.5 Accountability 2.0: Towards a new framework

7.5.1 Risk-aversion and rigidity

Despite disagreements on its manifestations and emphasis, the drive for improved accountability in the international humanitarian sector has, to a large extent, been embraced by key actors. Yet some commentators have questioned the assumption that increased accountability is inherently positive (Davis, 2007; Dempsey, 2007; Ebrahim, 2005; Everett & Friesen, 2010). Ebrahim (2005) is concerned that accountability "is not the

simple and clear social panacea that its advocates might pitch" (p. 60), and that it can play out in a variety of ways, some of which are undesirable and ultimately undermine the goals of humanitarian aid.

As discussed previously, in the 1990s MSF and other NGOs warned of linking accountability with technical standards (Grünewald et al., 2001; Stobbaerts & de Torrenté, 2008; Terry, 2002; Tong, 2004). Indeed, it seems many of their fears have come to pass. The quest for increased accountability has been largely technocratic in nature, focusing on compliance with standards, codes of conduct, and results-based management. This may have resulted from a conflation of accounting and accountability. The former was developed for financial purposes, i.e., "do the numbers add up?" Yet, in an effort to address other accountabilities, the fiscal accounting framework has been imposed on non-financial structures, such as organisational and social systems. Non-financial accountability mechanisms have, consequently, been forced into a narrow and constraining paradigm. This has resulted in reifying account factors—constructing them as ends unto themselves—while obscuring or simply ignoring other important elements in the accountability process. A blogger on humanitarian aid noted that trying to manage chaotic contexts, such as crises, using tools created for simple ones, such as finance and logistics, is flawed and ultimately detrimental to the goals of relief work (MoreAltitude, 2010). Similarly, humanitarian scholar Ben Ramalingam (2013), in his book *Aid on the Edge of Chaos,* states that "accountability systems have reinforced certain framings of the world that are simply not consistent with reality" (p. 122), arguing that current aid accountability processes are inappropriate and ineffective to address the complexities of the real world.

More and more commentators have argued that this produces a stifling, conservative, and risk-averse culture in the humanitarian sector (Buchanan-Smith & Scriven, 2011; Everett & Friesen, 2010; Featherstone, 2010; Gross Stein, 2009; Krause, 2014; Minear, 2004; Ramalingam, 2013). In 2004, ALNAP undertook an evaluation of the relief work in Darfur and found that increasing preoccupation with accountability, while helpful in many ways, also "undermined a certain essential aspect of humanitarian risk-taking" (Minear, 2004, p. 113). A similar UN-led study on Darfur found that minimum standards and codes of conduct were constraining rather than assisting or guiding aid workers in their programming (Broughton & Maguire, 2006). Another report revealed that accountability requirements

were “a strategy for humanitarian containment, not humanitarian action” (Young, Aklilu, Badri, & Fuddle, 2005, p. 113).

Buchanan-Smith (2011) raises concern about the “alarming evidence of a growing tendency towards risk-aversion in the sector, associated in part with the drive for accountability, which is resulting in a stifling culture of compliance” (p. 7). Hilhorst (2002) suggests that creativity and improvisation are also being suppressed, which can create a culture of inertia and rigidity (p. 366). Dempsey (2007) notes that humanitarian actors may find the quest for increased accountability superficial—focusing on box-ticking—and at worst “paralysing” for those without appropriate expertise or knowledge (p. 315). Hoffstaedter and Roche (2011) describe humanitarian agencies’ accountability to their donors as a type of “theatre” in which accountability processes become a type of “performance”. Davis (2007) contends that “[f]ashionable methods such as key performance indicators and other metrics designed to boost performance have been strikingly ineffective” (p. 15).

This growing conservatism and risk-aversion in the aid industry—in part because of the increased calls for accountability—is significant. Effective humanitarian action is grounded in humanitarian leaders’ and managers’ ability to be creative, courageous, and flexible in complex, ever-changing environments (Buchanan-Smith & Scriven, 2011). “[T]he primary responsibility”, writes Davis (2007), “is for a humanitarian to have the decency to show up and stay around for a while, visibly, and to engender normal human relations of empathy and compassion for victims of crisis” (p. 18). These are the qualities that need to be fostered, yet the conventional appeals for more accountability have contributed to their devaluing, as success is defined in terms of adherence to standards, contracts, and other procedural obligations.

Beyond these commentators, wider recognition is growing that the drive for increased adherence to technical standards—while important—is insufficient. Studies commissioned by ALNAP have highlighted the practical impact of limited and narrow technical definitions of accountability and have proposed a more expansive approach (Buchanan-Smith & Scriven, 2011; Gross Stein, 2009; Minear, 2004). While these efforts are useful in reframing accountability in terms of broader processes instead of outcomes, some commentators ask us to go deeper and look at the ethical, social, and personal aspects of accountability.

Everett and Friesen (2010), scholars from the University of Calgary, wonder if the concentration on the technical and strategic has obscured an essential element of accountability: the moral or ethical aspect. They draw on Strathern (2000) to argue that ethics are an inherent component in the meaning of accountability: the concern or caring for the other is the very essence that grounds the desire for improved accountability in the first place (p. 470). Ignoring this aspect to focus on strategic dimensions can potentially obfuscate understanding of the needs and demands of affected communities, and ultimately may lead to dehumanising practices (p. 469).

Organisations affect others' lives, and this is the very reason they need to be held to account (Unerman & O'Dwyer, 2006). Traditional indicators do not capture all the factors essential to a quality response, such as the humanitarian staff's investment, experience, and efficacy in collaboration or other social skills (Everett & Friesen, 2010, p. 477). Disregarding these fundamental aspects can threaten or undermine accountability efforts.

Other commentators are concerned as well. Zarneger Deloffre (2010) contends that, during the 1994 Rwanda crisis, humanitarian agencies' understanding of their moral duties—that is, their principles, values, and ethics—rather than their obligations to laws, contracts, and standards, were the primary influence in their decision-making regarding their accountabilities. Ebrahim (2003), Fry (1995), and Willmott (1996), among others, also express concern that the heavy emphasis on accountability tools, such as performance reports and assessments, does not allow for the full realisation of ethical or personal accountabilities. Grove and Zwi (2008) assert that the prioritisation of measurable outputs represents a "crucial weakness" in humanitarian action (p. 71); they propose a more holistic "Peacebuilding Filter", based on social justice, social cohesion, cultural and conflict sensitivity, the promotion of trust, and good governance, with which to assess health-related and humanitarian programming. Even Davis (2007), whose seminal paper on accountability and humanitarian aid sought to reframe accountability entirely as a procedural rather than moral issue, highlights that "virtuous" accountability is needed in which trust, compassion, and care are valued and fostered.

7.5.2 Socialising and individualising accountabilities

The second phase of this research, which focuses on the manifestation of *socialising* permutations of accountability in the two case studies, stemmed from the strikingly different RH responses in Myanmar and Haiti. In Myanmar, despite (or perhaps because of) the restricted international response, limited resources, and blockades by the government, RH actors worked together in an incredible display of commitment, trust, empathy, creativity, and communication. This is juxtaposed against the Haiti response, which, despite the most robustly funded RH intervention to date with many of the leading experts present, saw a generally poorly coordinated and inadequate RH response. This research explores if and how socialising accountability operated in these contexts, and whether it has any merit or explanatory power.

Socialising accountability, as articulated by accounting scholar John Roberts (2001) from the University of Sydney, emphasises the interdependence between self and others, where relationships are seen in both instrumental and moral terms (p. 1554). Closely related concepts are peer, horizontal, and collective accountability. My research uses the term "socialising" to emphasise accountability as an interpersonal process. By contrast, *individualising* or hierarchical accountability, underscores competition, exclusion, defensiveness, and fixation on the self. This parallels Emeritus Professor of Accounting Richard Laughlin's (1996) classification of accountability, which he divides into "contractual" and "communal" contexts. The former includes formal relationships with clearly defined individual roles, responsibilities, and outputs, whereas the latter encompasses informal and less structured conduct and relationships and emphasises strong trust among agents.

Roberts (1991, 1996, 2001, 2009) has written extensively on the issue of socialising and individualising accountabilities in the context of corporate governance. He argues that accountability is often constructed in a way that promotes self-absorption: "accountable" individuals live in fear of being scrutinised, criticised, and ultimately failing. Roberts takes his cue from acclaimed philosophers Judith Butler (1988, 1997, 2005) and Orona O'Neill (2002, 2006) who suggest that traditional incarnations of accountability often tap into deep psychological roots: fears of rejection and yearning for acceptance. Butler (2005) asserts that typical notions of accountability, which focus on accounting for the actions of an individual, are prone to the violent (i.e., self-berating) pursuit of an unachievable ideal and

are thus untenable. Accountability in this sense is often anxiety producing, laced with a sense of wanting to “acquit oneself” (Butler, 1997). Such individualising accountability is ultimately counterproductive as it obscures the inter-relational aspect of action and decision-making and arouses personal angst due to the inability to achieve the ideal (e.g., standards) (Roberts, 2009).

Negative consequences for failing to live up to an ideal—whether this is shame in the eyes of others or actual punishment—creates additional reluctance to embrace this type of accountability. Indeed, accountability in this sense is a painful endeavour, entailing potential personal critique and rejection, requiring deep courage to overcome (which ostensibly few individuals can muster) (Roberts, 2009). Butler (2005) paints the drive for accountability as a world where individuals “follow norms of prescriptive value... [and are] motivated less by any desire to do good than by a terrorised fear of punishment and its injurious effects” (p. 16). Ultimately, this accountability generates a type of paranoid narcissism (Roberts, 2009), undermining efforts to achieve the desired outcomes and, particularly in the context of humanitarian response, to be of assistance to others.

Despite its intentions to make the unknown visible, accountability in its individualising form paradoxically supports concealment. Due to fears of judgment, the efforts to “give account” often focus on the simple, easy, and unfettered. Complex, frightening, and opaque aspects are obscured as they open the self (or the organisation) to criticism. Strathern (2000) suggests that in this sense transparency and accountability “work backwards”. This type of accountability is dangerous in that it can support a culture of avoidance and deception (O’Neill, 2002), thus eroding individual and organisational integrity, prioritising “keeping up of appearances and fighting shadows” (Tsoukas, 1997, p. 838). In response, agencies and their staff come up with informal strategies to avoid blame and carefully manage their reputation and identity, such as manipulating facts (“spinning”) or flooding the account holder with information (Roberts, 2009). Indeed, it supports precisely the opposite of what accountability seeks to achieve.

Individualising accountability can be attractive in that it clarifies and simplifies what is required from the account holder. Logframe indicators and checklists are easier to handle (from a managerial and personal perspective) than engaging in critical, in-depth dialogue. Individualising accountability offers what O’Neill (2002) describes as the “fantasy of total

control": agencies (and their staff) become blind to the complex realities they have worked to conceal and start believing in the artificial identity they have constructed. As a result, preoccupation with maintaining the false appearance is prioritised over learning, communication, risk-taking, and even impact. Further, stakeholders often reward the simplicity of technical accountability (e.g., in a humanitarian context, indicators for how many toilets were built in a refugee camp) as it makes the complex and murky appear tangible and clear-cut. Weinberger (2007, in Roche 2009) also speaks to the fantasy of control that accountability seems to offer. He laments:

> *"Accountability has gone horribly wrong. It has become "accountabilism", the practice of eating sacrificial victims in an attempt to magically ward off evil… Accountabalism is a type of superstitious thinking that allows us to live in a state of denial about just how little control we individuals have over our environment… It eliminates the human variations that move institutions forward and provide a check on the monoculture that accounts for the most disastrous decisions… Accountabilism tries to squeeze centuries of thought about how to entice people toward good behaviour and dissuade them from bad into simple rules by which individuals can be measured and disciplined… Bureaucratising morality or mechanising a complex organisation gives us the sense that we can exert close control. But grown-ups prefer clarity and realism to happy superstition" (p. 1015).*

Roberts draws on O'Neill's (2002) concept of a more "intelligent" and compassionate form of accountability in which hierarchy is broken down and active enquiry is valued over adherence to pre-set indicators or scripts. The quest for perfection is abandoned and the acknowledgement of one's own and others' inadequacies and limitations is fostered. Fantasies of complete control through technical standardisation are let go. Butler (2005) describes this refashioning as having potential to situate accountability within a framework of humility and generosity (Roberts, 2009). Thus accountability is construed as a social, not just an internal, process—engaged with both the self and the other—allowing for room to be vulnerable, unsure, and ultimately authentic:

> *"What emerges in this space is something of the weight of our practical dependence upon each other which accountability as talk, listening, and asking questions then allows us to explore and investigate. Accountability is thereby reconstituted as a vital social practice—an exercise of care in relation to self and others, a caution to compassion in relation to both self and others, and an ongoing necessity as a social*

practice through which to insist upon and discover the nature of our responsibility to and for each other" (Roberts, 2009, p. 969).

Roberts' socialising accountability recognises the limits of the individual and incorporates the social context into accounting for actions. It allows for the breaking down of self-interested thinking, which is ultimately constraining and stressful, and supports flexibility and space knowing we cannot do everything ourselves and we are ultimately linked with those around us (Roberts, 2009). Others are then seen as resources, rather than threats that point out one's shortcomings (Roberts, 2009). In this context, the essence of intelligent accountability can be seen as engagement with otherness, and directly challenges the notion that we are separate, autonomous entities who can afford to ignore collective interests.

Roberts (1991, 1996, 2001, 2009) suggests that essential characteristics of spaces that foster socialising accountability are those where talking is encouraged, frequent face-to-face contact is established, and hierarchy is minimised. Instead of guardedness that often accompanies communication in hierarchical settings, participants with minimal power dynamics have more opportunity to relax and open up, thus fostering inter-relatedness and interdependence (Roberts, 2001). Lars Lindqvist and Sue Llewelyn (2003) from Linköping University and the University of Edinburgh, respectively, describe this space as a local forum for direct communication with peers who endeavour to understand one another and to establish an agreed ethical framework. It is in this forum that group members can listen to each others' worries and complaints without judgment or reprove, in what Fry (1995) describes as a process of "committed listening" and Waters (1988) as "good conversation". Peers and colleagues support the individual to find her or his authentic voice and prioritise ethical considerations over funding and procedural objectives, thus encouraging a nurturing and supportive form of accountability (Fry, 1995).

Intelligent, socialising accountability is rooted in ongoing discussion and inquiry, rather than blind trust (O'Neill, 2002). People *do* accountability; it is active, not static. Rather than taking an occasional "snapshot" in the form of reporting against logframe indicators, for example, socialising accountability is a continuous process that takes place over time (Roberts, 2009) and requires mindful engagement with the world beyond the self.

Individuals are asked to emotionally “show up”—that is, to be present, vulnerable, and genuine—on an ongoing basis.

In sum, Roberts, Butler, and O’Neill are, in many ways, calling for accountability without judgment. They suggest an accountability framework rooted in acknowledgement of our own and others’ opaqueness and blind spots, which fosters mutual patience and acceptance. This, in turn, can create a space for honesty and visibility, allowing the muddy aspects to come to light, which has the potential to result in a deeper and more impactful accountability.

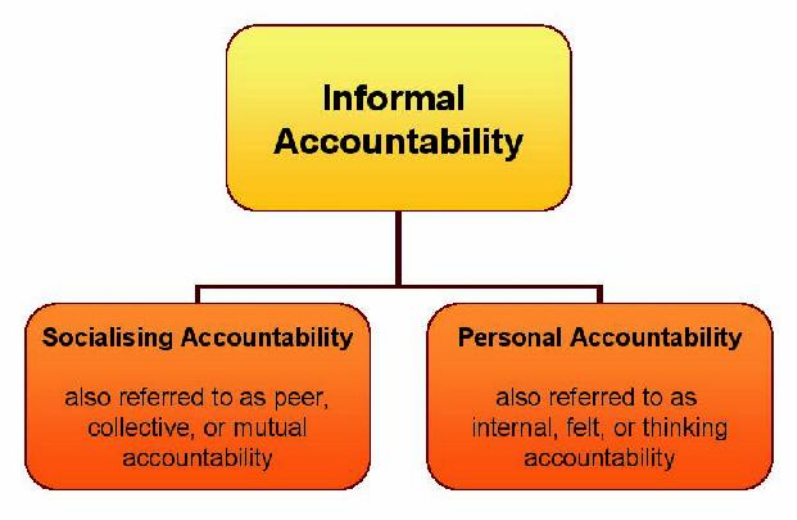
7.5.3 Personal accountability

It is important to distinguish Roberts’ notion of socialising accountability with what Fry (1995) terms “felt responsibility” (p. 182). A number of scholars have written about an internal sense of obligation or duty, i.e., “taking responsibility for oneself” (Cornwall, Lucas, & Pasteur, 2000, in Ebrahim, 2005, p. 3). Willmott (1996) calls it “thinking accountability”, Ebrahim (2005) and others discuss it in terms of “internal accountability”, Sinclair (1995) terms it “personal responsibility”, and Laughlin (1996) expresses it as fidelity to “higher principles”. These variations all seek to describe acting in accordance with personal value systems and honouring personal conscience.

Lindqvist and Llewelyn (2003) discuss the notion of operating from a moral position and draw a distinction between accountability and responsibility: the former suggests external controls, whereas the latter connotes personal ethics and inner psychological controls (p. 252). Fry (1995) similarly articulates that accountability connotes “being held responsible (by another”) based on mutually agreed parameters; *feeling* responsible, on the other hand, is essentially subjective, personal, and individualised (p. 183, emphasis mine). Fry takes this further by problematising the impact of this differentiation and suggests that the lack of alignment between felt responsibility and external accountabilities is a primary obstruction in advancing meaningful accountability. To address the lack of alignment, both Sinclair (1995) and Fry (1995) suggest that personal accountability can be fostered within an organisational culture that articulates shared values and beliefs. Laughlin noted in 1996 that the details of this type of accountability remain vague; although some research has been done in this area in the past 20 years, further scholarship is needed.

Personal accountability can be seen as the ethical cousin of socialising accountability. Despite being distinct concepts, both are constructed as counterbalances to structural and strategic accountabilities in an effort to develop a more holistic approach. Both are forms of informal accountability, which I outline in Figure 7.2. Roberts situates socialising accountability within the context of a social process that can engender a safe space to develop and express this personal, internal accountability. They are not entirely discrete but rather offer different emphases towards a similar mission: to develop more nuanced and meaningful understandings of accountability that go beyond the technical and mechanical.

Figure 7.2: Forms of informal accountability



7.5.4 Critique

Roberts' (1991) first article on socialising versus individualising accountability has been criticised by different scholars, Lindqvist and Llewelyn (2003). Although they agree that socialising accountability has numerous merits and should be fostered in the workplace, they also argue that Roberts' construction of accountability is binary and propose a more complex and interdependent understanding of accountability. They recommend a "responsibility/accountability" framework in which traditional structured forms of accountability are not inherently problematic and have the potential to complement socialising aspects, resulting in a more holistic and realistic expression of accountability (Lindqvist & Llewellyn, 2003).

They suggest that Roberts conflates individualising accountability with hierarchical accountability. Hierarchical accountabilities are set forth by management and are imposed on “junior” staff. However, Lindqvist and Llewelyn disagree with the Weberian/Marxist conclusion that a sense of alienation, fragmentation, and isolation inherently results. Indeed, they point out that top-down accountability structures can be acceptable and useful in cultural settings that value cooperation and interconnectivity. In addition, they worry that emphasising socialising accountability over its hierarchical counterpart can result in a nebulous understanding of responsibilities, objectives, and tasks, thus undermining the efficacy and goals of the organisation as a whole.

Roberts’ thinking has evolved since his original 1991 article. In later works, he draws on a variety of famed intellectuals, such as Giddens, Lacan, and Foucault, to develop a more complex understanding of socialising and individualising accountability and how they manifest (Roberts, 2001, 2009). However, he maintains this original dichotomy, which Lindqvist and Llewelyn, among others, have criticised (Bourguignon, Saulpic, & Zarlowski, 2010; Munro & Hatherly, 1993).

7.5.5 Socialising accountability and humanitarian action

In the chaos of an emergency, talking and listening are essential. Each crisis has its own set of unique challenges and opportunities, and invariably involves a wide number of players, many of whom may be new to the particular setting or circumstances. Humanitarian personnel must discuss and reflect—with their colleagues, with the affected population, with themselves—in order to effectively, creatively, and appropriately respond to the situation. Most aid workers recognise that collaboration is essential for successful humanitarian action. Fostering socialising accountability can help humanitarian staff by “reminding them of their dependence upon others and their own human limitations” (Roberts, 2001, p. 1556) and contribute to a more effective and appropriate humanitarian response.

Some commentators have indeed noted the detriment of castigating organisations for failing to meet idealistic standards and benchmarks (Dempsey, 2007) and the futility of striving for “impossible perfection” that current humanitarian accountability mechanisms encourage (Stobbaerts & de Torrenté, 2008, p. 49). Not only are anxieties of being critiqued

commonplace, but so are fears of criticising others as well, mainly due to concerns about possible negative repercussions (Montclos, 2010). These fears and anxieties contribute to closed, defensive organisational cultures that inhibit the flourishing of deeper and more meaningful accountabilities.

At the same time, the humanitarian field may be more amenable than the private sector to consider socialising accountability. Roberts, Lindqvist, and Llewellyn explore socialising accountability within a corporate context; however, the humanitarian industry is distinct in that it is part of the voluntary sector and is not bound by the "bottom line". (Nevertheless, as discussed previously, humanitarian agencies are often hamstrung by their dependence on donors and prioritise funding interests over those affected by crises.) Though overt corruption and fraud do occur, many humanitarian agencies strive to adhere to their primary principled goal: to alleviate suffering and, at the very least, do no harm. Concurrently, international humanitarian staff may engage in arrogant and competitive behaviour amongst themselves, which has the potential to frustrate socialising efforts. MSF, for example, has been criticised for its isolationism, lack of participation in coordination efforts, and arrogance (MSF, 2012).

Nonetheless, informal, socialising forms of accountability are not unknown in the humanitarian sector. An increasing number of reports and evaluations have included calls for what can be understood as socialising accountability. For example, as early as 2006, an IASC assessment of the Cluster Approach noted that field staff were concerned about rigid responsibilities imposed by the Cluster system and emphasised the need for *mutual accountability* "that is earned through trust and relationships building" (IASC, 2006, p. 9).

A second Cluster Approach evaluation, conducted in 2010, found that the humanitarian reform process broadly had led to an increase in the different types of accountabilities, including *peer accountability,* which was shown to enhance discussions, leadership, and good quality programming (Steets et al., 2010, p. 44-46). A 2010 study on leadership in the humanitarian reform process found that vertical, hierarchical accountability was counterproductive and that agencies were interested in fostering some form of *mutual accountability*; a survey from this study found that 90% of respondents thought aid effectiveness would increase if humanitarian agencies prioritised the broader goals of the response over individual agencies' interests (Featherstone, 2010, p. 16). The IASC 2011-

2012 Reform Statement includes a point on increasing ways for IASC members to hold each other *mutually accountable* in all aspects of humanitarian programming (IASC, 2011). The 2013 Humanitarian Accountability Report acknowledges that a salient issue for the humanitarian field is the absence of *mutual and collective accountability,* which remains "elusive in practice" and is often eclipsed by formal accountabilities (HAP, 2013, p. 10).

Further, appeals for enabling an *accountability culture* have gained momentum (HAP, 2013; Hilhorst, 2002; Lloyd et al., 2008; Stobbaerts & de Torrenté, 2008). The 2008 Global Accountability Report notes that nurturing accountable behaviour, such as openness, listening, receptiveness, and learning, has been largely overlooked and that other accountability efforts are hollow and ineffectual without addressing these deeper issues (Lloyd et al., 2008, p. 19). Stobbaerts and de Torrente (2008) reframe accountability as an organisational state of mind, which includes "a willingness to ask difficult questions about one's operations, to seek and share the answers, and to learn from the process" (p. 49). A 2012 assessment of the applicability of the Transformative Agenda in South Sudan found that developing an environment that fosters participation and inclusion increases *collective and mutual* accountability, which are essential for compliance with technical accountability processes (IASC, 2012b, p. 2).

Interest in more fluid, non-technical forms of accountabilities has also emerged from "the ground up", that is, from humanitarian aid workers themselves. A number of current or former relief agency staff members maintain blogs in which they have expressed dismay at the current trends and have highlighted the need for more dynamic and social approaches to accountability (cf. Ausland, 2010; J, 2010; MoreAltitude, 2010; Ramalingam, 2013). One writer suggests that traditional forms of accountability, specifically project evaluations, do not engender learning or meaningful accountabilities. Instead, he suggests that these established methods are self-deceptive processes that ignore the intended goal of determining whether an intervention is effective and impactful (Ausland, 2010). Another blogger notes that HAP's checklists, for example, are ineffective and unmanageable at the onset of a response; he proposes that the *principle* of accountability, whereby organisations leave it to quality staff to make appropriate decisions regarding accountability in the midst of turmoil, should be cultivated (MoreAltitude, 2010, emphasis in the original).

These calls for peer and mutual accountability, an accountability culture, and accountability principles reflect interest in moving away from the procedural and hierarchical and exploring collective and horizontal forms of accountability with an emphasis on talking, listening, and openness.

7.6 Conclusion

Definitions, understandings, and expressions of accountability have evolved over the past 20 years in an effort to meet the ever-growing needs and complexities of the humanitarian sector. Formal accountability mechanisms, such as Sphere standards, and reform processes, particularly the Cluster Approach, have received attention, funding, and support to push the agenda forward. While recognising the positive results of these efforts, they have not solved the “humanitarian accountability dilemma”. This research questions whether we need more of the same, or if more subtle, nuanced, and essential elements are being overlooked. It explores the various dimensions of how socialising accountability manifests in humanitarian settings, how actors perceive it, and whether it has any merit or explanatory power. As such, we turn to the second phase of this research, which explores the role and value of socialising accountability in the RH responses in Myanmar and Haiti.

8. Chapter Eight: Phase II – Socialising accountability in Myanmar and Haiti

8.1 Introduction

The second phase of this research explored the role of socialising accountability in the RH responses after natural disasters in Myanmar and Haiti. Socialising accountability can be difficult to identify as this form of accountability is often more opaque and intangible than formal accountability structures and process. Further, reflections of socialising accountability may be difficult to tease out as they are shaped by multiple factors, including formal accountabilities and interpersonal dynamics.

The literature on socialising accountability is dominated by conceptual debates; few scholars provide examples of practical application. Roberts (1991), who situates his research within a corporate context, suggests that informal spaces for sense-making, such as talking in office hallways or over after work drinks, and lack of hierarchy are key elements that support the development of socialising accountability. Munro & Hatherly (1993) suggest that engaging all actors in designing the goal for which they are responsible and continuous examination of behaviour among peers contribute to increasing inter-personal accountability. Fry (1995), whose work focuses on non-profits, proposes that shared goals, ongoing dialogue, and an internal sense of duty enhance socialising accountability. Lindqvist & Llewellyn (2003) identified unstructured relationships with frequent face-to-face contact as important while Bourguignon et al. (2010) highlight the importance of trust and the role played by national culture in promoting socialising accountability. This body of literature is instructive but does not provide a detailed framework with which to understand my case study data.

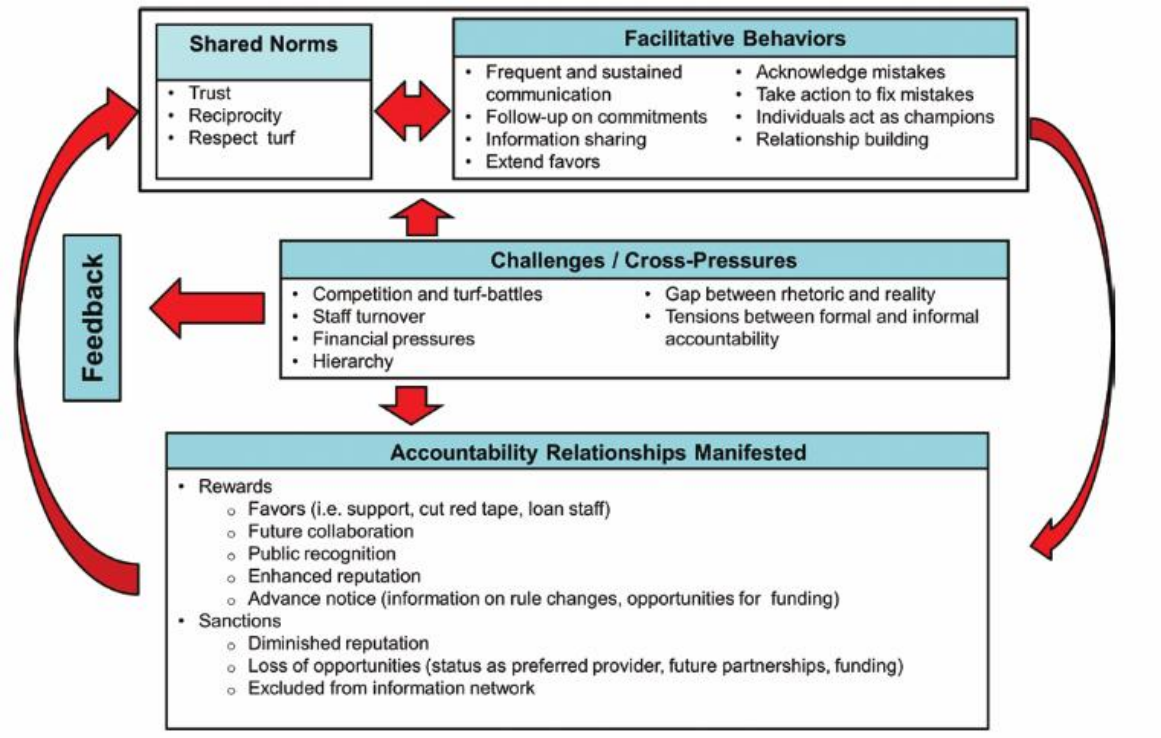
Using a grounded theory approach, Romzek et al. (Romzek et al., 2012; Romzek et al., 2013) developed an innovative model that outlines practical dimensions of socialising[33]

[33] Romzek et al. use the term "informal" accountability rather than "socialising". This research defines informal accountability as encompassing both socialising and personal accountability, although Romzek et al. define it in terms of socialising accountability only. To avoid confusion and maintain consistency, this paper uses socialising accountability rather than informal accountability when referring to their work.

accountability in inter-agency, non-profit coordination (Figure 8.1). In 2012, Romzek, LeRoux, & Blackmar proposed a preliminary model for socialising network accountability, which Romzek, LeRoux, and other colleagues reinforced and extended the following year. The expanded model identifies four areas that promote or undermine socialising accountability: 1) shared norms, 2) facilitative behaviours, 3) rewards and sanctions, and 4) challenges and cross-pressures (Romzek et al., 2013, p. 8-9). Specific elements of each core area are also outlined.

This model developed was based on research of interagency network coordination of non-crisis social service organisations in the United States. Applying the model to a humanitarian context is potentially useful given that the social service agencies studied by Romzek et al. and humanitarian agencies are both non-profit service delivery organisations participating in inter-agency, non-formalised coordination. This chapter draws on the expanded framework set out by Romzek et al. (2013) and uses it to describe and make sense of the ways in which socialising accountability played out in the Myanmar and Haiti crises. I explore the applicability of the framework to the humanitarian context, which entails different and arguably more complex inter-agency relationships, accountabilities, and challenges than in the U.S. context alone. Through this analysis, I extend the model by suggesting additional categories for socialising network accountability in humanitarian settings.

Figure 8.1: Model of informal/socialising accountability among network organisational actors



Source: (Romzek et al., 2013, p. 10)

8.2 Methods

Phase II sought to answer the research question "How did socialising accountability manifest in these two settings and what was its impact on the RH responses?" Methods for Phase II consisted of in-depth, key informant interviews with primary actors in the RH responses in the two settings. For the Myanmar case study, six extensive, semi-structured interviews were conducted with staff from two UN agencies, one INGO, and one non-UN/non-NGO international organisation. Phase I data were also re-analysed and, of the 49 humanitarian informants, I found that 38 respondents representing nine agencies including six INGOs, two UN agencies, and one local NGO explicitly mentioned accountability or referenced different manifestations of accountability. These data are integrated within the presentation of this chapter.

For Haiti, eight in-depth interviews were conducted with representatives from one UN agency, five INGOs, and one national organisation. Phase I data were re-analysed and

included: I found references to different forms of accountability by 17 out of 41 interviewees representing eight INGOs, one national agency, and one UN agency.

The preliminary model for socialising network accountability developed by Romzek et al. (2013) was used to organise and make sense of the findings. Details on Phase II methods are outlined in Chapter 2, section 2.3.3.

8.3 Overview

As highlighted earlier, socialising accountability in Myanmar was strongly reflected in the national RH/HIV Technical Working Group. On average, ten to 15 people participated in the Technical Working Group; participants were Myanmarese nationals and international personnel who had worked in Myanmar for more than a year. Participation in the Technical Working Group was consistent, with minimal turnover of members and leadership. All informants found the Technical Working Group essential to advancing RH. They stressed a strong sense of commitment to implementing the MISP and to other members of the Working Group.

In contrast, I initially assumed, based on Phase I findings, that socialising accountability did not significantly manifest among RH actors after the Haiti earthquake. However, findings from Phase II demonstrated that socialising accountability did play an important role in the RH response. Unlike in Myanmar, socialising accountability was mainly cultivated and expressed *outside* of the RH Working Group, which served as a springboard for interpersonal working relationships but was not the space in which these relationships were developed.

The effectiveness of the RH Working Group in Haiti repeatedly changed during the first six months after the earthquake primarily due to high turnover of participants as well as fluctuating quality of RH Focal Points. Informants described a diverse range of experiences in the Working Group that varied depending on the timing of their involvement in the response, their professional and organisational mandate, their familiarity with the MISP, and the type of agency with which they worked (local, government, INGO, or UN). Participants' experience of the Working Group was heterogeneous: some described a high quality Working Group that coordinated well—with one Haitian UN representative calling the group

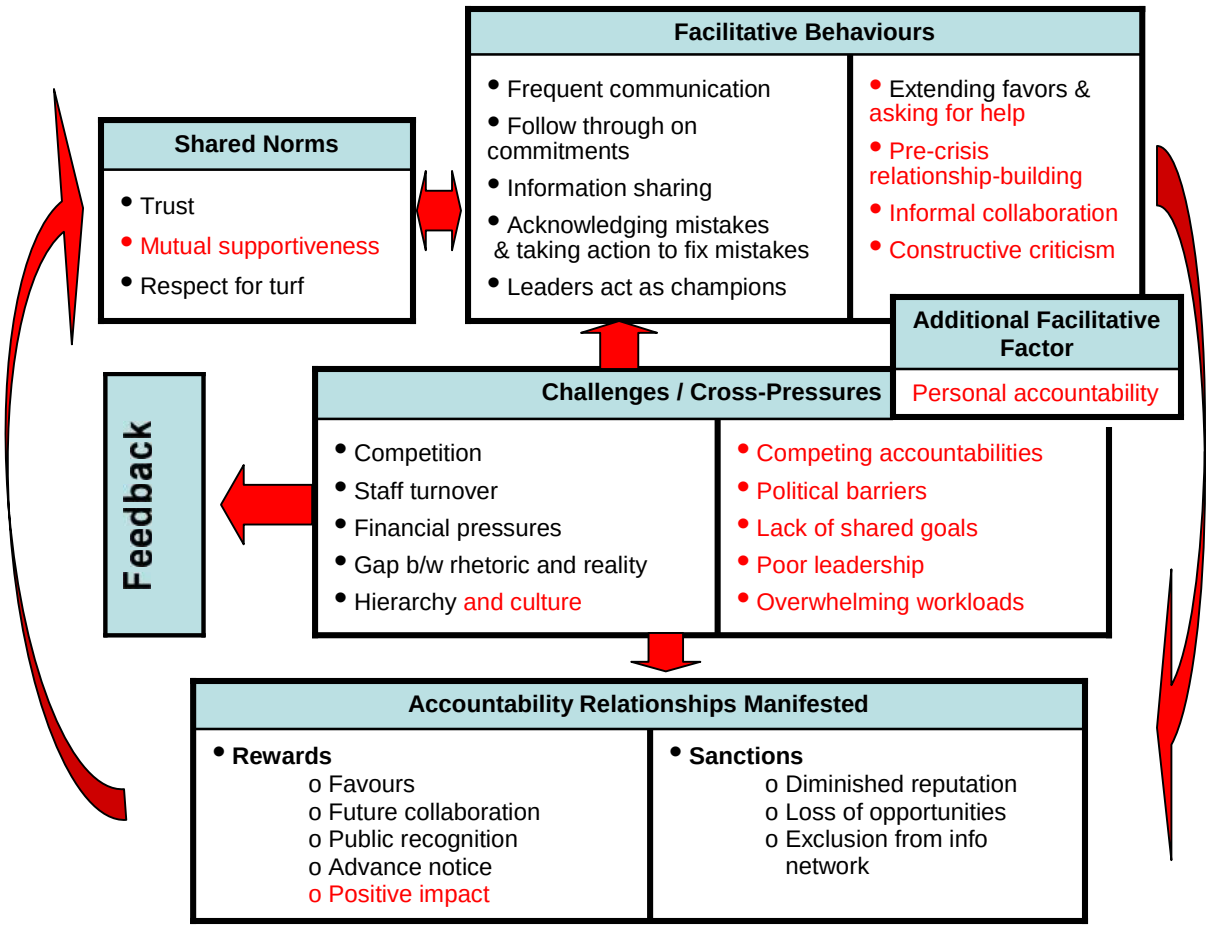
a “family”—while others found it fragmented and competitive. One international representative working with a local NGO remarked that the Working Group offered no added value to her work.

All informants in Haiti also participated in some kind of informal network or collaboration to varying degrees outside of the Working Group, which was described as valuable by all. Expression of socialising accountability waxed and waned in the Working Group given the changing constellation of members and Focal Points, while it was more consistently fostered informally outside of the Working Group.

8.4 Socialising accountability manifested

Romzek et al. (2012) describe socialising accountability as emerging “from the unofficial expectations and discretionary behaviours that result from repeated interactions among network members in recognition of their interdependence in pursuit of their shared goal(s)” (p. 443). As outlined earlier, the authors outline four elements that reflect, support, or undermine socialising accountability: *shared norms*, *facilitative behaviours*, *informal rewards and sanctions*, and *challenges*. Building upon these categories, I developed Figure 8.2, which modifies the model developed by Romzek et al. based on the findings from this research.

Figure 8.2: **Author-modified and extended model of socialising accountability among inter-agency actors in humanitarian settings (based on Romzek et al. 2013)***



*Red text denotes additional categories included by author

8.4.1 Shared norms

Shared norms are expectations of groups or communities of the acceptability of its members' behaviour. Romzek et al. (2013) pinpoint *trust, reciprocity*, and *respect for institutional territory* as key shared norms that promote socialising accountability in inter-agency coordination (p. 11). Analysis of the data from the two case studies against this framework confirm trust as an essential social norm underpinning socialising accountability in the context of the RH responses in Myanmar and Haiti. However, the norm of reciprocity is too narrow and limiting a concept to describe the findings. Deeper analysis suggests that *mutual supportiveness*, an extension of both reciprocity and trust, may better reflect the realities on the ground. Further, only certain aspects of respect for institutional territory are

found to be applicable to the findings, such as agencies respecting each other's programmatic boundaries.

Trust

Scholars have identified trust as an essential component of effective network cooperation (Klijn, Edelenbos, & Steijn, 2010; Laporte, 1996; Noteboom & Six, 2003; Van Slyke, 2006). Trust, in this sense, can be defined as having an expectation that another actor is reliable, predictable, and fair (Zaheer, McEvily, & Perrone, 1998). However, in a humanitarian emergency, some commentators have asserted that developing trust among aid actors is particularly challenging given the chaotic, ever-changing nature of humanitarian response (Minear, 2002; Stephenson, 2005).

In Myanmar, all respondents emphasised trust as an essential component of effective inter-agency coordination. A humanitarian focal point with a UN agency described how existing collaborative relationships enabled trust in the RH/HIV Technical Working Group:

> *"We are very close. We have a lot of trust. Many are our existing partners and this is the way we work before the cyclone. So we always discuss the innovative ideas and how to improve our projects and how to deal with the government. Like that we used to solve problems together, work together, for the benefit of people. We already have trust".*

The openness and transparency of the group was reflected in the ability of its members to—in the words of one RH Focal Point—"really talk" without fear. The members expressed that the Working Group, at least before the visa blockage was lifted, was a safe space in which to voice their concerns, confusion, and struggles. They were able to express vulnerability; as noted in Chapter 4, one NGO staff person remarked, "I didn't know what we were supposed to be doing" with regard to MISP implementation. They also engaged in subversive behaviour, such as deciding as a group to provide medical care for rape survivors without informing the police, which is required by law, reflecting deep levels of trust. Trust among Working Group members enabled collaborative, sometimes conspiratorial behaviour to achieve collective goals. Some members, however, commented that the participation of government representatives thwarted openness and transparency and thus limited trust within the group.

In Haiti, most of the informants described the RH Working Group as being relatively open at the beginning of the response, although trust was not perceived as the working norm. A representative from a local NGO commented:

> *"Trust is taking it too far. There were always too many new faces, and a lot of suspicion about motive. There were so many stakeholders present. You had large INGOs, you know, Save, CARE, whatever. They have so much power. I think there was always a kind of communication but also distrust. We don't quite know who you represent or what your end game is here".*

However, in Haiti, trust manifested more in informal spaces and was one of the key elements to enable the emergence of effective, interpersonal working relationships. An international health adviser from a large U.S.-based NGO reflected:

> *"There were some people I knew from before, and those were the people I gravitated to [outside of the Working Group]. I thought there was trust between us as there was some semblance of friendship… You are heard and respected, and I trusted people to do that, to be respectful and not, you know, think they were doing better".*

An international global health adviser with a large INGO also noted that actors were able to communicate more freely outside of the Working Group:

> *"The informal coordination is my favourite—that is where we can really talk and solve problems*".

A women's health coordinator with a national NGO agreed:

> *"I felt that the Working Group was the point of departure. It was where we met people, but the real conversations happened outside".*

<u>Mutual supportiveness</u> → *Modified from Reciprocity*

Romzek et al. (2012) reference Putnam's (2000) concept of reciprocity, which entails voluntarily helping another person(s) with the expectation that they will do the same in the future. The concept implies an element of self-interest or *quid pro quo* in that any support given will be recompensed at a later date. Trust facilitates reciprocity and vice versa (Roberts, 2004).

None of the findings suggest reciprocity was a key element in facilitating socialising accountability among RH actors in Haiti and Myanmar. In both settings, the informants described voluntarily helping or receiving help from fellow colleagues without a sense of future obligation or expectation. Commitment to the issue, rather than future reciprocity, was the motivating factor. For example, an expatriate health coordinator with a national NGO who had worked in Haiti for many years shared:

> *"I spent a lot of my time helping other groups, large and small, how to work in the country, even though this is not my job. I spent a lot of time online, on the phone, meeting people, taking them to the warehouse, helping them to fill out paperwork. I felt happy to do it in the beginning… For me the driver is the women served".*

Although she was unable to sustain providing this support, her decision to limit the time she spent helping others was due to high workload and competing accountabilities, rather than frustration with the lack of reciprocity:

> *"I really believe that it was a worthwhile effort, but I spent a lot of my time helping other groups, large and small, how to work in the country. I thought, this is insane, this is not my job… [After one year], I said, No no no, I don't have time to do this".*

Mutual supportiveness extends beyond trust and reciprocity. It implies that colleagues can rely on each other for support in times of distress. Mutual supportiveness as a social norm is distinct from supportive behaviour. As opposed to a safe space or openness that is reflected in trust, it construes the willingness to take action. Mutual supportiveness entails a broader culture of reliability in which actors trust that certain colleagues will take action to help each other when in need. In Myanmar, a Myanmarese senior UN representative remarked:

> *"Some of the members*, *they know they can ask advice from the other members. It is good. Supportive, very positively supportive".*

Another Myanmarese senior official from a different UN agency noted:

> *"…[T]he supportiveness among the [Technical Working Group] members is one of the keys to its success. For example, one agency can't offer everything the community needs. So if we can fill each other in in terms of these needs, then we become stronger. So this is how we see ourselves, supporting each other, rather than duplicating activities in the same area, because that will mean you are wasting resources".*

In Haiti, a senior health adviser from an INGO described how RH actors supported each other outside of the Working Group and also implied that they could cover each other's weaknesses:

> *"There was a woman…from WHO, she's fantastic—she was the one who first called us to an outside meeting. It was just a group of people struggling to do things. It was very very informal—some of us were having coffee—but very very good things discussed. We were talking about, these people are not accessing services, who should go there, who could go there. It was very practical, very pragmatic. And it was great because then we could come to a consensus on an issue that we could take back to the Ministry of Health. So there wouldn't be any single agency individuated but we would discuss as a group and put it forward together and cover each other's back. That was good".*
> [Emphasis added.]

Respect for institutional turf

Romzek et al. include the notion of *respect for institutional turf* as a critical norm to foster socialising accountability. They argue that impingement of one agency into another's programmatic and physical space has the potential to cause significant strife, and adherence to these boundaries is important for effective inter-agency cooperation and coordination (Romzek et al., 2012, p. 445).

In humanitarian settings, this territorial respect in regards to spatial boundaries may not be as applicable given the unique situation of an emergency. Based on the feedback from respondents, agencies prioritised responding to needs over negotiating institutional territory, at least during the acute phase. Duplication of services was common in both settings but was not intentional; indeed, decisions regarding sites for programme implementation had more to do with ease of access to affected communities than deliberate transgression into another agency's field site. Although frustration at this duplication was expressed, it was targeted towards the lack of coordination and mapping of services, rather than the actions of specific agencies.

Respecting programmatic boundaries proved more complicated. In Myanmar, none of the respondents noted programmatic intrusion as an issue. In Haiti, however, it played out on two different levels. At the field level, tensions existed between international development agencies that had been working in Haiti for a long time and newly-arrived humanitarian

actors. Respondents suggested that development agencies did not feel engaged or listened to by relief agencies, which were perceived as appropriating programmatic sectors—specifically the response to gender-based violence—without consulting non-humanitarian organisations.

Difficulties stemming from lack of respect for programmatic territory was also evident at higher levels during the Haiti response, again, primarily related to the gender-based violence response. For example, representatives from UNICEF, UNIFEM, and UNFPA headquarters fought over which agency would lead the Gender-based Violence Sub-Cluster. One RH Focal Point expressed exasperation:

> *"UNIFEM and UNICEF were already doing GBV [gender-based violence] in Haiti and I said fine, keep doing that, please continue, but then UNFPA headquarters got very upset and started fighting in headquarter meetings about who was going to take the lead in this, which was crazy. It was really ridiculous. I felt in the field there wasn't that competition [to be the lead Gender-Based Violence agency]. Not at first".*

Another representative from an INGO remarked on the turf competition:

> *"We all need to be collaborating together. To get away from this territorialism and move forward and do the best job you can. And don't worry about putting your flag in the ground".*

8.4.2 Facilitative behaviours

Certain behaviours augment socialising accountability. Romzek et al. (2013) identify eight enabling behaviours: 1) *frequent and sustained communication,* 2) *information-sharing,* 3) *acknowledging mistakes,* 4) *taking action to fix mistakes,* 5) *following through on commitments,* 6) *relationship-building*, 7) *individuals acting as champions,* 8) *providing favours* (p. 10).

After deeper analysis of the findings from this research, I have adapted their framework. I modify the categories of individual champions, provision of favours, and relationship-building and include additional behaviours such as *informal collaboration* and *providing constructive criticism* (Figure 8.2). Romzek and colleagues' categories are explored first, followed by my additional dimensions.

Frequent and sustained communication

Ongoing communication is critical for successful collaboration and promotion of socialising accountability. Romzek et al. (2012) note that this communication can take various forms, including meeting in-person or by email or phone. Other scholars, such as Roberts (1991, 2009) and Lindqvist and Llewellyn (2003), claim that frequent face-to-face encounters are essential for the enactment of socialising accountability. Their research focuses on relationships within a single company, not inter-agency relationships. The data from this study demonstrate that in-person communication was preferable but not critical. An international health manager for a national NGO in Haiti preferred in-person engagement:

> *"We were working towards what felt like common goals, so I was able to communicate with those people and that was helpful for me. In my role as [unofficial] ambassador to smaller NGOs, I would meet with them at Log Base. I had lots of phone calls and emails, but face-to-face worked best".*

Frequent face-to-face meetings, however, are not feasible in many humanitarian settings due to restricted travel as a result of insecurity or physical destruction of roads and airports. One respondent in Haiti suggested that attending daily or bi-weekly coordination meetings in-person was unethical as it took time away from addressing urgent health needs, and she relied on meeting notes instead. Many informants in both settings commented that they or their partners were too overwhelmed during the response to consistently attend the coordination meetings. A Myanmarese senior representative at a UN agency described these challenges:

> *"The main disadvantage is at that time, the meetings conducted on daily basis. Every afternoon or something like that. So staff are exhausted. So it is time consuming, so it is a waste of time for staff. They become exhausted. They don't have time to rest or do other work. Most of the staff are involved in many Clusters at the same time. There is one staff involved in health, nutrition, RH, protection, everything. They cannot split their body, including me".*

Another Myanmar UN official found that she was able to respond to needs through phone calls and email:

> *"All [not just Technical Working Group members] are quite free to calling me or emailing me and asking their needs. This is quite usual. Implementing partner or not, no problem.*

They always ask me for IEC [information, education and communication] material, for queries and sometimes commodities. If available, I provide it. If not, I reply".

Likewise, an RH Focal Point in Haiti explained that many of her relationships were maintained through phone calls:

"Too many meetings to attend… I spent so much time in meetings. My relationships were really built over the phone. When we're in the Working Group we are discussing, but all the time I am on the phone with them, sending email, this is how the relationship remained alive. It wasn't just at the Working Group. No no no".

Information-sharing

Sharing information has been recognised as critical to successful coordination in humanitarian settings (Parmar, Lobb, Purdin, & McDonnell, 2007; Stephenson, 2006; Zhao et al., 2009). Effective implementation of services, which saves lives and preserves the well-being of crisis-affected communities, is contingent on receiving timely and accurate information from partners. Information exchange can be both formal and informal. Formal information-sharing in the health sector typically includes providing updates on programme implementation in coordination meetings as well as filling out forms about service provision requested by sector leads and MoH. Strategic management of requested information can prevent duplication of services, enhance implementation, and guide appropriate funding requests and ordering of supplies. Knowledge exchange can be difficult in humanitarian settings due to inter-agency competition, time constraints, disinterest in collaboration, and duplicate requests of information from different actors (Parmar et al., 2007; Stephenson, 2005, 2006).

In Myanmar, frequent and transparent information exchange was commonplace in the Technical Working Group meetings and was essential to enhancing a culture of accountability. Members remarked that it helped to understand gaps in programming, geographically as well as in service provision. This sharing of information helped strategic planning and to "support each other for the solution", as noted by a Myanmarese UN representative. One of the RH Focal Points explained the link between information-sharing and socialising accountability:

"…[W]e have regular reporting among members. And then when we are sharing our experiences. If they need additional services or support, then others would be available

to provide the needed services. In other words, keeping each other informed and keeping each other up on issues that would contribute to increased accountability among the members".

In Haiti, information-sharing operated on a number of levels. Data and information from the RH Working Group, as a Cluster sub-group, should be fed back to the Health Cluster. A systematic feedback loop was not established by WHO, despite requests from two RH Focal Points. They attributed the lack of responsiveness to WHO not prioritising or understanding its commitments to RH as well as staff being overwhelmed with their workloads. Less formal feedback, such as providing updates from the RH Working Group at Health Cluster meetings, was inconsistent. An international health director at a large INGO remarked:

"The Health Cluster and the RH sub-cluster don't communicate. One is driven by WHO and the other by UNFPA. That is the worse set-up for coordination and it is like that in all countries. These organisations don't coordinate internally. Agencies hold important information and don't see the value and importance of sharing information".

One of the Working Group leaders in Haiti tried to coordinate with WHO to ensure RH data were included in health assessments:

"I can't tell you the number of times I asked, WHO in particular, are you conducting a health study? Because if you were, I wanted to include questions on RH. They all had a health component, can I see the questionnaires. Silence… It was crazy".

In the RH Working Group itself, two Focal Points noted the difficulty of receiving feedback despite formal requests for information. One lamented:

"*…[O]ne of the hardest things that I had to do—and I only convinced two people to do it—is to give information as to what they are doing where".*

The informants who had participated in the Working Group in Haiti admitted that they did not respond to formal requests for information from the RH Focal Points. Some of these were even members of the IAWG Secretariat and thus knew the value of sharing information. The reasons they provided for their behaviour were multi-fold: a lack of sense of accountability to the RH Focal Point (and more towards the MoH); lack of follow up by the Focal Point; time constraints; and too many requests for reports from different sources,

such as the RH Focal Point, the MoH, and the Health Cluster. They described a sense of being overwhelmed by competing accountabilities to different actors. This was identified as a challenge to socialising accountability, explored further below.

Informants offered insights into why *other* actors were hesitant to share information. They suggested others' reluctance stemmed from competition for funding and visibility, and that withholding information provided a sense of power in a chaotic and competitive environment. A Haitian national and one of the RH Focal Points commented:

> *"I have to say at first it was very frustrating because people did not want to share data. It was like pulling teeth. Everyone was coming to meetings but no one wanted to share. The MoH rep attended the meetings and asked for data every week. Next time, bring data—how many people you saw, what the problems are, etc. Nobody. I am still trying to understand this. My perception was that there was so much visibility with Haiti. Everyone wanted to feel important. Everyone wanted to feel that they mattered. So if you don't give data, people may assume you may know something, you may know something they want. That's the game. That's true for UN and NGOs".*

The situation described reflects a lack of trust among Working Group members, which eroded socialising accountability. Indeed, a NATO assessment of the Indian Ocean tsunami response documented that mistrust and lack of common goals among government, national, and INGOs thwarted information-sharing (Huber et al., 2008). By withholding data, agencies are less vulnerable to criticism and thus less accountable, both informally and formally.

Other reasons reported for not sharing data, as noted above, included competing accountabilities and feeling overwhelmed; some informants said that others did not understand the value or benefit of information-sharing. They also noted that the situation was so chaotic—in terms of sustainable funding and trying to implement services—that people may not have felt comfortable sharing information because their programming and planning was uncertain. Whatever the reason, lack of data sharing or strategically withholding data undermined the development of socialising accountability among Working Group members in Haiti.

Informal information-sharing outside of the Haitian RH Working Group, however, proved more effective. RH actors were more honest about their challenges and vulnerabilities. The same Focal Point described the importance of sharing information outside of the Working Group:

> *"I had an unbelievably hard time getting information from the other agencies. Informal networking—that's what helped me. Because I ended up having relationships with people that were not formal. They would admit things to me outside of Working Group. So I could go on and do the work that I needed to do".*

A senior health advisor with an INGO explained how agencies outside of Port-au-Prince worked together to set up informal information-sharing in the field and clarified the type of information that was shared:

> *"Actually most of our information happened outside of the Working Group—the majority of it. There wasn't a Working Group outside of the capital so every week we met in the other areas at the field level. We set up our own meetings to meet the other partners. Some of the coordination was happening at [our] offices in Léogâne. We talked about guidelines, about how much incentive we were paying health workers, how are you referring patients. All that happened outside of the Working Group".*

Acknowledging and taking action to fix mistakes

Romzek et al. (2013) assert that accepting responsibility for mistakes and taking appropriate action to rectify errors are essential for building trust and thus enabling socialising accountability. Conceptually, this makes sense and is supported by their data. However, the issue of "mistakes" was not explored during the data collection for this research: questions regarding mistakes were not asked and, after careful analysis of Phase I and Phase II data, references to mistakes, errors, failures, or misunderstandings were not found. The model introduced by Romzek and colleagues was used to understand the findings, but not to guide data collection, keeping in line with a constructivist grounded approach.

Follow through on commitments

Adhering to commitments is vital to the creation of mutually accountable relationships and building rapport among agencies (Romzek et al., 2012; Romzek et al., 2013). "Keeping

one's word" enables a culture of trust, openness, and supportiveness. The data from Myanmar and Haiti highlighted the importance of following through on commitments.

In Myanmar, reliability of other agencies as well as their sense of responsibility toward commitments was mentioned as important by respondents. A UN official noted:

> *"The members are very committed and responsible…And we try to fill in the gaps—the gaps of one another".*

Upon analysis of the findings, follow through on commitments seemed to be a given among RH actors in Myanmar. The reliability of the actors was generally not questioned by informants, and transgressions or compliance failures were not mentioned. For example, an assistant representative from a UN agency described the dependability of the Technical Working Group members after a process of division of labour:

> *"Among the members of the Technical Working Group, we identified among ourselves who are the service providers, who does information and education, who works with the community. So among ourselves we have mapped out who is good at what. So when we are in need of provision of services, we assign those organisations who can provide. Among ourselves we have MMA [Myanmar Medical Association] and MSI and they are providing outreach services, so we could count on them to go out to the affected areas to provide mobile services to the communities".*

A Myanmarese national from a large INGO described how certain Working Group members helped others maintain their commitments, reflecting the ways in which socialising accountability and follow through on commitments mutually reinforce one another:

> *"Sometimes we have to meet together and with our Working Group it is a little bit difficult for other team members to concentrate on broader goals. They may be busy with other tasks. We need some time for us to push to concentrate on Working Group matters, with other agencies to set the goal. It is not only one person to push others, but it must be work together and meet together and try to meet objectives and goals. Some team members focused on the broader goals and forced the other team members".*

In Haiti, RH actors were less reliable in following through on Working Group commitments, as evidenced by their lack of data-sharing described above, a basic albeit non-contractual requirement for participation in inter-agency coordination mechanisms (IASC, 2012e). A

related issue that emerged is agencies' hesitancy to commit to action in the first place. An international health adviser with a large INGO remarked:

> *"Agencies were afraid of over-committing, so were more reserved. We needed to find a way to support one another".*

Informants described the caution towards *making* commitments, rather than *follow through* on commitments, as a primary concern.

Informants made sense of this reservation to commit as a visibility issue, rather than a fear of being held accountable. The challenging operating environment slowed implementation and agencies could not establish programmes at their usual speed. Competition and a desire to "save face" prevented agencies from honestly disclosing their difficulties in service provision. One of the Haiti RH Focal Points explained:

> *"People would say, we're doing EmOC [emergency obstetric care] and condom distribution, but then when you ask them, how many women did you see, they said, no, we are planning to do it, we are setting up. They would first tell you they were doing it, but then they were actually planning to start because it was taking much longer to than they thought to start implementing their projects. But they would talk to you as if they had already started. I think they really wanted to do it and were planning to do it. I don't think it was the [fear of being held] accountable piece. I think it was more about being visible".*

Pre-crisis relationship-building → *Modified from Relationship-building*

Romzek et al. (2013) include an additional behaviour that was omitted in their initial model: relationship-building. They suggest that the quality and character of interpersonal relationships within a network form the basis of socialising accountability. The authors demonstrate the value of "getting along" and investing in the development of positive relationships.

Findings from the two case studies strongly indicate that interpersonal relationships were exceptionally important in amplifying socialising accountabilities. As noted above, trust, an essential social norm to support socialising accountability, is built as relationships deepen over time. Yet the respondents described *pre-existing, pre-crisis relationships* as paramount to advancing RH implementation and socialising accountabilities. This modification of the

category set forth by Romzek et al. may be specific to the humanitarian context: meaningful relationship-building can be exceptionally difficult during an emergency.

Humanitarian field assignments are often short and staff turnover high. For example, the average deployment with OCHA's Emergency Response Roster is 45 days (UNOCHA, 2011e, p. 2). Gender Standby Capacity Project (GenCap) deployments average 9.9 months (IASC, 2012a, p. 5). In Haiti, five different RH Focal Points coordinated the RH response over the course of four months. Within U.S. non-profits, however, a 2010 report found that employees remain with their organisation an average of 6.2 years (Bluewater Nonprofit Solutions, 2010). Other research on multi-agency, non-profit collaboration in the U.S. has demonstrated that positive pre-existing relationships augment network cooperation (Scott, 2005).

In both case studies, all informants emphasised the importance of pre-existing relationships in promoting and reinforcing socialising accountability. Romzek et al. (2012) note in their article that actors will collaborate together if they have been rewarded for doing so previously, although they do not explicitly include this in their model.

In Myanmar, a Focal Point for the Technical Working Group commented that the establishment of the Working Group itself was contingent on prior relationships:

> *"Pre-existing relationship and friendship is the most important. Networking each other is very important, otherwise we will not assemble in RH sub-cluster".*

A Myanmarese officer with a UN agency explained that previous collaboration and relationship-building with RH actors contributed to increased cohesion as the social norm of trust was already established:

> *"Many are our existing partners and this is the way we work before the cyclone. So we always discuss the innovative ideas and how to improve our projects and how to deal with the government. Like that we used to solve problems together, work together, for the benefit of people. We already have trust".*

In Haiti, informants described how pre-existing relationships helped foster socialising accountability in the informal sphere, particularly among national and community-based organisations. One of the RH Focal Points stated:

"I think definitely for local organisations, connections were more important than the Working Group meetings".

She also gave an example about how one colleague's pre-existing connections helped the RH response, including knowing who *not* to approach for information or collaboration. Negative pre-existing relationships that undermine trust can be useful in that problematic individuals are recognised in advance and can be managed accordingly to minimise damage to inter-agency networking and socialising accountability during a response. She said:

"...[M]y colleague always knew—not just who was in charge, but who was more open and who better to approach first. That turned out to be very very useful and helpful. I don't think [UN agency] would have been able to do much without him and his connections. And people respected him. People looked forward to working with him. So that really helped".

An RH consultant with a small international agency in Haiti discussed the importance of pre-crisis relationships in terms of trust-building as well as feeling heard and validated outside of the competitive Working Group setting:

"Knowing people was very important to build trust. And to have comfort. The ability to be yourself and not be shy and not think that someone else is being more effective, doing it better or getting there first. For me, knowing a couple of people there already was such incredible comfort. To just feel comfortable speaking Creole in front of everyone, or doing a little bit of French and making sure you weren't making a fool of yourself. That wasn't my concern so much but it was that you are heard, and respected, and I trusted people to do that, to be respectful and not, you know, think they were doing better".

She went on to describe the value of informal relationships and friendships, and the impact resulting from a loss of those connections:

"Success is so much about personalities and personal connections and the desire to work together and the social desire to be together. The most successful collaborations I've had is because we like each other, personally, not because we worked together necessarily. Usually it's because the other RH person and I get along. My best Haitian colleague left Port-au-Prince and because of that our RH team and programme is very

weak right now. Because what drove it for the past eight years was our friendship, the power of that relationship. And now I'm kinda stuck actually. And that was a relationship that existed long before the earthquake. Now we are trying to work with people who are newly added to the team and it is not as strong. We don't have the personal connection. Now I don't know what to do".

In addition, a women's health coordinator with a national NGO in Haiti described the advantages which pre-existing relationships and networks had brought:

"People who arrived in Haiti after the earthquake and wanted to do good but just landed on the ground and had no idea where to start. A lot of that was just about that I had relationships and knew where things were…I did have knowledge and history there and quickly became very grateful for the level of access that I had working with [my local NGO]. I didn't recognise prior to that how important and unique that was. I knew who to call, how to get thing through customs. I had fluent Creole. I worked with a Haitian organisation which had good relationships and good access. And that was helpful".

She noted the challenges of bringing in international actors who were unfamiliar with the operating environment:

"To bring in all new staff specialised in reproductive health in that environment—even people who had been in disasters all the time—I would say that in PAP [Port-au-Prince] it was a very extreme environment in Haiti, which is already a very complicated place to work. It didn't work to have people who don't know Haiti at all to have them wandering around to different sites in that environment. Had they known something about those expectations, what it ought to look like, maybe that would have been helpful. I would have liked to see that".

<u>*Leaders act as champions*</u> → *Modified from Individuals act as champions*

Romzek et al. (2013) propose that socialising accountability is enhanced when individuals "go beyond the call of duty" to ensure services are provided to affected communities (p. 13). They did not include this behaviour in their preliminary model (2012) but added it after further research.

They argue that individual champions who are in "pivotal positions" reinforce socialising accountability (p. 14). Although they conclude that staff turnover of champions in leadership

positions particularly undermines socialising accountability (p. 18), they do not conversely propose that individual champions must be in leadership positions in order to have a significant impact. Indeed, the example[34] they provide suggests that "pivotal position" is relative and implies that anyone can act as a champion.

In my research, however, informants stressed that champions specifically in formal leadership positions were critical to either reinforcing or eroding socialising accountability. Indeed, good quality leadership is increasingly recognised as an essential component of a successful response in the international humanitarian sector (Buchanan-Smith & Scriven, 2011; Featherstone, 2010; Knox Clarke, 2013). Leadership is one of the four key pillars[35] of the Humanitarian Reform process: the second pillar requires commitment to strengthening the Humanitarian Coordinator role, which is designed to enhance accountability though effective leadership.

In the context of the two case studies, "leader" refers to the Focal Points for the RH coordination mechanisms as well as those in senior management or leadership positions, such as the Country Representative or Assistant Representative of a UN agency. Outside of the RH Working Groups in the informal sphere, leaders did not emerge, according to informants, and collaboration was generally non-hierarchical.

Effective and respected leaders employed strategies specifically to increase group socialising accountability. Champion leaders in both settings emphasised information-sharing, consistent engagement with members, conflict management, and collaborative

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[34] Romzek et al. describe what makes up an individual champion: "In our study, these [individual champions] can be caseworkers or individuals who occupy pivotal positions in the collaborative network, such as county administrators who oversee multiple agencies or family court judges. One respondent captured the notion of the champion as follows:

> *'If you've got someone who's real vested in it, whether it's the foster care worker, or the family, that's done a good job of tracking a kid's history, advocating, keeping up on it, real case management type stuff. [The individual] doesn't necessarily have to be a child mental health worker or foster care worker, [just] someone, ONE key person who's been pushing it, who's been advocating. It's the old squeaky wheel. . . . Sometimes you get a sympathetic foster care worker who puts a lot of extra time into that family.'"*
> (Romzek, et al. 2013, p. 14. Emphasis in the original.)

[35] The four pillars of the Humanitarian Reform process include: (1) establishment of the Cluster Approach to streamline the coordination of humanitarian assistance; (2) strengthening leadership though the Humanitarian Coordinator system; (3) ensuring adequate, flexible and predictable humanitarian financing through the creation of the Central Emergency Relief Fund (CERF); and (4) building partnerships between UN and non-UN humanitarian actors (UNOCHA, n.d.).

problem-solving to enable cohesion and integration among Working Group participants. Informants found that outgoing personality, commitment, innovation, and imagination were also critical leadership traits. In both settings, champion leaders reached out beyond the Working Group members to bring in others from community-based organisations and government agencies and nurtured them.

Organisational champions, particularly the agency designated to lead the RH response, are important to effective service implementation. The lead RH agency in the respective crises supported the establishment of a Focal Point to facilitate the coordination of the RH response. Further, the behaviours and attitudes of this lead RH Focal Point and other senior leadership were critical to advancing both socialising accountability and strengthening the RH response. Respondents in both settings remarked that the Working Groups would not have been effectively established without the leadership of these individuals. For example, a roving operations officer in Haiti said:

> *"Until [the first RH Focal Point] showed up on the scene, it was like no-man's land with reproductive health. I truly believe there would not have been [a reproductive health working group] had she not been deployed. This wasn't something that was coming down from the PAHO Health Cluster coordinator saying, UNFPA please send someone because we need to get this up and running. Absolutely not".*

In Myanmar, informants described the leaders of the RH response as strong. The primary Focal Point for the Technical Working Group remarked how champion leaders enhanced group cohesion:

> *"Leadership played an important role to make them unite, active, motivated, and worked together".*

A Myanmarese assistant representative with a UN agency described the importance of outreach to individual agencies by the dedicated leaders to support cooperation and strengthen the unity of the response:

> *"I think that leadership is very important among ourselves. It takes a committed and strong leader to bring the group together. For instance, in our Technical Working Group, there are some members who only show up certain times and then they disappear. In instances like that we want to make sure we follow up to make sure that they come back to us. And then we try to work with them, ask them what is their problem, why*

aren't they there, to make sure we don't lose them completely. So that kind of follow up is also necessary. I think that goes back to the leadership. If the leader is not keeping an eye on the members, then you gradually lose out".

In Haiti, leadership was particularly emphasised by informants as critical to informal accountability. Informants described the respective RH Focal Points at the onset of the response and five months after the earthquake as strong and effective. A number of weaker leaders facilitated the Working Group between these two Focal Points, whom informants described as contributing to group fragmentation.

An international health adviser to a large INGO, present at the onset of the response in Haiti, described how the first RH Focal Point established the group and brought in key actors:

"I think having [the first RH Focal Point] down there at first was absolutely brilliant. She's just fantastic I have to say. She brought all the kits, she brought all the forms, and she sat down and said we are going to have a reproductive health coordination meeting whether the Health Cluster decides or not! That was good, that was fantastic. And she spoke French as well which helped with her connection to the Ministry of Health. She dragged the Ministry of Health guy to the meeting! That was all brilliant".

The Focal Point of the Working Group five months after the earthquake was also described by informants as a champion leader and important enabler for socialising accountability and group cohesion. She increased trust and information-sharing through requesting Working Group members to conduct formal presentations of their work in which they described both successes and weaknesses of their programming, highlighting the importance of innovation and creativity in effective leadership.

From the perspective of the RH Focal Point, the significance of the personality of the Focal Point in developing strong relationships with group members was a key factor:

"I'm [a] very open and friendly person, and it made it really easy for me to create these networks of people in [a] very informal way. And I think the success of the Working Group was because, I have to say, I developed very humane relationships. People were attached to me. Even now I still get emails from people asking me how I'm doing".

She went on to describe how she led an informal coordination group outside of Port-au-Prince and reached out to small groups to participate, reflecting champion behaviours:

> *"I also did a Working Group in Léogâne. It was not really formal, just four or five INGOs. MSF went around to all health centres to see how many and how small they were. They developed that list with the phone numbers and I called every single one of them, explaining to them what the Working Group was, that it was a place to express the problems they were having. They had never been reached out to, and a lot of people came. Some people had to take two buses and walk a number of miles and they came. I'm really, really proud of that Working Group in terms of coordination".*

Finally, she described her relationship with the Working Group members, highlighting how good leaders can foster personal relationships and build individual and group trust, which underpin socialising accountability:

> *"I don't know if it's true for all the sectors, but in terms of reproductive health, maybe because I am a native of Haiti and speaking Creole and being open and friendly person, I definitely made a lot of connections and things were done not because I officially asked. People just did things and I know it was because I created that relationship. On my last day I cried, and the Ministry of Health rep came and surprised me, and he doesn't usually come to the Working Group. He came and felt like I had a connection with a lot of people. And we felt like a family in that Working Group. And people do more things for each other when you feel that way. They understand the importance doing the networking; it became instinctive. I'm not sure of other settings, but I would reinforce non formal networking has a big role for each other and the population".*

<u>*Extending favours and asking for help*</u> → *Modified from Extending favours*

The data from this research support Romzek and colleagues' assertion that giving and repaying favours reinforces socialising accountability. In the context of an RH response in a humanitarian emergency, the RH Focal Point is tasked to help and assist others. However, members of the RH coordination mechanisms in both settings, not just the Focal Point, voluntarily provided favours and support for each other without a formal contract.

In the context of the two case studies, certain behaviours among individuals participating in the RH response might be classified as "favours". Yet the expectation of reciprocation as result of the favour was not evident, as explored above. A corollary to extending favours is

asking for help. Favours are often provided upon request by others. Requesting assistance reflects a safe interpersonal space in which expressions of vulnerability are welcomed, thus cyclically feeding back into the social norms of trust and supportiveness and thus strengthening socialising accountability. Romzek et al. (2013) do not highlight the behaviour of "asking for help" and focus only on extending favours; yet findings from this research indicate it is useful to draw out this aspect to explore further.

In Myanmar, informants reported that providing favours and asking for help were commonplace. One Myanmarese UN official gave an example of how she responded to a request for training assistance:

> *"Many organisations have interest in maternal health care and MDM are not our partner but they request through the Health Cluster meeting that they are interested people and they contact us by e-mail and they requested training for their new staff. So I organised a five-day training for all MDM staff".*

In Haiti, in the initial weeks of the response, the first RH Focal Point noted that members felt comfortable to ask for help:

> *"In the beginning I felt that people really shared and wanted to know if they were doing the right thing and that they had a place where they could refer and work together. But I don't know what happened after I left".*

However, respondents commented that group cohesion quickly disintegrated as Focal Point turnover was rapid and new Focal Points were put in place. The lack of trust in the RH Working Group that ensued undermined members' ability to ask for help and thus for others to extend favours in return. Nevertheless, asking for and responding to help manifested outside of the Working Group context. A women's health manager with a local NGO discussed how the Working Group provided a space in which to make initial connections, with requests for assistance occurring outside of meetings:

> *"Sometimes it was as basic as JPHRO [J/P Haitian Relief Organisation] called me and I had met a rep of theirs at a Working Group meeting. They were transitioning to trauma care clinics for the populations and they said, well, we just need some help, we need some help thinking through this, can you just come for a day to be with us. So we went. For a day a colleague and I went up to see them and spent the day with them and they*

showed us what they were doing and how they were thinking about staffing and supplies. And we shared information. So a lot of it was informal".

A senior health adviser from an INGO reflected that her agency both requested and provided help in the informal sphere:

"I remember [NGOs] coming to our office and asking us for help. I remember one who was very off line—a group that was doing traditional medicine or whatever—so the level of responses was varied. But when people did come through we did share whatever we had in terms of guidelines and other material. I think people were open to listen to get advice and what have you. And the same for us, we went out of the way to get any materials that others were using, like EmOC policy. We had to go around looking for who had it. So I think having that informal level is important and much more effective because we can look for specific information where in the Working Group meetings we wanted to get in and out of the UN compound! That was everyone's concern. And we didn't want to ask some questions as well—they had the agenda and they wanted to get through it. I think the informal is actually a good source of information".

~~A~~ number of informants noted that they wanted to offer assistance to other agencies, but did not have the capacity to do so due to lack of time and resources (further explored below).

Six months after the Haiti earthquake the RH Working Group stabilised with more consistent membership and a strong Focal Point. Requesting help and receiving favours moved into the formal coordination space as trust and mutual supportiveness among members developed. The Focal Point at that time gave an example:

"[*In the Working Group] one NGO said, I have this problem, then another NGO said, we can train you for that, we can train your nurses, we can help you. It started to be really creative among them instinctively".*

New factor: Informal collaboration

Research findings suggest that another key behaviour, closely related to extending favours and asking for help, is *informal collaboration* among partners. This is distinct from performing favours, which involve an imbalance: one partner is in need and another provides assistance. Collaborative partners, on the other hand, both benefit and contribute.

Agencies decide to work together to further their goals, rather than request or provide assistance from others. Romzek et al. (2013) do not make the distinction between informal collaboration with partners and favour-giving. However, the findings from this research highlight the importance of differentiating the two concepts to distinguish the ways in which both behaviours support socialising accountability. I explore this issue below and justify why this additional factor deserves attention and naming.

Informal or non-contractual collaboration between agencies was commonplace in both case study settings. Collaboration often resulted from agencies sharing information, identifying gaps, and then strategically deciding to work together to address them. Examples include joint advocacy, establishing referral mechanisms, and supporting one another's direct service delivery.

In Myanmar, collaborative efforts were spawned both within and outside of the Technical Working Group. A Myanmarese INGO programme manager said:

> *"In [the Technical Working Group], we have to do something together like translation, documentation. [Then] we feel accountable between us. And sometimes not. If we are working together, then we have accountable to other team members".*

An international INGO country director in Myanmar explained that she met with representatives from other NGOs providing RH care and they collectively decided to pool their funding to establish a referral system for emergency obstetric and newborn care. A Myanmar RH Focal Point provided an example of how information-sharing and joint advocacy helped advance MISP implementation:

> *"In the [Technical Working Group] meeting, every member raised issues from the field and find* [sic] *the collective solution and segregate the role and responsibility through coordination on ground. For instance, ART [anti-retroviral therapy] prophylaxis for sexual violence survivor were not in place in Township hospital. UNFPA coordinate[d] with NAP [National AIDS Programme] and other members raise[d] awareness of ART where it is in place and link[ed] with TMO [Township Medical Official] in the field to be able to use this".*

In Haiti, collaboration was primarily initiated outside of the Working Group context. As a result, RH actors had to deliberately seek out others for collaboration. An RH consultant

with a small INGO illustrated how she facilitated informal collaboration with the MoH to support emergency obstetric and newborn care services:

> *"We were just so small and so poor and so limited in terms of staff. It was just a matter of deciding that clinical issues were priorities—when people would come into our clinics we had to treat them. We had to immediately set up collaboration with a facility to take our emergencies. That was not in collaboration with NGOs, but with existing MoH facilities. I knew that was a model that could work. We ended up having a decent relationship with the local maternity hospital".*

Finally, an international senior RH adviser in Haiti highlighted the importance of collaboration for MISP implementation:

> *"Ideally is to work with other organisations, local and international, to do the whole thing in a collaborative way. I think it's the only way to do it. Each organisation doesn't have all the skills, or all the capacity. It kind of sets up you up for failure. You just can't do it on your own. We all need to be collaborating together".*

New factor: Giving and receiving constructive criticism

Accountability involves calling others to account. In a social context, this entails providing critical feedback regarding others' behaviour. Questioning others about their actions and responsibilities is essential to enhancing socialising accountability; indeed, it strikes at the heart of what makes someone accountable. This confrontation is often the most challenging behaviour as, unlike formal mechanisms, frameworks for holding someone accountable are not in place. Individuals must creatively and strategically decide how to hold others to account in an informal, peer-to-peer manner. Actors in both case studies found innovative and comfortable ways to do so.

Romzek et al. (2013) do not include providing critical feedback or calling others to account in their model. The data for this research clearly demonstrate that sensitive, appropriate confrontation is critical for enabling socialising accountability and for supporting successful implementation of services.

In both settings, critical feedback was not given publicly. A gentler and more diplomatic approach was employed to minimise potential defensiveness of the feedback recipient. In

Myanmar, a Myanmarese senior UN official explained how she and her colleagues patiently addressed agencies that had an ineffective, hierarchical orientation:

> *"If you need rice, but if I give you a blouse, you don't need this one. It is not appropriate. We need to listen to our beneficiaries and their coping mechanism. A bottom up approach, not a top down approach. But [some agencies] have some misunderstanding or misconception, some harmful behaviour. We need to make the correction. But we cannot force—they cannot change abruptly. They can change voluntarily and gradually by themselves. But we need to provide the correct way on how to make changes".*

A Myanmarese assistant representative from another UN agency described her agency's strategic approach:

> *"In the [MISP] training, there are certain standards to be followed, and certain key messages to give out. So we trained humanitarian actors and related government ministries on MISP. And we have members [in the Technical Working Group], and we wanted to make sure the trainings are properly conducted. If anything is out of line, we don't openly criticise. We would sit down with each member and say, let us review how this training went. Shall we do it this way, that way, et cetera. Of course we don't fight in front of everybody, but we need to have this supportive role so that if any wrong messages are given out, we can make sure the messages get corrected so that in later trainings they will not give out wrong messages. So that is normally how we do it".*

At the onset of the RH response in Haiti, however, critical feedback was provided informally as the norms to support socialising accountability, such as trust and mutual supportiveness, were weak in the Working Group. An international RH adviser with a large INGO contrasted her experiences with criticism inside and outside of the Working Group meetings:

> *"I don't recall much critical feedback [in the Working Group]…People weren't very honest, I don't think. Not in the meetings. There was a lot of side talk away from the meetings where people were more honest. But I think in the meetings they listened but there was not a lot of constructive criticism in the group. They wouldn't voice their opinion. If they heard something they didn't like or they didn't agree with, they would just go ahead and did their own thing rather than question or challenge something. We usually stayed after the meeting and then talk and divide something and email or phone call and then meet in the field. It was dependent on time—what they could arrange. We could offer more critical feedback then".*

An international women's health coordinator with a local organisation in Haiti commented that critical feedback may have been welcome in the Working Group, but that the leadership did not foster it:

> *"For those who came in from the outside, who had been in Aceh, they had a vision of what that looks like. Haiti is full of small fragmented groups, with mission [faith-based] groups, and with those folks, there was no saying, this is what you need to do. I actually feel that people would have been responsive to that level of leadership and direction because most people were trying to fill the gaps. They wanted to help. They were doing the things they knew how to do whether they were the things that were needed or not".*

As noted previously, the Working Group in Haiti became more cohesive and supportive over time. As a result, constructive feedback was increasingly welcomed by members. A Haitian RH Focal Point described her approach to facilitate socialising accountability:

> *"[We were] able to give feedback in the Working Group. It became that way over time. But we needed to be careful on how to give feedback. You don't want to insult anyone either. We did it by theme if we didn't have enough information. If we did GBV not well, then a GBV person would come in. Whoever was best placed to give more critical feedback, on top of the other agencies who were also able to give. Then HIV, bring HIV person in, then youth. I'm not a specialist but I can facilitate, see what's needed—bring technical people. Make it possible for them to do what they needed to do".*

8.4.3 Rewards

Individuals who are compliant with social norms and behaviours that support socialising accountability reap benefits for their participation. Romzek et al. (2012) outline socialising accountability rewards including *receiving favours*, *opportunities for future collaboration, public recognition and enhanced reputation,* and *advance notice of key information* (p. 447). I explore the findings from my research against these categories and add an additional type of reward: *impact* (Figure 8.2).

Favours

A benefit of participating in socialising accountability-enhancing norms and behaviours, such as extending and asking for help, is *receiving* help. Informants described a variety of rewards they derived from participating in the informal social network created by RH actors.

Common examples include receiving programmatic support including free training sessions. A consultant in Haiti described how a colleague from another agency spontaneously offered to help with a camp survey during an informal dinner. In Myanmar, a programme manager from an international development agency expressed the importance of receiving favours:

> *"We received a training on how to implement RH activities. We didn't know what to do especially when people are just trying to survive… It was very encouraging for us to have them at that time".*

Other examples of rewards include receiving critical information about logistics, such as where and how to procure materials and how to navigate bureaucratic hurdles. In both settings informants described the importance of receiving guidance on ordering and using the Interagency RH Kits, which in Haiti was particularly challenging given the burdensome procurement process for medical supplies.

Additional rewards relate to recommendations on hiring staff and facilitating connections. A women's health coordinator with a national NGO in Haiti described how others profited from her informal help:

> *"So talking to them about basic services, about what Haitian staff they had, because maybe we knew somebody, or we knew somebody who knew somebody who knew somebody, like, oh you're in Carrefour, we know people there. Or you should really talk to this group that's already there. So we did a lot of that informally".*

Future collaboration

Building strong relationships by abiding by social norms and engaging in supportive, responsible behaviour may be rewarded with useful collaborations in the future. Participation in socialising accountability mechanisms can lead to the development of formal partnerships in contracts, such as a Memorandum of Understanding or a grant. For example, a Haitian national working with a small INGO consistently reached out to UNFPA, which later hired her as an RH Focal Point.

In Myanmar, participation in inter-agency coordination and engaging in behaviours that support socialising accountability had significant impact on future collaboration. For example, UNFPA was impressed with the participation of an NGO in the RH coordination mechanism at the field level and later asked them to be a partner. In addition, agencies

forged exceptionally strong relationships during the Cyclone Nargis response and this benefited the response in future crises. A Myanmarese assistant representative with a UN agency explained:

> *"We are now better coordinated. We have a better system. We know who is doing what. We can draw on different expertise and also know who to tap for what services. So that is why we are in a better position now responding to [Cyclone] Giri and to the earthquake in 2011".*

An RH Focal Point also described how agencies continued to collaborate after the Cyclone Nargis response:

> *"To compare with condition before Nargis all members became more close [to] each other and even though they were separated after, they still have communication and asking help from each other. Networking is still running among INGOs and local NGOs, but I am not sure among UN agencies".*

Public recognition & enhanced reputation

Public recognition by peer agencies, especially those with high standing, can boost an organisation's reputation (Romzek et al., 2012). Increased social standing is particularly useful to secure additional funding from donors. The rewards from peer acknowledgement were evident in Haiti, although not in Myanmar where public recognition was not mentioned by informants or noted during observation.

One Focal Point for the RH Working Group in Haiti explicitly sought to build cohesion among Working Group members and asked each agency to present on their work to date. This provided an opportunity for them to showcase their accomplishments to colleagues. Representatives from national agencies often had a difficult time speaking in coordination meetings, and presenting gave them a more structured opportunity to do so. In addition to enhancing agencies' reputation, the presentations helped increase members' self-confidence, enabled problem-solving and collaboration, and helped build trust and cohesion in the group. Again, this reflects the cyclical nature of how rewards, behaviours, and norms reinforce one another. The RH Focal Point explained the impact of members presenting to colleagues:

> *"In May, five months after the earthquake, I took over the coordination and by June started to get [Working Group members] to do presentations. I gave them different*

dates. Now, since it's been several months since they've been there, they felt somehow more prestigious to do a presentation. They had fancy slides. Even other agencies that were not doing RH were coming. Instead of going around the table, we would give formal presentations and then discuss—who had similar issues, activities, advice for others, could they participate. It was helpful at facilitating each other in our work…I feel doing a presentation—feeling valued, then connecting more with each other—that's how I feel we became a family".

Advance notice of funding and related opportunities

Romzek et al. (2012) suggest that an important reward for participating in socialising accountability processes is receiving advance notice about possible funding opportunities (p. 447). Although this may have manifest in the case studies, none of the informants referenced this benefit.

New factor: Long- and short-term impact

The ultimate objective of humanitarian action is to save lives and alleviate suffering (ReliefWeb, 2008a). Romzek and colleagues did not include in their framework what I found to be the most important reward as a result of engaging in socialising accountability mechanisms: impact. This research indicates two kinds of impact: immediate programmatic impact and longer-term systemic change. These reflect the two parallel goals of humanitarian actors: effective agency specific interventions (such as implementing a programme to prevent HIV transmission) and achievement of broader objectives of the response (such as meeting the RH needs of the affected population.)

Regarding short-term rewards related to effective programmatic implementation, a local doctor in Myanmar highlighted the role inter-agency advocacy played in the legal prosecution of a perpetrator of sexual violence, a rare success:

"Survivors don't come in time. There was one case of father-daughter rape and the mother took her to the clinic because she was pregnant. And now the father is now in prison for rape… Coordination between the agencies working together helped successful prosecution".

In regard to short-term rewards in Haiti, a few informants noted that women's lives were saved as a result of collaborating with and relying on other agencies for emergency obstetric and newborn care services.

In terms of achieving longer-term, systemic change, formal and informal inter-agency networks that reflected socialising accountability played a critical role. A Myanmarese senior UN representative described how engaging members of the government in the RH Working Group acted as a form of advocacy to advance gender equity:

> *"We had a lot of problems [with the government] before, but now we can discuss freely and the government is very receptive. Why? Partly due to advocacy. The government has always been with us through the Technical Working Group. They participate most of the time, not every meeting. I think these have opened their minds. Since then we have achieved a lot. I always tell everybody Nargis was a blessing in disguise because before we were never able to bring up gender to the government".*

Indeed, informants reported that the MISP is being integrated into Myanmar's National Reproductive Health Strategy, which they in part attribute to the participation of government representatives in the RH Technical Working Group.

In Haiti, informal and formal collaboration and networking among RH actors enabled putting RH on the humanitarian agenda of the broader response, a significant impact. A Haitian national and RH Focal Point reported:

> *"The reaction to reproductive health by other UN agencies is for it to be a backseat. Since the earthquake, reproductive health got a lot of publicity, got noticed. Seemed easier to get funding for it than previously. It just seemed that maternal health, pregnant women, became something of interest…To go back to the informal thing, reproductive health gained credibility and validity as an important theme through the Working Group. We were able to spread the word a lot".*

8.4.4 Sanctions

Sanctions are an important element of accountability systems as they impose consequences for behaviours that are not in accordance with agreed norms. Concern about possible sanctions, even in an informal context, can be a motivating factor to adhere to

group expectations and thus reap the benefit of that participation. Indeed, Schillemans (2008) argues that heavy handed formal sanctions may backfire, but that "weaker" sanctions, such as public shaming, may have more effect (p. 178).

As explored in the previous chapter, enforcement mechanisms for formal accountabilities are limited in humanitarian action. Imposition of socially-based sanctions may be more effective in certain circumstances, or may enhance the activation of formal accountability mechanisms. Questions specific to sanctions were not asked of the informants in Phase II. However, some informants did reference what can be interpreted as informal sanctions.

Romzek et al. (2013) describe three examples of informal sanctions: *diminished reputation, loss of opportunities* such as funding or collaboration, and *exclusion from information networks.* These sanctions played out to varying degrees in the two case studies. The primary informal sanction reported by informants and observed during data collection was withholding information from groups that engaged in behaviour incongruous with the social norms set forth by RH agencies.

In Myanmar, the RH leadership made significant efforts to engage organisations and create a culture of inclusion among agencies involved in the Technical Working Group. Sanctions were referenced only in regards to government representatives. Many informants reported feeling uncomfortable sharing information or voicing opinions during Working Group meetings when government officials were present, particularly on issues related to sexual violence. Viewed through a socialising accountability lens, government officials were deemed untrustworthy, as they could punish agencies through intimidation and revocation of funding for programming that they considered inappropriate. The government representatives were thus informally "punished" by being excluded from receiving information about the crisis response.

In Haiti, informal sanctions primarily manifested through the exclusion from information networks of groups that were providing inappropriate services as well as those that did not seek out or were not receptive to guidance on humanitarian standards. Many of these agencies lacked prior emergency experience. Perhaps as a result of this inexperience, they did not prioritise inter-agency relationships and did not participate in norms and behaviours

that support socialising accountability. As a result, they were excluded, and in some cases actively shunned from informal networks and information-sharing processes.

An international operations officer working on RH in Haiti discussed how some groups undermined the response and were thus specifically avoided:

> *"The Scientologists were all over! John Travolta had chartered a plane into PAP [Port-au-Prince] from the very beginning and put 18 scientologists on it. They were at the [general] hospital wearing their yellow t-shirts and trying to do energy healing or something like that. They required a huge amount of energy and resources to get them out of our way".*

This example also highlights the importance of agreed minimum standards for effective engagement.

An international RH adviser with an INGO in Haiti described how some agencies with inappropriate priorities were not sought out to participate in the informal networks and simply left alone:

> *"People were coming and doing a lot of odd things or extremely random—it was very weird…They were trying to do more advanced stuff, like breast cancer screening or uterine screening. Just really odd, really high level things. We were like, we just want to implement the MISP! We just want to give out clean delivery kits… It was like cliques. You had a few groups, like those who really wanted to do MISP, and then you had groups who really wanted to do other things".*

However, other agencies did not participate in certain key social norms and behaviours but did not incur sanctions, either. For example, as noted previously, MSF in Haiti offered above market salaries for midwives, thwarting not only other agencies from hiring local midwives but also contributing to the disruption of the local economy. Further, informants reported that one of the interim RH Focal Points in Haiti—employed by UNFPA—focused on the provision of emergency obstetric and newborn care to the exclusion of other life-saving services of the MISP. Despite significant frustration on the part of other RH actors, these agencies did not face informal sanctions due to their relative power and political weight.

8.4.5 Challenges to informal accountability

A variety of external and inter-personal factors can challenge socialising accountability. Romzek et al. (2013) identify six primary barriers: *staff turnover, competition, financial pressures, tensions between formal and informal accountabilities, gap between rhetoric and reality*, and *hierarchy.* Based on the findings from the two case studies, I modify hierarchy within a cultural context and broaden the category of tensions between informal and formal accountability to include *competing accountabilities;* I also extend these challenges to include: *political barriers*, *lack of shared goal*, *poor leadership*, and *overwhelming workloads* (Figure 8.2). The significant number of additional challenges identified may, in part, be attributed to the humanitarian context in which actors face numerous accountabilities and must navigate a difficult operating environment.

I exclude fiscal pressures as this did not emerge from data analysis. It should be noted, however, that the lack of financial constraints in the two case studies is an aberration as inadequate funding is a common source of inter-agency competition in emergencies (Kent, 2004) and a primary challenge for RH implementation (Vann, 2012).

The conclusions below are reached primarily as a result of data analysis from the Haiti case study. In Myanmar, socialising accountability was not challenged to a significant degree.

A women's health focal point with a national Haitian organisation poignantly expressed a sentiment regarding the overarching inter-agency coordination challenges in Haiti that was shared by a number of respondents:

> *"I remain deeply deeply saddened by the missed opportunities. There was a moment in the [RH Working Group] and in the coordination when I felt a tremendous sense of hope that this terrible event was going to somehow lead to significant change. Overall in Haiti but specifically in RH and visibility issues for RH for women and girls. There was so much will, so many passionate people, talking to each other for the first time ever. I also was able to spend a lot of time in camps and with the women's groups in PAP [Port-au-Prince] and it really was quite inspiring to see how much human capital and intellectual capital was already there. And it was a question of how do we coordinate it and get it to work together. I was really saddened by the fact that that didn't happen. In retrospect*

maybe it was Pollyanna-ish to think that it really could given the huge burden of destruction that happened all around. But I definitely had that feeling for a little while".

Staff turnover

Romzek et al. (2012) assert that the stability of successful inter-agency coordination mechanisms is contingent on the consistency of its participants (p. 449). Repeated social interaction over time builds bonds among members that enhance trust and socialising accountability; conversely, high staff turnover erodes trust and thus retards the enactment of accountability to peers (Romzek et al., 2012). The negative impact of the ebb and tide of humanitarian actors was evident in Haiti although not in Myanmar where the majority of RH actors were Myanmarese nationals who consistently participated in the Working Group.

In Haiti, all informants reported that one of the biggest challenges to accountability, and to the response broadly, was the rapid turn over of staff, particularly those in leadership positions. Despite the strength of certain RH Focal Points, their respective assignments were short-term with five Focal Points appointed over the course of four months. One health adviser with an INGO confirmed:

"It was lack of leadership, definitely lack of leadership—that was the key issue. The people that were in charge were changing constantly".

The influx and exodus of health agencies contributed to the continuous shifting of Working Group membership. For the first five months after the earthquake the majority of the participants were internationals with short-term contracts. One UN official in Haiti noted the impact:

"*When agencies themselves are not stable, then the response is not stable".*

The exclusion of local Haitian actors from access to the UN Log Base where RH Working Group meetings were held exacerbated the problem. Their consistent participation later in the response—given their limited staff turnover as local nationals—helped stabilise the group.

The flow of information was disrupted as handover processes were not prioritised given competing accountabilities. One of the RH Focal Points commented:

"High turnover was extremely frustrating. One of the major issues for the first five to six months. You would make these relationships and then the person would have to leave. Then you'd have to start to know people all over again. You'd get tired having to summarise, to discuss everything. That happened so many times. Just really really high turnover".

As a result, trust within the Working Group could not take root given the continuous flow of new people. One Haitia UN representative remarked:

"I do feel to have social accountability in Haiti was difficult because the human resource was too inconsistent".

The high staff turnover also contributed to the lack of commitment and follow through. One of the Focal Points of the Working Group in Haiti elaborated:

"NGOs failed to see—as much as they were in crisis about whether they would get funding and who they could work with—was that there was crisis with UN agencies too, the high turnover of staff in UN agencies. None of the interim people wanted to commit to anything, which was unbelievably frustrating".

A women's health coordinator with a Haitian development agency was unfamiliar with humanitarian relief work and struggled with the turnover:

"Having not have worked in emergency response, I didn't understand that there are specialised teams and thinkers, and that you have your emergency response, and then your transition response and there is a huge amount of turnover of personnel which for me was very very challenging to keep up with. I could not figure out who was coming, who was going".

An international senior RH adviser with many years of emergency experience also found the situation in Haiti particularly challenging in terms of human resources:

"The [RH] Working Group was just too big. There were too many players. In these big, mega emergencies, there are always these people who pop out of the woodwork and who knows what the heck they do. You'd go to these meetings and they were just ginormous. Nobody could get a word in edgewise. People would just go on and on and on. It wasn't getting anything done. It was people saying they were going to do things. And things never did happen".

However, as a result of the high staff turnover and lack of trust in the Working Group, informal networks flourished as actors found value in casual collaboration. The same informant continued:

> *"In the smaller groups, it was easier to plan, but then it would be discussed at the next meeting if that was actually going to happen. It fed back into the Working Group, but it was in the smaller groups to get anything accomplished. I think there was a general frustration with so many actors, so many people not doing anything, so much lack of experience".*

Competition

In their 2012 preliminary model on informal accountability, Romzek and colleagues primarily frame non-profit competition within the context of an inter-agency struggle for funding. Although the findings from Myanmar suggest some competition regarding funding was present, financial support for both emergencies (during the time parameters of data collection) was robust, which helped minimise competition in this regard. In their expanded model, Romzek et al. (2013) include "turf battles" in the competition category, which better reflects the way in which competition manifested in the two case studies, particularly in Haiti.

The data from Haiti suggest that competition extended beyond the financial and played out as rivalry for institutional visibility. Indeed, a multi-country survey on collaboration among humanitarian actors suggests this is not unique to the Haiti response: "In an effort to gain a competitive advantage, [humanitarian] agencies may withhold information about needs assessments, security, lessons learned, and successful strategies" (Parmar et al., 2007, p. 416). An assessment of the Indian Ocean tsunami by NATO also documented that competition and "turf wars" for visibility among humanitarian INGOs eroded coordination and cooperation (Huber et al., 2008, p. 19).

In Myanmar, informants noted that in the broader response, UN agencies competed for shares of available funding, such as CERF. However, among the RH actors, inter-agency competition was minimal. An RH Focal Point said that although some competition for funding existed among NGOs, "I do not think coordination was affected".

A Myanmarese assistant representative from a UN agency in Myanmar explained her agency's efforts to explicitly minimise competition:

> *"We see competition as very dangerous as this will divide the dynamics of the group and it will create non transparency among ourselves. So we also shared among ourselves, who is going to ask what donor and for how much. That is what I mean by transparency. By keeping it all open and making sure everyone else knows what is going on, that can help reduce the competition… But you cannot totally eliminate it out of every member. I'm sure some members feel competition but we try our best to eliminate that because that is not a very healthy attitude to have among us because we have one goal only, the goal is to help the affected community".*

In Haiti, respondents reported that competition for funding was nominal given the significant funding that poured into the response. Yet competition for visibility was widespread. The unprecedented level of scrutiny from the media and the unprofessional commentary from the broader public, with limited understanding of the realities of humanitarian response, contributed to agencies jockeying for position. A RH adviser with an INGO remarked on the publicity:

> *"I think these big super emergencies are a huge issue, and I don't think the Clusters are able to deal with them. The publicity, the social pressure—we had so much media pressure…There was all those celebrities criticising the NGOs".*

The close examination of the response fostered lack of trust, information-sharing, and transparency among agencies, and undermined socialising accountability. Human Rights Watch (2011) noted that in the Haiti crisis, "Some NGOs undoubtedly do not want to advertise their ineffectiveness or inefficiencies" (p. 70).

One of the RH Focal Points in Haiti described the intensity of the competition:

> *"Actually it was really a competition about the survival of an NGO in Haiti. So if you don't know what I'm doing, you are going to think I'm doing something important. You think you are going to need me. It was a competition for funding and for image, to be seen, to be visible. There were so many people; it's easy not to be visible. You wanted to be the agency known for doing a, b, c".*

She noted how the competition compromised risk-taking and lesson-learning, fundamental aspects of an effective humanitarian response:

> *"Because of all the visibility of humanitarian response, people are more careful of the risks they are willing to take because the next thing you know it's going to be in the news a lot more and faster than development activities".*

Competing accountabilities → *Modified from Tensions between formal and informal accountabilities*

The expanded model of socialising accountability includes tensions between formal and informal accountabilities as a common inter-agency challenge. Indeed, Kenis and Povan (2007) suggest that a primary difficulty to successful networks is balancing organisational and network objectives. Humanitarian actors are plagued by a disproportionate number of organisational, inter-agency, legal as well as interpersonal accountabilities that are formidable, and at times, impossible to reconcile. I broaden this category, which juxtaposes formal with informal accountability, to *competing accountabilities:* that is, tensions between formal accountabilities or even tensions between informal accountabilities—such as personal versus socialising—can all undermine socialising accountability. Challenges to socialising accountability due to accountability tensions strongly manifested in Haiti, though to a lesser extent in Myanmar.

In Myanmar, participants described the multiple accountabilities with which they grappled, although none described this process as insurmountable or even unduly challenging. All respondents stated they felt responsibility toward crisis-affected communities as well as a strong sense of accountability toward fellow Technical Working Group members. Nonetheless, challenges to socialising accountability due to conflicting accountabilities did manifest. For example, a Myanmarese programme officer with a UN agency remarked on the challenges faced by some of the other group members:

> *"We cannot force them to do all the MISP activities. They will do whatever they can do. It depends on their capacity and funding situation and staff capacity skills. I can say the core members are very much accountable to the MISP. Some are not core members. Their mandate is for livelihoods or something like that—some are HIV or recovery—they may not give the highest priority for the MISP".*

Just half of the interviewees in Myanmar mentioned accountability to their donor, which is surprising given the emphasis on donor accountability in the literature. A Myanmarese assistant representative from a UN agency commented on the tension between socialising and donor accountability:

> *"The thing is that we don't have funds channelled through the group. We are all independent members, so each one of us have our own donors. We don't have one donor to support our group so we work with many different donors. So therefore we all have different accountability issues. If you ask this question to different members, they may have a different idea. They may have a different experience, but yes, we are accountable to donors and need to work within their mandate and within what is expected of us".*

In Haiti, informants described a wider variety of accountabilities to which they tried to adhere, such as codes of conduct and commitments to the MoH and the Health Cluster. Whereas informants in Myanmar expressed minimal vexation at the lack of alignment of their accountabilities, participants in Haiti were obviously frustrated.

A women's health coordinator with a national NGO noted the difficulty of prioritising RH with other emergency needs:

> *"I think the immediate concerns were lodging, wat/san [water/sanitation], emergency surgery, etc. There were so many competing needs that far overshadowed what we were doing with reproductive health".*

One of the RH Focal Points in Haiti noted the direct impact of the tension between donor and socialising accountability:

> "[*Working Group members] could not commit to Working Group goals and collaboration. Their activities depended on funders' interests".*

Lack of alignment between accountability to informants' organisations and their inter-agency accountabilities challenged socialising accountability as well. In Myanmar, one of the RH Focal Points remarked:

> *"There was tension with [the UN agency I worked for], I felt. I would like to travel to field to support township level reproductive heath working group members, give them training on GBV and the MISP. But I cannot do as I would like to do".*

In Haiti, an RH Focal Point working with a UN agency described how the lack of organisational support undermined her ability to effectively coordinate and support partner agencies in MISP implementation:

> *"I was held accountable by my organisation to certain things which I found sometimes conflicted with my accountability that I felt towards the beneficiaries. I was very much aware of trying to get a reproductive health response going, trying to get RH kits into the area and working with partners. A lot of people had asked us for RH kits and were keen to join the Working Group and start talking about how to implement the MISP. And my headquarters was not very responsive to that. And finally when a logistician came he had to set up our office and he didn't have time to help me with the kits which is logistics work. It took up a lot of my time—going to the warehouses, following up with orders, stuff like that. It took about three weeks before I could really focus on the RH coordination. And then my organisation was asking me to make sure we were doing GBV work and they were criticising when I said [another UN agency] was taking care of that. There were a lot of visibility issues and demands from headquarters where I expected them to listen more to my requests".*

Gap between rhetoric and reality

Romzek et al. (2013) add a new category to their expanded model that challenged socialising accountability: the gap between rhetoric and reality. Organisations and institutions may profess their commitment to inter-agency networking and cooperation but do not provide adequate support for success. The field of humanitarian response, particularly UN agencies, has been highly criticised for providing lip service to coordination and partnerships. Despite a plethora of international guidance on inter-agency coordination, this has not translated into systematic practice in the field.

A common tension within the RH sector is the Health Cluster's lack of support for RH services and RH coordination in the field, despite global rhetoric and guidelines to the contrary. In Myanmar, one UN representative recalled:

> *"The chairperson of the Health Cluster said, 'please stop, please stop' when we tried to raise the issue and share some points on RH. They only want to hear what they are interested in".*

An RH Focal Point in Haiti said even the Health Cluster—at the field level—did not receive enough support for coordination, which she attributed to competition and visibility issues:

> *"These big emergencies become a visibility thing at headquarters. And then they seem to forget what the people in the field need. I heard the same thing from WHO. The health coordinator in the field said they didn't even have the administrative staff to support them. Whereas on the ground they were supposed to implement coordination, at headquarters they were doing the visibility game".*

Despite rhetoric at the global level on the importance of engaging both local organisations as well as affected communities in coordination and planning, neither group was integrated into the RH coordination mechanism in Haiti at the beginning of the earthquake response.

Hierarchy and culture → *Modified from Hierarchy*

Romzek et al. (2013) include hierarchy as a new category under challenges in their expanded model. Their description of hierarchy relates to behaviours and attitudes of professionals at different levels within an inter-agency network (p. 18). My research focused on coordination at the field level and did not explore coordination at the regional or global levels. Hierarchy was identified as a challenge to socialising accountability, and, in the context of this research, it relates to social and cultural rankings rather than institutional levels. Romzek and colleagues' research focuses solely in the United States. Given the mixture of nationalities and languages in international humanitarian response, considering the cultural context is in this study particularly important.

The social norms of the broader national cultural context play a significant role in the way socialising accountability is understood and expressed. Bourguignon et al. (2010) assert that "societal culture frames the appropriation of accountability forms either as a resistance factor or as a facilitator depending on the different processes by which accountability is enacted" (p. 22).

Although it is beyond the scope of this thesis to fully explore the intersection of culture and accountability in Haiti and Myanmar, it is well documented that both settings lack formal accountability mechanisms at all levels of government, reflecting widespread corruption and a culture of impunity (Transparency International, 2013). Broadly speaking, neither country is oriented to informal accountability processes, and a culture of challenging authority and

speaking out against injustice is lacking given the repressive political environment in both settings.

Data from the two case studies found tensions between national and international staff, which weakened socialising accountability. National personnel found it difficult to assert themselves with international actors present and sometimes expressed feeling intimidated, despite evidence that this was unintentional on the part of international staff. This can be attributed, in part, to different cultural norms related to the interplay between assertiveness, authority, gender, and economic class. The expression of these cultural differences led to a sense of hierarchy based on nationality. In turn, the development of openness and trust was obstructed.

In both case studies, informants commented that international actors played a useful role in terms of higher level advocacy, providing humanitarian expertise, and fostering egalitarian attitudes and decision-making particularly regarding gender. In both settings, national staff reported that participation in the Health Cluster was especially challenging. For example, one UN officer in Myanmar said that in the Health Cluster, "Our national people cannot say anything there".

In the respective RH Working Groups, however, the experiences in the two settings contrasted sharply. The Technical Working Group in Myanmar had few international staff so issues which revolved around diverse cultural backgrounds did not emerge. In Haiti, the RH Working Group was dominated by international staff, which resulted in an unintentional cultural divide that fostered hierarchy and undermined trust.

In Myanmar, a Myanmarese senior UN official described the cultural challenges of working on RH with expatriate staff:

> *"[Regarding international staff], the common aim and objective is the same, but the context is different. Their country and Myanmar country context is different. Why don't you do it like this, why don't you do it like that? Sometimes they complain to the other national staff, but we need [to] explain [to] them that we cannot do it like that because of the cultural constraints. For example, the abortion clinic, something like that. And to introduce EC* [emergency contraception] *for unmarried women and girls. It is very very difficult in Myanmar. So some of the expatriates don't understand… It's very difficult for*

the national staff. Conservative group and the authorities on one side, and then very advanced group, expatriates on the other side. National staff in the middle. We become the hamburger. We are in the position of baking the cake: heat on both side".

In both settings, the lack of a shared language hindered national staff from expressing themselves. The RH Working Groups were not held in the respective national languages but in English, and in Haiti, sometimes in French. Many national actors did not speak either language or did not feel confident in their speaking abilities.

In Myanmar, when asked about the challenges related to language barriers, an officer with a large INGO described how national actors were worried that their lack of ability to adequately express themselves in English could potentially cause negative repercussions from the government:

"There was some reluctant discussion between international and national staff. National staffs didn't discuss entirely due to avoid misunderstanding, to avoid the sensitive issues of Myanmar Government. Some national staffs didn't want international staffs to record everything, scared to spread this issue in world-wide".

In Haiti, an international RH adviser with an INGO spoke to the lost opportunities that arose from not conducting the Working Group in the national language, Creole:

"The language issues—people in the communities didn't speak French—French was an elite language. That created barrier right there. Just understanding the different things that were going on in terms of their perspectives on health and the environment after the earthquake. There were a lot of things we didn't know, and there are a lot of rich cultural issues that we should have been more aware of. And learning what the local organisations had been doing previously. I don't think anyone knew".

In Haiti, some representatives from local NGOs felt estranged and unappreciated in and out of the Working Group; this led to limited participation in its activities. Informants commented that Haitians felt intimidated and shy around international staff, with one person pointing out that the culture of Haiti "was not very aggressive".

An expatriate women's health coordinator with a Haitian NGO described how the lack of understanding and engagement on the part of international representatives impacted local actors as well as service provision:

> *"I think the basic feeling among new groups who had just come into Haiti was that there was nothing here. And that's not true. There was a lot. It was incredibly alienating to Haitians—that attitude of nothing works and there's nothing here, what have you people been doing for all these years. Which wasn't true… With the local Haitian women's groups, I think if people had known what some of them do, I think it would have been very helpful to understanding how to better implement things in Haiti".*

She also commented on the role social and economic status played in the ability of national actors to equally participate in the RH Working Group:

> *"I think in order for them to have a word in edgewise in these meetings—at least with the grassroots organisations I worked with—they would have really needed an advocate who was accustomed to how the Clusters work and a strong personality. I think one thing how the coordination meetings worked was that you really had to stand up and talk really loud or no one would listen. The grassroots women's orgs I worked with, particularly those led by women of lower socio-economic class, although incredibly strong in their own communities, they were not comfortable, even amongst the bourgeois Haitians, in terms of speaking up. That would have been a challenge".*

The discomfort and sense of hierarchy in the Working Group fuelled informal networking among Haitian groups. She went on:

> *"I think definitely for local organisations, connections were more important than the Working Group meetings. I started working more with local women's organisations later that year, and I think they felt that there was no purpose to be at the Working Group meetings. Their attitude was very much, we know our work here and we know our communities, and we don't need to figure out how to work in Haiti. I think they also felt looked down upon or unrecognised for the work that they had done. A lot of the perception of the Working Group was that it was a place to be seen".*

New factor: Political barriers

Complex emergencies occur in settings with fragile and often repressive governments, and humanitarian relief requires responding agencies to collaborate with these government

authorities. Strained relationships with government officials can create barriers to successful service implementation as well as weaken socialising accountability, which depends on norms of trust and transparency. Given the high-income and stable political and policy contexts of the case studies analysed by Romzek and colleagues, political barriers were not identified as significant. However, in this research, engagement with government authorities challenged socialising accountability in both settings, although more so in Myanmar.

Although informants in Myanmar describe some surprisingly positive relationships with certain government representatives, political barriers were rife. A Myanmar representative with a large international organisation spoke directly about the erosion of social norms due to the inclusion of government representatives in the Technical Working Group:

> *"We could not trust at the central level because [the Department of Health was] there".*

She suggested that the primary way socialising accountability could be fostered was through establishing "separate meeting with INGO level, and then raise issue to concerned [government] Department with proper planning".

On occasion government representatives sympathetic to RH were themselves afraid to speak to higher-level officials:

> *"Sometime, the person who represent the DoH [Department of Health], he or she may not have influence. They were afraid to say to their influential supervisors. So we cannot change to policies and politics".*

In Haiti, government authorities did not seem to actively undermine socialising accountability, although the majority of informants suggested that their meaningful participation in the Working Group could have strengthened group cohesion and accountability. For example, a consultant with an INGO described how increased engagement by MoH officials could have enabled information-sharing and collaboration:

> *"If [the Ministry of Health representatives] sat at the head of the table and said, hey, you have got to start coming with specifics, you gotta start coming here with more, we need proposals, we need such and such. I think maybe people would say, whoa, they are not kidding. It probably would have had to come from Haitian leadership. Those are the*

people they would have listened to most. I guess they were almost too tame and I can see how that happened, but I think it would have been ok to say you have to do better".

New factor: Lack of shared goals

Fry (1995), writing about socialising and individual accountability in non-profit organisational cultures, contends that in order for inter-personal accountability to become "nurturing and enabling" it requires, *inter alia*, "a shared vision and mission that are continually discussed and understood in the context of today's issues and needs" (p. 189). Additional research has demonstrated that lack of goal congruence can challenge successful network cooperation (Meyers, Riccucci, & Lurie, 2001). Inter-agency goal conflicts may also undermine information-sharing (Sarnaddar, Nargundkar, & Daley, 2006), highlighting another way in which the different elements of socialising accountability reinforce and weaken each other.

Romzek et al. (2013) emphasise the importance of an agreed goal in fostering inter-agency socialising accountability, and, in their expanded model, assume that collective goals are fundamental to service networks (p. 10). However, they claim that group support of the very broad goal of "mutual recognition of interdependency" is sufficient (2012, p. 452). My research suggests that recognition among actors of their mutuality is not enough to enable socialising accountability. The findings demonstrate that a defined, bounded goal among actors working in a specific sector is essential. Conversely, other research has confirmed that divergent goals inhibit successful coordination in humanitarian settings (Tierney, 1985).

In Myanmar, all but one of the respondents reported that the Technical Working Group had a clear goal. Understandings of this goal varied: for example, some respondents understood the Technical Working Group goal to be RH implementation broadly, while others specifically noted MISP implementation. However, despite the slightly different understandings of the goal, the strong *sense* of a shared goal helped increase the cohesiveness of the group.

Conversely in Haiti, informants' responses regarding a shared goal or vision of the RH Working Group were ambiguous and contradictory. The initial Focal Point of the Working Group explicitly identified the goal of MISP implementation, but this was not maintained or made clear over time as other Focal Points and members cycled through. The majority of

respondents commented that they were not aware of a common Working Group goal. Two informants noted that a shared goal was in place, but later in their interviews offered contradictory responses. This feedback reflects a sense of fragmentation among Working Group members and a lack of clear vision for the group as a whole.

For example, a global health adviser with an INGO compared the RH Working Group during the earthquake response with the coordination during the cholera crisis in Haiti later that year:

> *"When I compare with the cholera response, there was a clear strategy, what we wanted to do as partners, as actors, it was good to have that. There was even guidance on pregnant women, which was great to see. It was so detailed, but there wasn't that in the earthquake response. It would have informed the response and made us more accountable and more committed to do what we agreed to do, but that wasn't there. This is key".*

An RH adviser with a different INGO in Haiti reflected that RH Working Group members desired a common goal, but blamed the lack of leadership for the gap:

> *"[RH Working Group members] were not really communicating with each other about a shared goal. That's what everyone wanted but wasn't happening. It was the leadership, the lack of leadership that was the issue".*

However, one RH Focal Point in Haiti who tried to establish a Terms of Reference that included a common Working Group goal described resistance from group members:

> *"There was an attempt at creating [a TOR], but members did not want to commit to what they considered "additional" work. I tried to explain that it may be more of a coordinated way to do their respective activities than adding new activities, but the actual putting it down on paper was met with resistance".*

Again, the fragmentation and challenges within the RH Working Group in Haiti helped foster socialising accountability among RH actors in the informal sphere. A women's health coordinator with a local Haitian NGO noted that she felt a common goal among the RH agents in her social network:

> *"I don't think there was a clear priority [in the Working Group]… I would go to that meeting once a week and I would just stack those days with outside meetings. Often I*

would spend the whole day in UNFPA offices. And that was because I had a lot of access there, I had done a lot of work with them and I knew people who worked there. We were working towards what felt like common goals, so I was able to communicate with those people and that was helpful for me".

New factor: Poor leadership

Whereas effective leadership was included as an enabler in Romzek and colleagues' model, poor leadership was not included as a barrier. In this research, however, poor leadership was found to be destructive, actively undermining socialising accountability. Literature on humanitarian relief work also cites poor leadership as a critical barrier to effective responses and accountability processes (Buchanan-Smith & Scriven, 2011; Featherstone, 2010; Knox Clarke, 2013). Humanitarian architecture is structured such that a lead organisation and individual are identified to facilitate coordination mechanisms. The case study data from Haiti confirm that weak leadership by both individuals and agencies were primary challenges to socialising accountability. In Myanmar, poor leadership of the RH Focal Point or the lead RH agency was not highlighted as an issue. On the contrary, informants stated that, in this regard, strong leadership in place.

In Haiti, a health adviser with an INGO suggested the dearth of emergency experience of some Focal Points contributed to the lack of group cohesion:

"There was no real charismatic personality saying, 'C'mon, we have to work together to do this, do that.' There really was nothing like that. Again, they [the RH Focal Points] changed so frequently. And there were a lot of people without emergency experience in the response. And for a lot of people that had experience, it was very discouraging to have very young and inexperienced people taking these leadership roles and not doing a very good job to begin with. You had a lot of people who had barely any experience in this response—a lot of the UN folks who had not been in those types of situations".

Similarly, a representative from a local Haitian NGO highlighted how the lack of leadership within the RH Working Group undermined the unity and strategic collaboration of the group:

"There were lost opportunities [in the RH Working Group]. There was a moment in which there was quite a lot of momentum to do real mapping. We had real mapping of services going on for a while in that Cluster, which was excellent. It was the first time any of us who had been in Haiti had any idea of what was going in the greater Port-au-

Prince area and understanding what resources were available to women and girls in terms of reproductive health. With real numbers, with real clinics—this clinic is open these hours, and it has this much personnel, and they will require you to pay or they won't, this is what they can do and this is what they can't do. It was pretty incredible to see that. But there just wasn't a person who was able to keep it updated and going. Once we had that information, there was a problem with then how do you communicate that information to the people who really need to know, which is the community. I was really surprised about how little was done".

One of the RH Focal Points criticised the lead RH agency for its poor leadership and lack of recognition of the importance of informal, social networks:

"Because to me UNFPA was not active enough—because it's a small development programme and this was an emergency. UNFPA is an old institution in Haiti and they are reluctant at adopting new strategies. The organisation didn't have that culture of moving fast, networking fast. I knew the key: the magnitude of the crisis is Haiti was so big and vast and we had to do it through networking, and do it fast".

She described in a follow-up email the impact of leaders who lacked a clear vision for the response:

"It was difficult to accept that the cycle of pain and loss would go on, not because we could not help, but because of personal attitudes fed by lack of vision. I have learned a great deal about the WEIGHT (not the value, as that is obvious) of personality and vision of others in achieving goals…We have to think comprehensively, globally, even in emergency. We have to approach from different angles in order to be efficient. Addressing one aspect alone, ignoring others, it's all going to fall apart. It's all inter-connected".

New factor: Overwhelming workloads

Finally, feeling overwhelmed due to high workloads was cited as a common challenge to participating in inter-agency coordination and collaboration, which Romzek et al. (2013) did not include in their model. Job-related pressures and psychological strain are inevitable when working in humanitarian crises. In both Myanmar and Haiti, informants described feeling stressed and overwhelmed by commitments and the needs of the affected

communities, resulting in the de-prioritisation of coordination and, in turn, the erosion of socialising accountability.

In Myanmar, the head of a French NGO run by Myanmarese nationals described the challenges his staff faced in participating in the RH coordination mechanism:

> *"Our clinics were overwhelmed. One to two doctors were seeing 100 plus patients per day. So they couldn't participate in the coordination meetings, and they didn't always get full coverage".*

A Myanmarese officer with an international development agency noted how high workloads prevented consistent participation in the RH Working Group:

> *"One time one team member attend[ed] [the Technical Working Group meetings] and next time another team member attend[ed]. So who is accountable? Should be more specific in the job description of the representative. It should be one person regularly. However, it is not feasible in our organisation. Sometimes one person is busy so another person has to go to attend the meeting".*

In Haiti, a consultant with a small INGO reported how lack of time obstructed collaboration:

> *"I saw [other RH actors] at the Working Group meeting and I was social with them [after the meeting]. You could still be social after the earthquake, which we did do, a couple times a week. But you know it all kinda turned out to be a lot of fantasy: wouldn't it be good if we could do your GBV project in our camp, how would go about that? Or that survey you're helping roll out in four camps, how can we be a part of that? We just weren't ready to do anything big around reproductive health… My CDC buddy who was helping with a survey, she wanted to work with us, but we couldn't do it at that time for fear that it would take away from other things they were doing, particularly WASH [water, sanitation, and hygiene] and camp management".*

One of the Focal Points of the Haiti Working Group tried to increase group cohesiveness and mutual supportiveness, but being overwhelmed by her own workload as well as dealing with visibility issues frustrated her efforts:

> *"I did have a hard time trying to get them to do something all together. They would help each other, but I couldn't get them to group together and do something together. For Midwives Day, I was proposing them to do a mini campaign—some flyers, messages—*

go to different camps and communities to discuss eclampsia, whatever. Everyone thought it was a great idea, but it didn't stick. Every time we try to do something, when it came time to do it as a Working Group, that didn't work out. Every one was so busy, and not enough a publicity for their own NGO. That was always an issue".

An international roving operations officer who worked on RH in Haiti described how her workload and broad mandate prohibited her from reaching out to colleagues and networking:

"If there were a Haiti now and we sent out a designated reproductive health person, they would have been able to tap into and exploit these resources and networks much more. I was in charge of 15 mobile clinics and my mandate was with primary health care, so it was much more difficult to do that [RH]. At that point in time it was too much to be able to do that".

An international global health adviser with a well-established INGO in Haiti remarked on how a better organised RH Working Group could have helped manage overwhelming workloads:

"No, I don't think we could really support each other [in the beginning]. I think the first few months we were all overworking and all over the place. On the other hand I think the meetings could have been better organised to make us do that".

Finally, an international health focal point with an INGO in Haiti described how work demands and pressures, rather than lack of commitment, undermined the RH response as a whole:

"I thought [the RH Working Group] was a great venue—a really good group of people. I never got sense of, 'We're doing that, back off,' at all. But every one was kinda on their own. No one had extra funds to share with those that didn't. There was not a big movement to pull the camps together and pool our resources and have a massive RH response—that's not what I got, even when I came back in August. It wasn't a lack of will on the people who love RH but an overwhelming sense of a million other things to do by each individual NGO. It was always an issue of bigger fish to fry".

8.4.6 Additional facilitative factor: Personal accountability

A key additional factor that facilitated and enhanced socialising accountability was identified from the data: personal accountability. Personal accountability, or an internal sense of responsibility based on one's values and ethical framework, does not fit into the categories of norms, behaviours, rewards, sanctions, and challenges set forth by Romzek et al., but is a rich form of accountability in its own right. Champion behaviour is related in that it may be one expression or reflection of personal accountability, but fealty to one's internal conscience entails more complex dimensions.

Personal and socialising accountability are complementary forms of informal accountability. Roberts (2001) proposes that socialising accountability can enable spaces to cultivate and articulate internal accountabilities. The findings from these case studies also suggest that personal accountability can strengthen and augment socialising accountability. Personal and socialising accountabilities reinforce one another and offer additional layers of accountability beyond formal mechanisms.

Personal accountability is a significant motivating factor in upholding external accountabilities. Bourguignon et al. (2010), in their study on accountability, professional identity, and societal culture, conclude that "autonomy cannot be defined within contracts, but it is the very condition of the internalised sense of responsibility, leading to achieving one's duties in accordance with both procedures and one's professional honour. When persons claim that '[they] did all [they] could do, it's normal', they refer to the professional internalised sense of duty which is not to be discussed with superiors nor embedded in a contract". (p. 22).

Indeed, all informants in the two case studies expressed that their drive, commitment, and efforts to coordinate with others to achieve their programmatic goals were in large part internally motivated. Personal and socialising accountabilities worked symbiotically to advance MISP implementation.
A Myanmarese senior UN officer explained that compassion, rather than formal accountability commitments, motivated her to participate in the cyclone response:

"It is not very concerned with accountability. At that time, it is my empathy. I empathise with the community that is suffering and we try to help the community as much as we can".

She also suggests that organisational mandate was not a driving factor for other individuals in the response:

"It's not about mandate of their agency. As you know, Myanmar is rich in resources and people are very poor. As service providers we understand that people need a lot of assistance, especially in emergencies. So, not because of the mandate. NGO staff are working hard because of their own enthusiasm to help the people. NGO work is not easy and as the educated person, if we work in own business or going abroad can earn more, much more".

The RH Focal Point in Myanmar commented that the internal ethics of the humanitarian actors helped advance MISP implementation:

"Ethical accountability played a role in MISP implementation because of saving lives of pregnant women who are endangered and to prevent women from sexual violence, to prevent community from HIV, are our inborn responsibility as a humanitarian worker".

A Myanmarese senior health officer at a different UN agency explained how her identification with the affected communities propelled her to respond:

"Because I am the woman. I want to help the woman and the girls. I have a daughter and a mother. So all ages are concerned with us. Also women and girls are most vulnerable and prone to get the violence anytime, domestic violence and sexual violence. Especially at the time of emergency or disaster. And also most of us don't like the discrimination. So all of us [are] against this discrimination against woman. We should have the same rights".

A Myanmarese assistant UN representative described the Technical Working Group members' internal sense of responsibility to the affected communities, to organisational mandates, and to peers:

"[There is] commitment among each one of us. We are committed to serving the community. We are committed to serving our own organisation. We are committed to the goals of this Working Group. Even though this is a small group, we believe that we

can work better together rather than individually. Through sharing of information, through supporting each other in terms of our needs".

In Haiti, informants expressed similar sentiments. For example, a women's health coordinator with a local NGO described her personal commitment to RH despite lack of support from her agency:

"For me, it's personal. It's my chosen path in life. I worked with a group who didn't have funding for reproductive health ever, earmarked funding at least…. When the circumstance happened, that's my specialty, that's where my head went to. It's that I'm just really aware of the invisibility of women and reproductive health issues".

Likewise, a roving operations officer in Haiti noted her personal drive as the key to addressing reproductive health, although it was not an organisational priority, and highlighted how this fed into coordinating with other agencies:

"For the previous year I had been doing 50% roving ops work, and 50% supporting the technical team in reproductive health. Clearly it was part of my personal agenda on the ground to further the MISP and I was aware of what that entailed. Networking accordingly and trying to engage as much as possible in the reproductive health sub-group once it was up and running… Reproductive health was only a small component of our rapid assessment—mainly looking at wat/san, hygiene, and shelter. In our rapid assessment, those engulfed all the initial priorities, and reproductive health was not one of those priorities. It was brought in as part of my personal agenda rather than organisational priorities".

An international RH adviser with an INGO in Haiti described the convergence of professional mandate and internal ethics:

"It was one of those situations where it was so obvious the need. It was so obvious the number of pregnant women on the streets, the number of women in the communities who were in really need. That was my mandate in my organisation but I'm also extremely passionate about it, so that's what I look for. I think a lot of people had a similar experience, but it was also so overt the level of inequities towards women… In some of the informal settlements, you could literally see women bathing nude in the street. It's so incredibly inappropriate. Nobody should have to do that. It was so obvious the need. It was in your face".

One of the RH Focal Points in Haiti similarly described what she saw as motivating factors for Working Group participants:

> *"Well, the organisations that attended the Working Group were already reproductive health NGOs or addressed it partly in their programmes. So, organisation mandate for sure. But I find that most people in reproductive health are personally committed to it. That is not the case with doctors who are sometimes simply put in that position. There is a difference between having a background in health and doing reproductive health than someone who specialises in reproductive health. The latter seems a lot more committed… I feel the people who are in reproductive health, they are passionate about it. That is from what I have seen anyway".*

She also explained that her own personal commitment to RH inspired and motivated other Working Group participants, highlighting how socialising and personal accountability synergistically reinforced each other:

> *"I love reproductive health! And that certainly plays a role in how stubborn I am when it comes to making things happen in the field. The [Working Group members] felt I was very passionate about reproductive health and they were interested in it. I made the connection between reproductive health and so many things—I linked reproductive health with everything, so they themselves saw it everywhere, in everything they did. Even for people who were not into reproductive health all that much at first".*

8.5 Discussion

Socialising accountability, particularly in regards to inter-agency relationships, is an emerging field with limited literature to date. Romzek et al. (2013) have identified this gap and developed a model to map out different layers of behaviours, norms, sanctions, rewards, and challenges that contribute to or undermine the development of socialising accountability. The model is the first of its kind; this effort is valuable to advance the discourse and provide new thinking around the issue. The utility of Romzek and colleague's framework within a humanitarian context is now considered. Deeper reflection on the findings themselves regarding socialising accountability in the two case studies is conducted in Phase III and the Discussion.

A discussion of the model must be contextualised within the divergent humanitarian and development case study settings. Romzek et al. developed the framework based on data from inter-agency, non-profit networks in the United States rather than coordination mechanisms in a complex emergency with a variety of local, governmental, and international actors. Diverse and unique elements are respectively at play, and the model developed from case study data from the United States cannot be neatly applied to an international humanitarian setting. International humanitarian crises arguably involve more complexities and thus more challenges than in a stable context. Indeed, Romzek et al. (2013) explore the intersection of network, coordination, and accountability, while I integrate two additional strands: humanitarian relief and RH service implementation. They identify five primary challenges to socialising accountability based on their data, to which I add an additional six. At the same time, given the significant similarities of the two contexts, the model provides a useful framework to layer into a humanitarian setting that can be extended, modified, and built upon, revealing new dimensions of socialising accountability processes.

Inter-agency competition was a barrier to the development of socialising accountability in both settings, although the drivers were different. At the field level during an emergency, programmatic territorialism may be minimised given agencies' prioritisation of the urgent needs of the affected communities and the lack of clear programmatic borders. As a result, moving into another's space, at least at the onset of an emergency response, is not inherently perceived as problematic as in a development context where programmatic boundaries are usually well-defined and actors are aware of these demarcations. Further, in non-crisis settings, competition for funding may be more intense as various international funding mechanisms, such as the CERF and flash appeals, are available for humanitarian actors, whereas the equivalent are not for development NGOs. Large scale crises in particular can generate a windfall of funding. At the same time, competition for visibility and jockeying for position is often pronounced in humanitarian settings, which often generate media attention and public criticism.

The expanded model did not include other challenges that clearly emerged from my research. Specifically, informants emphasised cultural norms and political constraints as factors limiting socialising accountability. These elements were not identified in Romzek and colleagues' case study data, most likely given the relative homogeneity of culture in

their domestic setting and lack of political involvement as a result of the agencies' NGO status. The roles of culture and politics are integral to international humanitarian action, although may play a part in coordination efforts in other development settings.

Finally, inter-agency coordination may be given greater value in emergency contexts. Coordination is institutionalised through, for example, the Cluster Approach and the MISP, which includes coordination as its first objective. Although Romzek et al. (2012) note the increasing recognition of the utility of networking in the non-profit sector (p. 442), inter-agency coordination does not appear to be as prioritised or systematised in the U.S. development sector. As a result, the authors conclude that the goal of "mutual recognition of interdependency" is adequate to support socialising accountability (p. 452). This conclusion contrasts sharply with the findings from my research that demonstrates that a clearly defined, collectively supported goal is essential for socialising accountability to flourish.

My research highlights the need for additional categories to be added to Romzek and colleagues' 2013 model. Their model did not include *calling others to account*, perhaps the most fundamental aspect of accountability. Although the authors assert in the text that "effective network accountability involves…challenging performance and monitoring activities" (2012, p. 443), calling others to account through, for example, providing critical feedback on conduct and programming, is not incorporated in the model.

The consideration of *impact* as a reward for participating in socialising accountability processes is also missing in the model framework. One could surmise that it could be considered redundant to include impact in the model as it is an implicit benefit and is indeed the goal of collaboration. However, by excluding impact, the model fails to explore a deeper layer of reward for participating in informal accountability. In the effort to bring attention to the relevance of socialising accountability, this omission may undermine the assertion that socialising accountability "is likely to be at least as important to effective network operations as formal accountability mechanisms, and perhaps even more so" (Romzek et al., 2012, p. 442). The findings from my research demonstrate that participating in socialising accountability norms and behaviours can reap two powerful rewards: short-term programmatic impact and the contribution toward longer-term systemic change. The inclusion of impact could strengthen the framework.

An additional constraint not reflected in the model was the role of overwhelming workloads. Extraordinary stress and resulting burnout are high in humanitarian settings given the intensity of working to save human life. A 2012 longitudinal study on the mental health of international relief workers found that reported anxiety increased from 3.8% pre-deployment to 11.8% post-deployment and depression from 10.4% to 19.5%, contributing to burnout and emotional exhaustion (Lopes Cardozo, Gotway Crawford, Eriksson, Zhu, & Sabin, 2012). Burnout due to high workloads and emotional stress are common among non-emergency NGO staff as well (Cornelius, Corvington, & Ruesga, 2008; Solomon & Sandahl, 2007). As demonstrated above, overwhelming workloads can undermine participation in socialising accountability, and integration into the model would be a necessary component of its adaptation to humanitarian settings.

Finally, data from my research demonstrated the importance of personal accountability in the development of socialising accountability, which is reinforced by the broader literature. Many individuals choose to work in the not-for-profit sector due to their desire to serve others within a personal ethical framework, although other complex factors are also at play (Mann, 2006). The drive for collaboration and subsuming self-interest over collective goals is present in both humanitarian and development settings; this sense of personal accountability is essential to the enactment of socialising accountability. In addition, personal accountability reveals another dimension of accountability that deserves further exploration.

8.6 Conclusion

Lack of attention to socialising elements represents a gap in the understanding of accountability and inter-agency coordination. The Phase II findings from the case studies in Myanmar and Haiti demonstrate that socialising as well as personal accountabilities were valuable to implementing the MISP. The weakness and underutilisation of many formal humanitarian accountability mechanisms underscores the importance of understanding and building on socialising accountability: its manifestations, influences upon it, and implications for humanitarian work.

Romzek and colleagues' expanded model for inter-agency, socialising accountability is an important and useful contribution to the scarce literature on this issue. Extending, critiquing,

and building upon the framework are warranted if it is to be adapted to humanitarian and other settings. While not the main focus of my work, the refined model I propose may be applicable to the humanitarian context and possibly other settings. In this respect, I hope that my proposed model modifications will be considered by Romzek et al., and others, seeking to understand how socialising accountability works in different settings.

None of the Phase II informants had previously considered the role of socialising accountability in the humanitarian responses in which they participated. The discussion enabled them to reflect on their experiences through this lens, and the majority, if not all, indicated that they found the experience of socialising accountability to be beneficial to advancing the respective RH responses. A variety of questions emerged from this phase. Do socialising and personal accountabilities have utility or value in humanitarian settings—beyond these two case studies? How can key elements such as pre-existing relationships and effective leadership be strengthened? How is its reproduction maintained to enhance predictable and effective accountabilities in emergencies? Through the iterative research process, the following final phase was developed in an effort to address these pertinent questions.

9. Chapter 9: Phase III - Emerging perspectives on socialising and personal accountabilities

9.1 Introduction

Findings from Phase I highlighted the lack of effective, formal accountability mechanisms for MISP implementation and the brought socialising accountability to the fore as a means to compensate for this gap. Phase II further explored socialising accountability in the two case studies and added new dimensions to a model of socialising accountability set forth by Romzek, LeRoux, and colleagues (2013). In particular, personal accountability was identified as another form of accountability that enabled the SRH responses. The third and final phase of this research weighs the practical implications of the findings on socialising and personal accountabilities by discussing the findings with experts in the field of humanitarian response. While the findings from the two case studies contribute to the literature on socialising and personal accountabilities, this study also hopes to provide practical contributions to help strengthen RH implementation and humanitarian accountability processes.

Feedback on research from practitioners outside of academia can provide useful insight into its applicability. The findings from Phase I and II were shared with two experts in the humanitarian health sector. The value of socialising and personal accountabilities was discussed and informants affirmed their importance as well as provided insights and suggestions as to how different components can be augmented and leveraged to promote more effective, appropriate, and respectful RH relief efforts. During Phase II data collection, informants were also queried on ways to reinforce socialising accountability and their responses are integrated below; personal accountability was not included as this emerged after Phase II data analysis. Suggestions for strengthening socialising and personal accountabilities relate to leadership, training, human resources, coordination, and the bridging the divide between humanitarian and development actors. The feedback is linked to broader literature to contextualise the suggestions and consider feasibility.

9.2 Methods

Phase III sought to answer the research question “What is the value of the concept of and practical support for socialising and personal accountabilities in advancing RH implementation in humanitarian emergencies and in what ways can they be strengthened?” Methods for Phase III included in-depth interviews with two additional key informants not involved in either case study. One was a UN representative working on health and RH in emergencies and was a member of the IAWG Steering Committee; the other worked on health and emergency disaster management, which included a focus on humanitarian accountability, at a different UN agency. Although the number of informants is small, they were not intended to be representative and were carefully chosen to open up insights into the humanitarian system and the potential utility of the research.

In addition, during Phase II data collection, all 14 respondents were asked how socialising accountability could be improved in humanitarian crises. These responses were coded and included in the Phase III analysis. Further details on Phase III methods can be found in Chapter 2, section 2.3.3.

9.3 Value of research findings

The two key informants for Phase III discussed the practical significance of the research findings. They commented that the findings bring attention to and provide evidence for often overlooked elements that are critical to an effective humanitarian response. Their feedback relates to multiple levels of the humanitarian field, including sectoral, organisational, and individual levels.

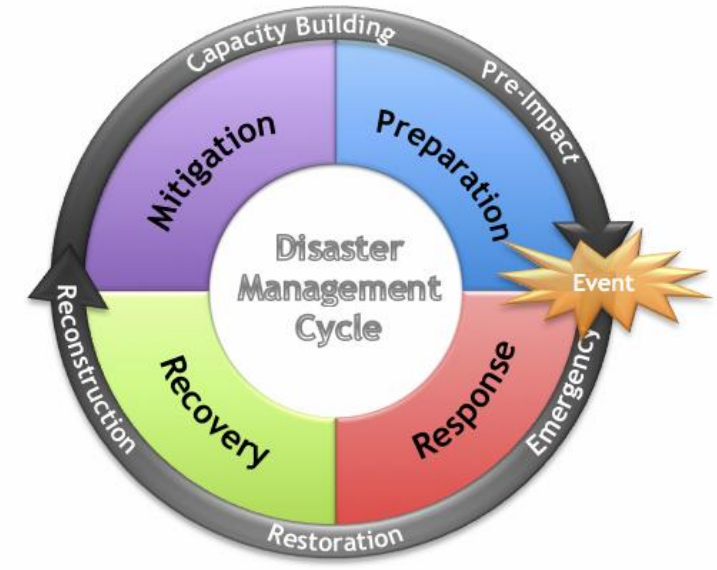
9.3.1 Humanitarian sector

Respondents described the ways in which the research highlighted the importance of emergency management as well as the repercussions of fragmented emergency management and response.

Emergency management

The emergency or disaster management cycle can be divided into four essential phases: prevention or mitigation, preparedness, response, and recovery (Figure 9.2). Efforts related to mitigation or prevention are also known as disaster risk reduction (DRR). A multi-sectoral emergency management approach provides a holistic framework for addressing all aspects of the disaster cycle and integrates social and cultural elements into the protection of public health. A robust, comprehensive emergency management system is said to reduce death, illness, and disability among crisis-affected communities (WHO, 2012c). Humanitarian agencies and donors have predominately concentrated on emergency response after a crisis occurs and have often overlooked emergency management strategies, sometimes to the detriment of affected communities. Indeed, a 2013 retro-respective report on DRR financing found that funding for DRR was actually higher during the 1990s, in terms of the overall financing for disasters (Kellet & Caravani, 2013, p. 7). Since 2003, the annual funding for DRR has levelled off at approximately 10% of humanitarian funding (Kellet & Caravani, 2013, p. 7).

Figure 9.1: Emergency management cycle



Source: (UN, 2014)

Nevertheless, emergency management including DRR are gaining traction, and donors and humanitarian agencies have focused increased attention and resources to address all phases of a crisis. For example, one of the first global efforts to address emergency

management was the establishment of the United Nations Office for Disaster Risk Reduction (UNISDR) in 1999; it serves as the focal point to coordinate international DRR and related emergency management efforts (UNISDR, 2013). In 2005 the landmark Hyogo Framework for Action was developed to promote building resilience of communities and countries to emergencies (UNISDR, 2005). In 2006 the Global Facility for Disaster Reduction and Recovery (GFDRR) was established by donors, UNISDR, and the World Bank to support efforts to the reduce of vulnerability to disasters (UNISDR, 2013). In 2012 DRR was on the agenda of key global bodies and fora, including the G20, Rio+20 and the Summit of the Americas (ODI, 2012). Regarding RH, UNISDR supports a sub-working group on DRR and RH within the Thematic Platform for Disaster Risk Management for Health (WHO, 2012c). However, the translation of DRR into practice is limited and the evidence base for its impact is weak (ODI, 2012).

One of the respondents strongly related the research findings to different aspects of a comprehensive emergency management approach and suggested they had implications for other sectors beyond RH. He noted that the findings provided evidence to support the importance of developing local capacity within a comprehensive, integrated, public health approach:

> *"[Your research] adds weight to what we've been trying to say in terms of building and supporting local capacity for a whole host of reasons… What we are trying to do is emergency work is seen as part and parcel of health system work. Too often even WHO and other health system models, if you look at discussion of social determinants of health, there isn't sufficient connection made—or sometimes any connection made—between primary health care, health systems, emergencies and disasters, and particularly humanitarian response, fragile circumstances, and so forth. Anything to glue these elements more together more effectively is a step in the right direction. Our goal is to be able to present this universe in a way that covers all of the bases, and from there you can start to prioritise. If we can't conceive of a set of approaches that are going to deal with all of the dimensions of the problem, then we are not doing our job properly. So that's the idea—to have a unified framework that uses common language, common elements. I think the evidence you are presenting supports that".*

Later in the discussion he described how, given humanitarian actors' traditional emphasis on acute trauma and infectious diseases in emergency health responses, RH can be

leveraged to challenge this approach and advance a comprehensive understanding of health broadly. He remarked:

> *"Another part is the way in which Ministries of Health and communities see health. The Ministry of Heath tend to look—certainly WHO has some influence here—look at infectious diseases all the time. Communicable diseases seem to be their primary concern, or looking at trauma care, but we can't have a situation where all of these aspects of people's health are not being addressed within an emergency. I guess that's where reproductive health and mental health and environmental heath comes in—to be seen as a holistic approach. One of the keys would be to say how does reproductive health connect more effectively with the whole health approach. So the questions go back to Ministries of Health and other key actors: are you fully embracing a whole health approach around disaster risk management and humanitarian response? That is as much about giving greater prominence to health issues in general, as it is addressing any particular issue in the health sector".*

He commented that the findings could be applied to a broader scope, such as challenging the ethics of traditional humanitarian action models. The research could potentially corroborate advocacy efforts related to culturally appropriate responses and increased engagement with affected communities, which are gaining heightened attention within a humanitarian accountability context (Featherstone, 2013). He expounded:

> *"One thing that you could draw comparisons with is not just reproductive health, but it's many other health disciplines. You could say it starts with the ethics of international assistance—in a way it's outsider assistance, not just international… The lack of association of international actors with local needs, such that the continuity of care is not something the international community has taken a great deal of responsibility for. So one of the things the humanitarian community places on—the emphasis on life-saving emergency care, as opposed to fully health needs of the community affected by disaster, which necessarily needs to address high priorities but also whole person and whole system as well. You run into all the inappropriateness of international assistance, which call up a lot of issues that you've just raised in terms of communication, culturally appropriate measures, and so forth… You can extrapolate [your findings] to many other dimensions of risk management, which is great. It adds understanding to a variety of areas—increases support and understanding for it…It's fabulous that you've been able to identify such contrasting experiences in two different locations".*

Fragmented approaches

The lack of a comprehensive, coherent approach to emergencies is evident in the emphasis placed on immediate results. Humanitarian agencies are traditionally oriented to reactive, short-term interventions with tangible outputs, such as the number of patients treated or tents distributed, rather than long-term change. Organisational mandates, which often focus on either immediate relief or longer-term development, are a significant contributing factor. Donors can also exacerbate the reproduction of this division (DFID, 2004; Kopinak, 2013 Mar; Walker & Maxwell, 2008). Robust scholarship has demonstrated that this approach is not only short-sighted but counterproductive, particularly in protracted settings that require a development orientation (cf. Kruk, Freedman, Anglin, & Waldman, 2010; Middleton & O'Keefe, 1997; Newbrander, Waldman, & Shepherd-Banigan, 2011; Pirotte, Husson, & Grunewald, 1999; Vergeer, Canavan, & Rothman, 2009). Nevertheless, many relief agencies and donors continue to prioritise immediate results over meaningful impact (Bruderlein & Dakkak, 2009; Gonçalves, 2008; Hofman, Roberts, Shoham, & Harvey, 2004; Watson, 2008). A literature review on impact assessment and humanitarian action highlights the ongoing emphasis on activities and outputs over outcomes and impact (Watson, 2008). A DFID (2004) report on DRR stated that there exists "…a perverse architecture of incentives stacked against disaster risk reduction. It is generally a long-term, low-visibility process, with no guarantee of tangible rewards in the short term" (p. 4).

The informant working on RH issues in emergencies discussed how the research findings highlight the problems associated with short-term, myopic interventions. She described her experience trying to address female genital mutilation (FGM) in a protracted, high density camp setting. According to the informant, the FGM prevalence, at 97% of the female population, had remained consistent since the camp was established 20 years before. Some interventions had been undertaken; however, none were effective in decreasing the practice of FGM, and one project even resulted in riots by the camp residents. The respondent identified an FGM programme that was highly successful in a number of similar settings, and spoke to one of the most senior members in her agency about implementing it in the camp:

> *"I told him, look, we are the protection agency and still we are 97%. And there are things we can do, but the only thing is that you need to accept the time frame. We can't do a one year project, or two year project, you are doing a project where you will see the first milestones, the first differences, after three years. And then real impact after 5*

to 10 years. But even after three years you have some tangible results. But don't ask me to have tangible results after one year. And let's stop doing the same mistake… So he came back to Geneva and went to community services and said, we need to have a regional project on FGM and that will be a two-year project. So they did the project proposal and sent it to donors and then by accident it arrived in my mailbox—you know, to rubber stamp it—and I said, What?! There is no way I'm going to rubber stamp this. It's repeating the same mistakes we've been doing since 20 years. Why do you want me to rubber stamp that? One year project, doing a film, training leaders, same mistake over again…Because we have a one year time frame at the end of the year we have to show results. And my result will be a film and so many people trained. What is your impact on FGM after 20 years? Nothing. And at that level, we need to change".

Although donor pressure is often blamed as the driver for rapid outcomes, the informant placed the responsibility on relief organisations:

"It's not the donor piece. It doesn't come from them. It comes from [my UN agency] structure—the fact that we have to report after one year…I get in trouble because I put something on the table that I am not able to achieve immediately. And I refuse to rush it because I said no, I just can't".

Both informants also noted that competition among agencies undermines a holistic approach to emergencies as well and contributes to ineffective, individualised responses. Although evaluations of emergencies have also found that inter-agency competition erodes coordination efforts (cf. Boin & 't Hart, 2010; Hedlund, 2011; Huber et al., 2008), this is often framed in terms of competition for funding. The informants found the research findings brought attention to the deleterious effects of inter-agency competition beyond jockeying for funding—such as competition for visibility—as well as underscored the importance of collaboration. The respondent working on health and emergency management reflected on the tensions between Ministries of Health, UN agencies, NGOs, and community-based organisations:

"Agencies feel threatened by community organisations if not NGOs. One thing that WHO is notoriously poor at, and I think Ministries of Health not so good at, is that it doesn't sufficiently recognise the roles of community organisations. So colleagues of mine from local, national or international NGOs, say, we can't engage effectively with Ministries of Health…And similarly Ministries of Health say to us, we don't know what

the NGOs are doing, we feel disempowered ourselves. You end up with a lose-lose situation because the government doesn't want to lose control and the NGOs don't feel recognised as legitimised actors. But they all rely on each other to make it happen. So I think these things are important characteristics".

After discussing the findings from Haiti, the other informant commented that competition for funding and visibility is becoming commonplace at the field level, and mechanisms to increase coordination, such as the Clusters, are not necessarily effective. Indeed, evaluations of the Cluster Approach have highlighted its coordination challenges (Humphries, 2013; IASC, 2006; Manfield, 2007; Steets et al., 2010). The respondent reflected that power dynamics undermine coordination efforts. She said:

"I think [competition] is a problem which is increasing. I have the impression that it's worse and worse—this story of competition and keeping the information for your organisation. Because it used to be something that used to be a headquarter thing—competing for funds, for donors—but you wouldn't find it so much in the field. Now I find that you find it in the field as well… At one point, I saw that maybe the Clusters could bring back some type of coordination where, because you share everything, you don't have this hiding of numbers or competition. But it doesn't work like that at all. Because there is very much a power relationship which is in this coordination mechanism".

She provided a first hand experience how lack of information-sharing and collaboration undermines trust and increases fragmentation. She struggled to provide practical recommendations to counteract this. She recounted:

"I really don't know how we can stop that competition. With MSF for example, they do nutritional survey and they give the numbers, the report, to the press before they give it to us. Which is really unfair. If there is really a problem, let's work it out. Once you've given it to the press… We all feel very bad, we still have to work together, but we feel bad. So then you have that working relation but no trust anymore. We work together because we have to, but what you did was not really nice and now we're going to be a bit careful. But I really don't know how to solve that".

9.3.2 Organisational level

The informants reported that working and coordinating with staff from other agencies—key aspects of socialising accountability—is essential to advance and implement RH programming in a crisis. The respondent working on emergency management noted that the findings strengthened arguments for the importance of pre-existing networks and building legitimacy with other agencies, particularly with Ministries of Health:

> *"If you take out the uniqueness of Myanmar, it still points to the key success factors for an effectively integrated approach to the response. What I think the two individuals provided was essentially a set of bridges. They already had the network of people which they didn't have to re-establish, that was already there. And then the connection with the Ministry of Health and the Ministry of Health recognising and respecting the legitimacy of these people providing the care. And whether they are community actors or part of the formal health system is not so important. These are the things that are often pointed to as barriers to effective care in any situation. These are good points that are coming out of your research that need to be reinforced".*

The other UN representative relayed an experience that suggested relationships did not necessarily have to be established pre-crisis in order to reap benefits. Her example demonstrates that group cohesion, trust, and reciprocity among disparate actors can also be forged at the beginning of a crisis response:

> *"At the onset of an emergency, there is cohesion because people want things to move and then it works quite well. You all have your tents, you're all living next to each other. In the evening you are together to eat and to discuss and because there is nothing else to do. And then you create personal relations and then it's fine and then after a few months you're in the UNHCR compound, the IMC compound, and then you see each other during meetings".*

When queried, she regarded this relationship-building process as organic and spontaneous and did not have suggestions as to how it could be more systematically fostered.

The informant working on emergency management submitted that effective collaboration requires prioritising broader goals over personal gain. Other research has shown that aid

staff with self-serving motives corrode efforts to serve the affected populations (Kopinak, 2013 Mar; Richardson, 2006). He commented:

> *"[Prioritising collaboration] seems to be the way that most of my working life has been the case. There seems to be a critical mass of people who get things done, or feel that they are in a place where they can move things forward because they trust one another—somehow they are able to work together because there is a diminution of the self interest in being able to move things forward. You can't move things forward if you're pushing your own barrow".*

9.3.3 Individual level

Informants reported that the research findings, particularly on personal accountability, call attention to the significant role individual empathy plays in an effective emergency response and in reinforcing socialising accountability. Empathy refers to the ability to know and feel what another person is feeling as well as respond compassionately to his or her distress (Levenson & Ruef, 1992, p. 234). It enables the individual to not only feel but understand the other (Slim, 2010). The UN representative working on RH remarked on the significance of empathy, particularly toward affected communities. Some Phase II informants also highlighted empathy as important to an effective response. The ability to authentically engage and connect with another human being—key components of empathy—support a broader culture of socialising accountability. Research on professional ethical behaviour has demonstrated that empathy can enhance personal accountability (Munro, Bore, & Powis, 2005), which reinforces socialising accountability processes.

The IAWG respondent shared her experience assessing an RH programme for sex workers in a refugee camp in Kenya. According to the programme managers' reports, all the right elements were in place: trained staff, consistent coordination meetings, and regular data collection and information-sharing. Nonetheless, the programmatic impact was weak. The informant described how she worked with the programme implementers to increase their capacity to empathise with and understand the women and girls they were trying to help. The informant recalled:

> *"During the meetings [the programme staff] were sharing information which for them was just numbers. There was nothing personal during the coordination meeting. We are conducting so many health education sessions with so many women. And they didn't*

see anything behind the numbers. And they didn't see any consequences. They didn't ask the right questions. You informed those girls about family planning for example, the adolescents, so what is the impact? Well, we don't see any more girls coming for family planning. And then I thought speaking with the same girls that they have a lot of misconceptions about family planning and basically it was not even a problem for them not to have family planning because they felt more at risk by going to the clinic and be seen going there than by getting pregnant and flushing the pregnancy. That's the word they used, "we know to flush it"… And then after that focus group discussion, which lasted three or four hours—really it was half a day—the team members started talking together. They said, you know, maybe we can help you with the content of the training, maybe we can help you do this, do that. And then they started looking for solutions".

The example demonstrates that increased empathy can support programme efficacy and, further, that empathic behaviours can be taught and learned, which is supported by other research (White, 1997). It also shows that effective leaders can facilitate inter-personal connection and influence group norms to reinforce socialising accountability. It suggests that the way in which people engage with their colleagues may reflect how they engage with affected communities.

9.4 Strengthening socialising accountability

Discussions were held with the 14 Phase II informants and the two respondents from Phase III on how socialising accountability can be strengthened in humanitarian settings. The insights below provide practical suggestions that help translate the findings into tangible recommendations. The responses relate to five areas: leadership, training, human resources, coordination, and the humanitarian/development divide. Personal accountability was not explored with the Phase II informants as it emerged as an enabler after Phase II data analysis.

9.4.1 Leadership

A 2013 literature review on leadership in humanitarian emergencies identified three aspects to effective leadership: setting forth the goal and objectives of a response, building consensus, and managing difficult environments to collectively achieve the goal and

objectives (Knox Clarke, 2013, p. 6). The informants' responses generally aligned with these three elements, although they stressed the importance of the leaders' personality and creativity as well.

All informants in Phase II emphasised innovative, visionary leadership to enable socialising accountability, particularly the RH Focal Point. Phase III respondents alluded to leadership through their respective discussions, but did not accentuate it as a way to reinforce socialising accountability or improve humanitarian response.

In Myanmar, an assistant representative with a UN agency described the ways in which a competent, trusted lead RH agency and RH Focal Point can negotiate some of the challenges to socialising accountability and help enhance the cohesiveness and integrity of RH response. She commented:

> *"I would think that continued leadership, strong leadership, with a leader that can really have the trust of the members—that is very important to have the continued interaction among the members… In fact, in the Technical Working Group we have only very few, a handful of providers. So when people disappear, it is very evident the group is getting smaller and smaller. So in this case we need to make sure they come back to us and find out what are the reasons they are fading out from us. So that kind of constant interaction is very much required. To keep each other, to make sure you hold them together. Because you have turnover, people leave, and when the new ones come they may not know of the existence of this working group. So you want to make sure we communicate now and then with the major organisations to ask who is your RH focal, to make sure if there is a new focal, that they come and meet. So that takes a lot of effort on [the part of the leadership] but I think it's worth it. It's worth it to keep this group going. So that in an emergency right away we can mobilise everybody".*

In Haiti, informants had a number of insights and suggestions given the leadership challenges they encountered. All noted that consistent, quality leadership guided by an agreed goal was essential for facilitating socialising accountability.

One of the RH Focal Points in Haiti described how leaders can engage local partners:

> *"In terms of informal relationships, I think it mattered the personality of the person doing the working group, the coordination. It's very very important. If you have someone who*

is reserved and distant, this is not going to happen. Especially in countries like Haiti, people are shy with expats. If you don't take interest in them, if you show that you don't care that they don't have a high school degree, you care that they are there, you care about what they can do, you make them feel important and that they are valued, then they become your biggest fan. And you do help them, this is not about flattering them. This is about making them see their own value, the value of their own organisation, if they don't have supplies or equipment".

Later she discussed other essential leadership attributes for enhanced accountability, such as navigating an increasingly risk adverse environment. She reflected:

"All of the dynamics matter—the leaders' personality, being a visionary or not, someone who will take action or not, and what you think of humanitarian response, risk-taking. Because of all the visibility of humanitarian response, people are more careful of the risks they are willing to take because the next thing you know it's going to be in the news a lot more and faster than development activities. All of that plays a role in accountability".

A different RH Focal Point for the Haiti response provided a number of innovative suggestions. She, as well as a health coordinator with a national NGO, proposed that the leaders should facilitate site visits as a way to reinforce network cohesion:

"What I wanted to do was offer more visits. Get people together once a month to invite others to their clinic to see what they were doing and discuss challenges with each other. I was thinking of doing something like this but in Haiti that was a huge challenge—transport and everything. I think visits by the [Focal Point] to the different centres to see how the situation is and see how you can help and make sure people get in touch with each other because everyone coming to one meeting for an hour doesn't solve all the problems. I think the role of the [Focal Point] is going to some of these places and sitting down and talking to people and seeing if there is a problem, checking to see if it is a wider challenge so you can also address it in the next meeting. I definitely think if you can get people to invite peers to show them what you are doing and to discuss one challenging issue with them, I think that will also help them be more proud of their work and to be more accountable".

She also suggested connecting with relevant actors through new technologies, which can enhance communication and coordination in emergencies (Meier, 2011). She suggested:

> "In the future, if we ever have to do it again, maybe with modern technology you could do a Skype or sometime. Maybe not just for the meeting but getting otherwise in touch because I was thinking little visits to each others' sites to learn from each other but that was just impossible there".

9.4.2 Training

Humanitarian organisations tend to use training as default means to address gaps, despite poor evidence of its impact (Clarke & Ramalingam, 2008). Yet humanitarian training has primarily focused on training individuals, rather than groups or teams. A review of the SPRINT Initiative shows that training inter-agency coordination teams can be a useful strategy to enhance collaboration (Beek et al., 2013). Another example from Oxfam Australia demonstrated that collaborative courses developed for its staff have successfully increased inter-personal connection, effective dialogue, and individual responsibility (Roche, 2009).

The two respondents from Phase III suggested integrating social and personal elements into technical training curricula could enhance qualities that are critical for enabling socialising accountability. After discussing how to cultivate these attributes, the informant working on emergency management proposed training participants from various organisations together to facilitate inter-agency coordination skills needed during a response. The respondent said:

> *"I can comment on that in terms of some of the things I've been responsible for. In terms of selecting people [for training], in who participates, there is certainly value in having more than one group of people who participate in training together. That sounds like what came out of the Myanmar experience--the two women who were the sparks for the work, they fed on one another. I wonder if only one had been doing it, I wonder if it would have been so much success. The point of ensuring that you create environments in learning programmes that are conducive to what you would like to see in the field. That's important. That there needs to be a lot of strategic analysis and problem solving in learning programmes so that people already understand how to facilitate solutions among a group of people. Those sort of things which you say are the*

soft side of things, but ultimately what really make the system work much more effectively".

The informant also drew on many years of experience working with a disaster preparedness training initiative and emphasised translating training theory into practice through integrating simulations of a real emergency response. Indeed, research on U.S. military simulation training suggests that knowledge transfer increases through the integration of "real-life" scenarios into training programmes (Kincaid, Donovan, & Pettitt, 2003). The informant explained:

"What we did in our learning programme in [the training initiative] was identify the key roles people played in emergency situation or emergency risk management, and that everyone's a leader, everyone's involved in developing capacity, involved in operations, involved in communication, et cetera. If you really want to be a manager, then you need to have many of these managerial qualities or managerial skill sets, some of which are generic, but others are linked to emergency work, and we haven't even touched the technical or clinical issues in that sense. We learned a lot over the course of a decade delivering these programmes that if you want to be effective not just in a learning environment but back in the practical environment, that you had to attend to your details. That is one way in which the results of the research can be applied in practical situations. The key for learning is to make it real. How do you do that? Whole bunch of role playing, group work, adult learning pedagogy. And that makes a big difference".

The other Phase III respondent remarked that socialising accountability often flourishes in the informal sector because it is based on interpersonal, rather than inter-agency, connections. She emphasised the importance of integrating personalised stories into training programmes to increase feelings of empathy. Some research has demonstrated that elements can be introduced into training programmes that can increase empathic feelings and behaviours in participants (cf. Crabb, Moracco, & Bender, 1983; Goldstein & Michaels, 1985). Further, empathy can augment pro-social behaviour and inter-group cohesion (Stephan & Finlay, 1999). The informant commented:

"I think what is happening is outside the meeting room is much personalised. I think it's no longer, I am UNHCR, I am CARE, I am IMC. It's, I am [my name] and I'm talking to this girl and that girl and this is what I heard. And then there is more because you are talking about people, then you are finding solutions for people, you see? It's much more

human. You need to put a face. So now the problem is how to make trainings that are actually efficient. People remember because they have good reason to remember. Someone was telling me I did a MISP training and two weeks later I had the same group for another training for emergencies, and then I asked them, ok, what are the priorities of the MISP? And they couldn't remember the priorities of the MISP two weeks later. Because probably I suppose, it remained very theoretical. I mean the training didn't seem very concerned, they didn't see the people behind the strategies. And I think probably what we need to try is to put the people behind the strategy on the things that we are teaching. When we do the SPRINT training, we do the exercise with the strings for GBV. People keep talking about it two three months later and telling me, oh, I remember this exercise, and how the person has to jump around. They can almost empathise with the person. I think for us the statistics are important, to see the impact of our activities, to lobby, to advocate for funds. For training, I think the statistics are pretty useless. Just during [the] Women Deliver [Conference], what do I remember? I remember this woman who came and said, look, I was raped, and this is what happened and this is what I did after rape. I think I will remember that woman for weeks, or months, or maybe my life maybe. I don't remember the statistics. So probably when we do the MISP, maybe it should start with that. With looking at the people behind the numbers. Exercises maybe all along the training, reminding people that we are not talking about an indicator that I want to reduce the maternal mortality. What you want to do is that you don't want Fatima to die. So yeah, so probably we need to include that much more in our training, to remind it on a regular basis, to have maybe a case study".

In addition to training, one study found that using electronic games can increase empathic feelings and behaviour: playing the *Darfur is Dying* game resulted in an increase in participants' willingness to help than others who only watched the game or read text containing the identical information (Peng, Lee, & Heeter, 2010). Another study demonstrated that online simulation role-playing helped augment empathy among Palestinian and Israeli students (Stover, 2006).

9.4.3 Human resources

The Phase III IAWG respondent suggested approaching the issues raised in the findings through a human resources angle. She proposed engaging human resource departments

to explore ways of recruiting humanitarian professionals with the personal skills and qualities that are crucial to fostering socialising accountability. There is some research to support this suggestion, including a review of human resource management literature by Stevens and Campion (1994) that provides practical methods for human resource personnel to identify potential staff with strong interpersonal and leadership skills. The informant noted:

> *"The problem is that when you are recruited at those kinds of position, this is really not the questions that you are asked. You are asked, technical questions on the one side, and on the coordination management side… Good people to talk to would be HR professional of humanitarian recruitment. I don't know because they might have some tips, some ways to do that".*

She also suggested increasing the number of staff to counteract burnout and assist with activities essential for inter-agency collaboration, particularly for data collection. Paul Spiegel (2007), the Chief of Public Health at UNHCR at the time if this writing, also suggested making available epidemiologists in emergencies to increase the quality and consistency of data collection. The informant, however, was sceptical about the practicality of this recommendation:

> *"When I was MSF, I was basically doing the work. I was there to do the work and nothing else. And now they have introduced a lot of, you know, let's do that research piece—and I'm someone who likes numbers and I use them a lot—but now I'm wondering whether if you want to do research, or if you want to do documentation, you should have two people. One who is taking care of the patient, and one who is there just for other activities like collecting data. I think it's not a very practical recommendation—I don't think it's really possible—I think it's already very difficult to find people to go to difficult settings. I don't know what to say about that".*

9.4.4 Coordination

Informants from Phase II and III put forth suggestions to strengthen the RH coordination mechanism. Most of the feedback reinforced the literature as well as the findings, including regular and accessible coordination meetings; consistent, committed working group members; an agreed goal and strategy for the response; and unobstructed, systematic information exchange. New suggestions were put forth as well. For example, some

informants noted that the MISP itself can be leveraged to facilitate inter-agency coordination, specifically through the first component, which advocates the establishment of an RH working group. In Haiti, an RH adviser with an INGO remarked:

> *"Ideally is to work with other organisations, local and international, to do the whole thing in a collaborative way. I think it's the only way to do it. Each organisation doesn't have all the skills or all the capacity. It kind of sets up you up for failure. You just can't do it on your own. We all need to be collaborating together… And the MISP is a tool that can be used better for collaboration".*

Other informants in Haiti put forth interesting suggestions to augment socialising accountability through the RH coordination mechanism. A representative from a local NGO concluded that successful collaboration could be enhanced by dividing the working group into sub-groups split between larger and smaller agencies. This speaks to the value of non-hierarchical spaces to encourage socialising accountability. Guidance on separate coordination mechanisms suggests that their establishment may be appropriate under certain circumstances but also warns of potential pitfalls, including redundancy and exclusivity (International Council of Voluntary Agencies, 2013). The informant explained:

> *"I think it would have been helpful for there to have been a recognition that there were different players represented who needed to be having different conversations. For instance, the scale at which Save the Children was working at in some areas—they needed to be talking to others working at the same scale and they needed to be talking to the government of Haiti. Whereas tiny organisations, like faith-based groups, those needed to have their own forum, their own sub-group of their own leadership to say, this is how we work in Haiti, this is where you can find meds. I think it would have been more efficient. I think often what was happening in the conversation was this sort of apples and oranges conversation because the scale was so different. Some of the bigger agencies are good at what they do, even in Haiti, but scale is so huge. They have ten mobile clinics running, serving huge populations and they are not mapped and no one knows where they are. And the government and UNFPA, those people need to know that in a very different way than they need to know about one clinic".*

One of the former RH Focal Points in Haiti noted that, although the RH Working Group is technically under the Health Cluster, it is not adequately integrated. She suggested institutionalising the Working Group within the Cluster System by assigning a pre-

determined lead agency, UNFPA. Other respondents also made this suggestion. The former Focal Point followed up by email to explain:

> *"[The RH Working Group] was not perceived as part of the Cluster system (no other country has had one before that they knew of), and was therefore not given the support to make it function as such (admin support, IT for database and mapping so that we could have a newsletter or monthly reports). I believe that it is important for UNFPA to commit to RH working groups wherever there is a crisis, because it is either ignored or simply narrowed down to EmONC [emergency obstetric and newborn care] structures available to the population by WHO. This should be reflected by the recognition of the RHWG in the Cluster system".*

Another RH Focal Point in Haiti proposed earmarked funding to support RH coordination. Although lack of resources for coordination has been highlighted in a number of evaluations and reports (Women's Refugee Commission, 2007, 2008; Women's Refugee Commission & UNFPA, 2004), there have been limited, if any, specific calls for earmarked funding for RH coordination. The informant stressed that receiving such funding should not privilege the political priorities of the donor over adherence to international standards, highlighting a common accountability tension. She said:

> *"Yes, actually one donor wanted to fund RH coordination surge through OCHA and I think that was a really good idea. We had a nice proposal out there but it didn't come through with the money. Real shame. We had a fight with WHO because they were very worried because they want the RH coordination. We were saying, look, there are agencies with mandates and this needs to be a coordination group within the Health Cluster. There are some donors who are interested in that but there shouldn't be just one donor who wants to do it. BPRM [the U.S. State Department's Bureau for Population, Refugees, and Migration] is funding the IAWG secretariat and the revision of the GBV guidelines, but the trouble with that is that they are still very worried about talking about abortion. It is very worrying because if BPRM is involved in the GBV guidelines, then we won't be able to have any abortion language in there. For the secretariat, money came specifically with the clause that there can be no abortion panel at the [annual] IAWG meeting… We can't talk about abortion in the meeting. That's a real shame. If there is interest in funding RH coordination from a donor, then they need to adhere to the standards in the [IAWG] field manual. No restrictions".*

During the discussion on Haiti with the Phase III respondent working on health and emergency management, he reinforced the importance of trust and safety for coordination efficacy. He emphasised the need to prioritise and invest in developing networks and social cohesion among aid workers to increase accountability and response efficacy, which is supported by literature on non-profit management (King, 2004). He elaborates:

> *"People are coming and they weren't prepared to be open and honest with the issues they were facing. That's not surprising. So what can we do about that? We need to have good strategies to move forward. Most people complain about the groups they are involved in. But it's not that they are complaining about meetings, but they are complaining about bad meetings. A small group of people, that's a meeting. But it is run in certain terms that people feel are a constructive way, whereas these other meetings seem to be—we can't underestimate how important well-run meetings are. You do need some ways to run these effectively otherwise it's so counterproductive. So even all of that stuff on meeting procedure or team building, I think that's what's being reinforced by your research. All of these things come together and it is for good reason that, in terms of good management, you have to invest in the things that are really important. The old story is, if it's really important, you gotta invest in it. Clearly those people [in Haiti] were able to move from a sense of frustration to a sense of vindication and validation [in the informal sector]. They were able to feel safe and secure and this was an important part of the process to them. Similar connections with Myanmar".*

9.4.5 Bridging the humanitarian/development divide

Informants from Phase II and III suggested strengthening in-country structures and inter-agency relationships pre-crisis to augment socialising accountability. Specifically, informants proposed bolstering the relationship between the responding agencies and government agencies, engaging community-based organisations, and strengthening the network of in-country actors pre-crisis.

Phase II respondents who worked in Haiti suggested both formal and socialising accountability could be strengthened by strengthening the authority and participation of the MoH in the RH response. Increased accountability to national authorities is an objective of the Transformative Agenda (IASC, 2012f). A global health adviser with an INGO proposed:

"The coordination should be done by the Ministry of Health, by a national body. I think the UN are great and brilliant, but I think NGOs including even the MSFs feel more accountable to the Ministry of Health. They respect them, we respect them, and we want to make sure anything we do is supporting them. So I think unless it's a political conflict, I think the NGOs would want to work with the national structure as feasible and as possible".

At the other end of the political spectrum, supporting local and community-based organisations to participate in formal and informal coordination mechanisms was also put forward as a possible enabler to increase socialising accountability. The Principles of Partnership[36] state that local actors should hold equal power in coordination, and close engagement with Cluster members increases accountability toward commitments (The NGOs and Humanitarian Reform Project, 2010). In Haiti, one of the RH Focal Points commented how skilful engagement with grassroots organisations can help integrate them into the RH response network and thus increase coverage and impact:

"They have people, manpower. They know the people, the community, their community trusts them. This is a big one I think. They can talk to them in ways that no other international NGOs can. And they will think quickly on their feet. They will know who to contact. They are invaluable, the small CBOs [community-based organisations]. Our failure was to reinforce them… As many NGOs and CBOs as we had, there were lots of small health centres that were neglected. I only learned of that because of the informal relationships, because it was only word of mouth… When you hear the word Cluster or working group, that is very foreign to nationals so one must be very approachable so they can go tell other people and then we can have a wider reach".

The Phase III respondent focused on RH provided an example of creating linkages with development networks before a crisis to utilise them for a strengthened response. She recalled:

"At one point we were talking about complex emergencies, where basically it is a humanitarian setting but it is long lasting, so you need to have humanitarian reactions

[36] In 2007 the Principles of Partnership were designed to put humanitarian actors on more equal footing. They were adopted by the Global Humanitarian Platform (GHP), an initiative created by UN and IOM agencies, the Red Cross/Red Crescent Movement and NGOs. The Principles are based on equality, transparency, results-oriented approach, responsibility and complementarity.

and development reactions. And you need to be able to match them. And I think that is the difficult part. I think if people understand that, that you need to pick from the humanitarian way of doing, and to pick from the development way of doing. Not for everything—at the onset of an emergency it's different, for certain technical things, it's different. I'm not saying you don't need to change everything. I'm just saying that you better match those to worlds. And I'm trying to do that with HIV by trying to work with the networks of HIV positive people who are there before an onset of an emergency and who are there after the emergency. Because HIV positive people are difficult to reach. If we manage to have those networks to work with us, then it will be much easier to reach those HIV positive people. But it's two worlds. Two different ways of functioning…What could be a good idea—I don't know if it's a good idea because I haven't succeeded up until now—but what could be a good idea is to connect those networks and the humanitarian workers for continuity of treatment during an emergency".

A Haitian national and RH Focal Point reinforced and extended this suggestion by proposing agencies develop a mechanism to facilitate the bridging of development networks through a crisis response. Indeed, an analysis of the Cluster Approach found that when NGOs and UN agencies have pre-existing relationships prior to a crisis, coordination efforts during emergencies are strengthened (Humphries, 2013). The respondent suggested:

"UNFPA and other agencies need to have a humanitarian machine. They should have someone all the time who can do humanitarian response to stay in touch with the networks and the local NGOs. So by the time there is an emergency, the network is already there, and all they have to do is tap into it".

9.5 Conclusion

Reflecting on the research with relevant actors validated the findings and illuminated linkages between increased socialising and personal accountabilities and effective humanitarian action. Informants agreed that the findings challenged the emphasis on formal accountabilities and reactive, short-term interventions and confirmed that socialising and personal accountabilities have value within the humanitarian sector because they can

support more effective, interconnected humanitarian action. Further, practical actions can be undertaken to support and cultivate elements of socialising accountability.

At the humanitarian system level, encouraging national capacity development, supporting linkages between development and relief agencies, and establishing pre-crisis coordination mechanisms, for example, are important elements of a holistic, comprehensive approach to humanitarian action. These findings provide support for the utility of the emergency management model, which has received scarce attention by humanitarian actors (ODI, 2012).

At the organisational level, fostering supportiveness, trust, and collaborative behaviours among inter-agency staff can enable not only more effective interventions, but potentially more respectful and meaningful engagement with the affected communities as well. At the individual level, empathy plays a key role in facilitating socialising and personal accountabilities as well as contributes to an effective response. Further, empathy may not be innate but can be cultivated. This is supported by broader research and disputes the notion that “getting the right people” is the primary solution to address these problems rather than strategic capacity development (Knox Clarke, 2013).

Although the research was situated within an RH context, feedback from the informants highlighted that the findings have broader implications for the ways in which emergency responses are organised and even how the humanitarian sector is conceptualised: prioritising and augmenting socialising and personal accountabilities can help facilitate a whole system and whole person approach to enable a more effective humanitarian response.

10. Chapter Ten: Discussion

10.1 Introduction

This research set out to examine the factors that enabled or hindered implementation of life-saving RH services during the humanitarian responses after Cyclone Nargis in Myanmar and the 2010 earthquake in Haiti.

Three iterative phases were developed to deepen analysis of emergent factors from each phase. Phase I explored the barriers and enablers to advancing MISP implementation during the two complex emergencies. Key enablers included effective coordination, competent and creative leaders, organisational and financial support, as well as awareness of the minimum RH standards. Barriers identified included limited numbers of skilled staff, inter-agency competition, socio-cultural and political obstacles, and lack of effective mechanisms to hold aid workers accountable for problematic behaviour. Two themes emerged from Phase I: lack of effective formal accountability mechanisms hindered MISP implementation while effective inter-agency cooperation appeared to foster a culture of socialising accountability that advanced MISP implementation.

Phase II explored these emerging themes more deeply and asked “How did socialising accountability manifest and what was its impact on the RH responses in Myanmar and Haiti?” Of the 14 in-depth interviews held with key actors in the RH responses, all reported that socialising accountability supported implementation of the MISP. I utilised, modified, and extended Romzek and colleagues’ (2013) model on inter-agency, informal accountability to identify supportive and obstructive social norms, behaviours, and challenges.

Enabling social norms emphasised trust and mutual supportiveness; enabling behaviours included frequent communication, acknowledging mistakes, and asking for help, among others. Challenges to socialising accountability centred on rapid staff turnover, poor leadership, and inter-agency competition. A key factor that reinforced socialising accountability, which was not included in Romzek and colleagues’ model, was a strong sense of personal accountability to RH implementation. In addition to acting as an enabler

for socialising accountability, personal accountability was identified as a new dimension of accountability in addition to formal and socialising aspects.

Phase III explored whether leaders in the fields of RH and health in humanitarian emergencies found value in the emerging insights regarding socialising and personal accountabilities and, if so, examined practical suggestions on the ways they could be strengthened. Two in-depth, key informant interviews were held, and I also discussed ways to strengthen socialising accountability with the 14 Phase II respondents. The two Phase III informants reinforced the relevance of the findings, which they said highlighted the importance of a comprehensive, holistic approach to humanitarian response and provided evidence for the significance of personal and interpersonal aspects, such as empathy and relationships. Phase II and Phase III informants gave suggestions regarding leadership, coordination, training, and human resources to augment socialising accountability and advance MISP implementation.

In sum, the two main findings of this research are: 1) lack of effective accountability mechanisms undermined MISP implementation in the RH responses after crises in Myanmar and Haiti; and 2) socialising and personal accountability partially compensated for these gaps and played critical roles in strengthening accountability processes as well as facilitating effective RH service implementation.

The research brings these informal accountabilities to the fore and explores how they operate as well as their value in a humanitarian response. The findings challenge the humanitarian sector's traditional focus on formal accountability processes and highlight the significance of socialising and personal elements. I argue that accountability emerges from a complex hybridisation process that includes formal, interpersonal, and personal dimensions. From this reflective research process, I propose an *ecological approach to accountability* in which accountability is understood as a dynamic, ongoing, interdependent process rather than a set of quantitative outputs. Further, applying this ecological approach may help augment a culture of accountability and advance RH implementation by identifying, engaging, and reconciling formal, socialising, and personal elements of accountability. The following analysis elaborates the ecological approach to accountability and explores theoretical and practical implications. I also reflect upon the methodology and suggest future foci for research.

10.2 Reflections on methodology

The use of constructivist grounded methodology applied to the two case studies proved an excellent fit for this research. Indeed, Charmaz's reconceptualisation of theorising as a practice rather than a goal parallels my own re-envisioning of accountability as an ongoing process rather than a static system focused on measurement.

Constructivist grounded theory abandons pre-established theory and affirms the social construction of the interpretation of data. It takes into consideration the experiences, values, and biases of the researcher throughout the research process. This approach encouraged fresh and reflective engagement with the data. The constant comparative method was utilised, and although cumbersome at times, it promoted analytic thinking and deeper reflection on emerging insights. Ongoing reflection through memoing was particularly useful and aided analysis.

Constructivist grounded theory supports a reflexive, thoughtful approach that allows for both inductive and deductive reasoning. It engages with "soft" factors, such as social, cultural, and psychological elements. This approach enabled the identification of subtle yet critical elements in the data that may have been overlooked by other methodologies. These soft factors, notably the inter- and intra-personal components of socialising accountability, formed the key findings of my research.

The three phases of this research were developed through iterative inductive and deductive loops. Each loop identified under-explored elements, which were examined more deeply in the following phase. The three phases helped organise the overall structure of the thesis. In addition, Romzek and colleagues' model (2013) was found to be useful for categorising Phase II findings. The model operated as an organisational tool rather than a theoretical frame that guided data collection and analysis and thus aligned with the constructivist grounded theory approach.

Chapter 2 outlined the four criteria that Charmaz (2005) set forth to evaluate constructive grounded theory studies: credibility, originality, resonance, and usefulness. The following self-assessment and critique explores the extent to which my work met these criteria. The limitations of this study have been previously discussed in Chapter 2, section 2.4.

Credibility

Charmaz relates credibility to the researcher's and informants' familiarity with the situation being studied and whether the evidence is robust enough to support the researcher's claims (2005). I have worked in RH in humanitarian settings for more than ten years including advancing global policy change and guideline development related to the field as well as leading the first capacity building initiative on MISP—the SPRINT Initiative—in the Asia Pacific region. I have been involved in a range of humanitarian evaluations of RH-related activities and am familiar with the key actors and with what happens on the ground. While my experience with, and knowledge of, accountability theory was limited before I embarked on this research, my understanding, insights, and hopefully contribution to the field have deepened greatly. Informants were selected on the basis of specific criteria, including the extent of their involvement in RH responses on the ground. This underpinned their credibility. In this regard, the credibility of the researcher and the informants is strong.

Regarding the robustness of the data and conclusions elaborated, I regularly shared my coding and writing with my academic advisors, and discussed the value of the data and the logic of my analysis with them and fellow PhD students. We established and I participated actively in a "PhD team" comprised of three other students researching related topics, all concerned with RH in humanitarian and development settings. This group collaboration provided space for critical discussion and additional feedback on written work. In many ways, it provided me with another setting in which socialising accountability was operational. Further, I attended two week-long training sessions, led by Dr. Pat Bazeley, on the qualitative research software NVivo. We discussed in-depth my coding and she provided valuable insights and suggestions. I also triangulated my findings with the informants themselves by sharing some of the findings for feedback and summarising key points during our interviews. Finally, I reviewed the literature again during my analysis to situate the conclusions within a broader discourse.

Originality

The criterion of originality refers both to whether the research is innovative and insightful. Does it make a contribution to the field and does it enhance our understanding and ability to analyse, predict, and intervene? Charmaz (2006) suggests exploring whether the findings "challenge, extend, or refine current ideas, concepts, and practices" (p. 182). Of the four criteria, originality is perhaps its strongest feature. A considerable number of evaluations of

RH implementation in humanitarian emergencies have been conducted since the early 2000s (Doedens et al., 2013; Krause et al., 2011; Marie Stopes International & Women's Refugee Commission, 2003; Women's Refugee Commission, 2003, 2005, 2007, 2008; Women's Refugee Commission & UNFPA, 2004). However, field evaluations by NGOs are often not methodologically rigorous and often leave much unanswered. Similarly, the literature on INGO accountability has been criticised for lacking maturity and discernment (Gray, Bebbington, & Collison, 2006). As noted in Chapter 7, socialising accountability is a new area that has not been explored in depth in an RH or broader humanitarian context. This study offers a nuanced conceptualisation of humanitarian accountability and contributes to a deeper understanding of the essential elements that underpin effective RH implementation.

Resonance

Charmaz (2006) describes resonance as the extent to which the analysis captures the complexity of the phenomenon studied and whether participants agree with the researcher's interpretations. This study intrigued my informants, and many expressed appreciation for the opportunity to review and reflect on their experiences through a new lens. They consistently affirmed the insights and analysis of the findings. However, the discussions demonstrated that the informants had difficulty embracing an expanded definition of accountability. Their understanding of accountability appeared ingrained within a technical context. The terms "socialising" or "informal" accountability appeared uncomfortable to describe the interpersonal and personal aspects of accountability. Few informants used these two terms during the interviews and preferred descriptive terms instead. In this sense, some specific language from the research did not resonate well with the participants.

Usefulness

The final evaluative criterion relates to the utility of the study and its contribution to the field as well as broader society. Indeed, Charmaz (2006) requests the researcher to ask whether the study contributes to the lofty goal of "making a better world" (p. 183). As suggested in the discussions of the previous criteria, this research hopes to enrich the debate by exploring a unique interplay of different fields. Further, an explicit goal of this research aligns with Charmaz's interest in making a meaningful contribution to the improvement of people's lives. The design of Phase III specifically sought feedback from key actors

regarding the utility and applicability of the findings. They responded positively, affirming the value of this work to the humanitarian field and to improving the health and lives of communities affected by crises.

10.3 Discussion

10.3.1 Bureaucratisation

A vicious civil war continues in Syria and has raged since March 2011. UNHCR reports the conflict has generated the worst refugee crisis in 20 years (Nichols, 2013) with over nine million people displaced or approximately 50% of the Syrian population (UNHCR, 2014b). As of November 2014, Za'atari camp in Jordan hosts more than 80,000 Syrian refugees, one of the largest refugee camps in the world (UNHCR, 2014c).

A UNOCHA news report, "Behind the scenes of the 'most complex' refugee operation in the world", described the harrowing conditions for aid staff at the camp. Violent riots, staff shortages, 12+ hour work days, and listening to refugees' heartbreaking stories were daily challenges (IRIN, 2013). Humanitarian workers struggled to implement basic services while keeping up with the continuous influx of refugees. They themselves shared only one set of overflowing drop toilets and had no running water (IRIN, 2013).

Many humanitarian staff choose to risk their lives and give up comfortable lifestyles to help others. The humanitarian aid industry is still in its adolescence and armchair criticism of humanitarian response efforts is easy to make given the myriad challenges and significant short-comings—both of the field and indeed *in* the field. The description of the working conditions in Za'atari camp is important if we are to ground critical discussions of humanitarian action in the realities of the field. One can imagine the difficulties in implementing basic RH health services in Za'atari, such as ensuring separated latrines to prevent sexual violence, operating services for different client groups, establishing regular coordination meetings, or consulting the refugees themselves.

The article describing Za'atari camp helps highlight the importance of both formal and informal accountabilities in complex, chaotic humanitarian settings. The pressing needs of a displaced population can easily bewilder and overwhelm aid staff. As such, certain formal

accountabilities such as minimum standards are essential: they provide guidance to humanitarian staff on the pre-determined, life-saving interventions that are critical to preserving the health and well-being of affected communities. Indeed, almost all the informants from Myanmar and Haiti commented that the minimum RH standards set forth in the MISP were helpful in guiding implementation of services. A division of labour between agencies is also useful in organising responses. These formal accountabilities can be seen as part of the bureaucratisation process of the relief sector.

Within the field of humanitarian response, the introduction of certain aspects of bureaucracy has been beneficial to counter chaos and haphazard decision-making. Although "bureaucracy" can connote a *Schimpfwort*, or bad word (Merton, 1967, p. 251), it was originally described by German sociologist Max Weber (1947) as the most rational and efficient means to construct organisations and systems. Characteristics of Weberian bureaucracy include a clearly defined division of labour, roles based on technical qualifications, and hierarchised systems organised to attain organisational goals (Weber, 1947).

Evaluations of international humanitarian action demonstrate the need for more streamlined, equitable responses (Broughton & Maguire, 2006; Darcy, Bonard, & Dini, 2012; Grünewald & Binder, 2010; Polastro, Nagrah, Steen, & Zafar, 2011; Polastro, Roa, & Steen, 2010). The findings from the Haiti case study, supported by other evaluations, clearly brings this to the fore and illuminates a response overwhelmed by inexperienced NGOs with unqualified and unprofessional staff (Bhattacharjee & Lossi, 2011; Grünewald & Binder, 2010; Haver, 2011; IASC, 2010c; Rencoret et al., 2010; UNOCHA, 2010c). The informants from Phase III described similar problematic experiences in the field, including haphazard and ineffective interventions as well as "the inappropriateness of humanitarian assistance", according to a senior health expert in a UN agency.

Efforts to address these shortcomings can be seen as bureaucratic in nature. For example, the IASC's Transformative Agenda, part of the Humanitarian Reform process, was launched in 2011 to address the ongoing challenges in humanitarian responses as a result of failures of the Haiti earthquake and Pakistan flood responses in 2010. Key aspects of the Transformative Agenda include the establishment of a pool of select leaders pre-deployment (roles based on technical qualifications rather than cronyism or nepotism),

streamlined coordination mechanisms (clearly defined division of labour), a steering committee and defined Cluster Leads to achieve collective humanitarian response objectives (hierarchical system to attain goals) (IASC, 2012c). At the time of writing, the Transformative Agenda is in the process of being rolled out, but is not yet well known at the field level (HAP, 2013).

Bureaucracy can improve accountability through outlining clear roles and responsibilities. Such a structured approach can be useful in emergency settings by providing a pre-determined template that can free up staff time and, counter-intuitively, support flexibility (Knox Clarke, 2013, p. 40) The findings from this research support the utility of integrating certain aspects of bureaucracy, such as leadership, division of labour, minimum standards, and common goals, into the humanitarian architecture. Indeed, a key finding from Phase I was that the lack of prioritisation of RH among humanitarian actors and the dearth of established mechanisms to ensure its implementation were critical barriers. Informants suggested that the introduction of bureaucratic elements, such as the establishment of an RH sub-cluster or a pre-identified RH lead agency, could assist in advancing the MISP in humanitarian settings.

10.3.2 *Déformation professionnelle*

Nevertheless, unchecked bureaucratisation of social structures invariably undermines its objectives. Weber himself observed that bureaucracy was a “structure of domination” (1978, p. 255) that threatened individual freedom and democracy, creating an “iron cage” of machine-like control (Kim, 2012). Bureaucracy is ultimately anti-flexible, anti-social, and anti-innovation. It engenders what Robert Merton describes as a “complete elimination of personalised relationships” (Merton, 1967, p. 195-196). Philosopher Jürgen Habermas suggests that bureaucracy undermines social relations and moral norms through the “technocratisation” and rationalisation of the *lifeworld*, or people’s engagement with the world around them ("Critical management theory," 2012). Indeed, the rational, technocratic approach of bureaucracy erodes the inter-personal, ethical, and creative elements that both the findings and the literature demonstrate are essential for an effective humanitarian response.

John Dewey proposes that bureaucracy leads to *occupational psychosis*—a blind or irrational application of skills and training that is out of touch with reality (Burke, 1954, p. 54-59). A similar notion is the French phrase *déformation professionnelle*, which refers to a distorted understanding of one's professional context (Robbins, 1986, p. 67).

In the previous chapter, an informant provided an example of occupational psychosis in action: she was requested to rubber-stamp a one-year project on female genital mutilation that required approximately five to ten years to make an impact, a point that she had previously made strongly to senior UN management. She noted that it was the UN structure itself, rather than donors, which warped the management into habitually approving futile projects with limited impact. Noteworthy is that input from the informant—a leading RH advisor who proposed the project—was not consulted in the development of the proposal. Instead, the proposal was produced by the Community Services department, a branch that had been criticised for its lack of professional staff and "its heavy reliance on 'implementation indicators' rather than 'performance or output' indicators" (UNHCR, 2003, p. 54). Undertakings are valued according to the perceived currency of the project goals rather than impact, reflecting a culture of "performativity" in which individuals or agencies perform deceptive gestures that *appear* to account for actions but are ultimately empty and meaningless. This façade is also termed by Najam (1996) as the "sham of accountability" (p. 346).

The FGM example highlights the fragmented nature of bureaucratic systems and the distortion of decision-making that is perceived as normal within the organisation yet as irrational and inappropriate from the outside. The key informant succinctly describes this expression of occupational psychosis by noting that this "is crazy!" To quote the author Joan Didion, "It is possible for people to be the unconscious instruments of values they would strenuously reject on a conscious level" (Didion, 1981, p. 107). Large bureaucratic structures can warp organisational priorities by prioritising the box-checking of indicators over meaningful change or impact.

A parallel can be drawn between the fields of humanitarian relief and psychiatry. In both sectors, the goal is to help alleviate the suffering of others. Within the U.S., psychiatric care has become increasingly bureaucratised and alienated from those it seeks to help (Bransfield & Bransfield, 2010). Manuals such as the *Diagnostic and Statistical Manual of*

Mental Disorders (American Psychiatric Association, 2013), while beneficial, have also contributed to the medicalisation of treatment and the erosion of the "therapeutic alliance", a positive, collaborative therapist-client relationship (Orlinsky, Ronnestad, & Willutski, 2004).This proves self-defeating as successful treatment is largely based on the intimacy and connection between therapist and client (Orlinsky et al., 2004).

Noted psychiatrist Bernadette Grosjean reflects that, "Once in the field, if a young psychiatrist has the courage to keep his or her eyes open, he or she realises that the world of mental illness is, for the most part, unclassifiable, unpredictable and much more difficult to treat than it is in an article in The New England Journal of Medicine" (Grosjean, 2012, para. 35). The field of humanitarian response is similarly erratic and uncertain, and requires flexibility and presence on the part of the aid worker. Guidelines such as the Sphere Manual provide important guidance but a successful humanitarian response requires personal values and interpersonal social skills far beyond the technical.

10.3.3 The rise of socialising and personal accountabilities

Traditional forms of accountability oil the bureaucratic machine. They ensure bureaucratic structures are in place and functioning. Similar to the consequences of unchecked bureaucratisation, the *accountabilitisation* of the humanitarian field has had a dualistic impact. Some formal accountability structures have benefited the field, such as integrating the MISP into various international standards and guidance, while others have constrained or undermined effective humanitarian action.

Accountability is conventionally understood as a system of measurement. Yet how can we measure or account for the alleviation of human suffering? Can we create guidelines on how to emotionally "show up" and engage with others in a crisis?

Returning to Za'atari camp in Jordan: it is made up of people, people in crisis, people in need, and people trying to assist. Formal accountability mechanisms—while important—also present an illusion of control in chaotic and volatile environments. Technical accountability processes may become reified, providing a sense of comfort to aid workers trying to manage what is in many ways uncontrollable. The idea that "what can be planned, should be planned" is far from reality. The technical mechanisms can erode the holding of

others to account as individuals may hide behind these mechanisms. A sense of responsibility for the other may diminish as the individual hopes that some external process will deal with transgressions.

Humanitarian response is comprised of human beings—like the aid workers and refugees struggling in Za'atari camp—and it is ultimately human beings who hold each other accountable. The philosopher Emmanual Levinas describes the power of the face-to-face encounter and the inherent responsibility to *the Other* this interaction generates (Bergo, 2013). An encounter with another person, even without speaking, elicits both fears of comparison and inadequacy as well as forges an ethical sense of obligation to *the Other* (Ferreira, 2008). As humanitarian personnel work in the field, side-by-side, face-to-face, a powerful accountability lies within these relationships.

Socialising accountability

The findings spotlight the value of the interpersonal, socialising aspects of accountability in advancing implementation of life-saving RH services in humanitarian settings. A number of scholars attest to the under-appreciated significance of socialising accountability to increase meaningful accountability processes that, in turn, help achieve established goals and objectives (cf. Dubnick, 1998; Gray, 2000; Lindqvist & Llewellyn, 2003; Munro & Hatherly, 1993; O'Neill, 2002; Roberts, 1991; Shearer, 2002; Spence, 2009). A 2010 review of the research on effective emergency management found that accountability "hardware", such as formal structures and legal frameworks, are overvalued (Boin & 't Hart, 2010, p. 367). They asserted that informal, interpersonal structures including inter-agency communication and coordination—key elements of socialising accountability—are what "matter most in shaping the quality of crisis responses". Amrikhanyan's (2009) research on state and government collaborations showed that "[i]n cooperative contracts, monitoring officials work jointly on overcoming obstacles, using common language, and maintaining relationships rather than enforcing rigid standards and looking for other providers…[O]pportunistic behaviour and the transaction costs are minimised, and performance is influenced by professional and informal rather than bureaucratic accountability pressures" (p. 526).

Research specific to non-profits, including the humanitarian sector, also suggests that socialising and personal accountabilities offer opportunities to fill the gaps of technical

accountabilities (Ebrahim, 2003, 2005; Fry, 1995; Hilhorst, 2002; Romzek et al., 2012). This was reinforced by my findings from Haiti and Myanmar where the Health Cluster, which is technically responsible for ensuring MISP implementation, had limited involvement in the RH response in Haiti and actively disregarded RH in Myanmar. Without this formal support, RH actors invested in interpersonal relationships to move the issue forward.

Essential enablers: trust and leadership

Of the components of socialising accountability identified in this research, I bring trust and leadership to the fore as primary enablers for RH implementation. Below I contextualise them within the broader literature.

Trust in groups and networks has been shown to increase coordination and efficacy (Kenis & Provan, 2007; Klijn et al., 2010; Laporte, 1996; Noteboom & Six, 2003; Van Slyke, 2006). Research on disaster response demonstrates that highly structured, bureaucratic systems cannot replace interpersonal trust and pre-existing relationships built through training or working together in previous disaster responses (Boin & 't Hart, 2010; Moynihan, 2009; Tierney & Trainor, 2004). A literature review on leadership and humanitarian response reports that "where success occurs, it is not a result of the structures and processes alone but equally a result of high levels of trust between agencies and strong interpersonal and inter-agency relationships" (Knox Clarke, 2013, p. 37). One study that interviewed 102 international and national aid actors found that trust was identified as one of the most important factors in the development of effective emergency response teams (Emergency Capacity Building Project, 2007, p. 5).

Trust is often contingent upon pre-existing relationships. Interpersonal trust among people and within groups underpins positive relationships. Trust and pre-existing relationships are mutually reinforcing: as the relationship grows stronger over time, trust deepens as well. The importance of this symbiotic relationship in advancing RH implementation was emphasised by respondents. In Haiti, a former RH Working Group focal person said simply, "Trust is how we became a family".

"Swift trust theory" suggests that even temporary groups—like coordination groups in a humanitarian emergency—can develop a type of trust that augments group cohesion and efficacy (Meyerson, Weick, & Kramer, 1996 in Knox Clarke, 2013). However, this trust

development is contingent on the group working together again in the future, which speaks to the importance of longer term relationships that are not valued in bureaucratic systems or, for that matter, the field of humanitarian response. Hackman and Morris (1975) assert that "group effectiveness…lies in the on-going interaction processes which take place among group members while they are working on a task" (Hackman & Morris, 1975, p. 46 in Stevens and Campion, 1994). Scholars focused on social capital have also highlighted the importance of interpersonal connections and relationships in enhancing accountability (Awio, Northcott, & Lawrence, 2011; World Bank, 2011) and enabling goal achievement (Awio et al., 2011; Coleman, 1990; Gray et al., 2006; Inkeles, 2000; King, 2004; Lin, 2001; Nahapiet & Ghoshal, 1998; Paldam, 2000; Prusak & Cohen, 2001; Putnam, 2000).

The value of trust in interpersonal and network relationships clearly comes to the fore in the findings from Myanmar. Positive pre-existing professional and personal relationships greatly facilitated the RH response and strengthened a culture of accountability among RH actors. In Haiti, trust and cohesion among RH Working Group members stabilised with increased participation from national actors who knew each other and had ongoing relationships. Further, the findings from Haiti point to the ways in which effective collaboration of the IAWG at the international level mirrors collaborative "team work" at field level. Informants who had established a relationship through the IAWG connected and coordinated with greater ease. This demonstrates the importance of ongoing vertical and horizontal linkages and networks at international and national levels and also supports other research demonstrating how establishing connections and relationships across many levels can augment accountability processes (Boin & 't Hart, 2010; Roche, 2009).

Effective leadership is the second key enabler for an effective RH response. The socially competent RH Focal Points in Haiti and Myanmar reached out and enlisted others into the Working Group. They helped to establish norms of trust and supportiveness to strengthen group cohesion and collective accountability. This fits with Bruno Latour and Michael Callon's Actor Network Theory, which proposes that leaders enhance networks through enrolment of others (Callon, 1986). In Haiti, RH Focal Points actively connected RH to other sectors in order to draw in more members to the coordination mechanism. In Myanmar, group leaders reached out to other health and RH actors to participate in the RH Working Group as well as connect them with the broader RH network. In this way, these effective

socially engaged leaders were able to effectively enrol others in both formal and socialising accountability processes.

The findings support a 2014 ALNAP study on leadership in humanitarian settings, which suggests that effective leaders are those who reinforce group involvement and shared responsibilities. This can enhance group accountability and improved performance, which was also reflected in the two case studies. A literature review on social capital and leadership in non-profit organisations found that leaders who "develop strategic partnerships, engage in advocacy, enhance community relations, and create a shared strategic vision and mission within the organisation and its employees" help achieve organisational goals (King, 2004, p. 471). The RH Focal Points employed these behaviours, thereby reinforcing socialising accountability.

In the social psychology discipline, research on bullying in American high schools suggests that engaging popular, socially connected leaders, rather than top-down measures, can cultivate positive, supportive group norms (Paluck, 2012). The relative impact of leaders' emotional intelligence on team cohesion, performance, and effectiveness within organisations has also been documented (Goleman, Boyatzis, & McKee, 2002; Prati, Douglas, Ferris, Ammeter, & Buckley, 2003).

Personal accountability

Intra-personal factors, such as personal ethics and commitment, also played an important role in advancing RH. All Phase II informants from both settings reported that a strong sense of personal accountability to the issue and the affected communities fuelled their efforts. They were emphatic in identifying ethical and empathetic considerations as a primary driver for the enactment of socialising accountability.

Numerous scholars have written about the importance of personal ethics in organisational accountability processes (Cornwall et al., 2000; Dubnick, 1998, 2003; Ebrahim, 2005; Fry, 1995; Lindqvist & Llewellyn, 2003; Sinclair, 1995; Willmott, 1996). Sinclair (1995), for example, argues that "personal accountability is regarded as particularly powerful and binding" as control is enforced through internal, rather than external, means (p. 230).

Hodge and Coghill (2007), in their research on the privatisation of the public sector, suggest that personal accountability underpins all other accountability processes and is essential for effective accountability mechanisms.

While some writers such as Davis (2007) reject ethical considerations and reframe humanitarian accountability solely within a procedural framework, the findings from this study indicate that personal values facilitate accountability and need to be taken into account.

Dubick (2003) queries, “Does accountability foster ethical or morally responsible behaviour?” (p. 406). I invert this question and ask, “Do (internal) ethics and morality foster accountability?” Although it is beyond the scope of this research to fully address this question, the findings demonstrate how personal accountability spurred actors to reach out to, support, and collaborate with other RH actors. The driver for these behaviours cannot be solely attributed to adherence to technical requirements, such as the first objective of the MISP, that mandate coordination. Respondents spoke about their RH-related work using emotive language such as “love”, “passion”, “my chosen path”, and “inborn responsibility”. Some expressed a sense of shame or guilt in their inability to meet the RH needs of affected communities. These emotions reflect a violation of their internal value system and moral obligations rather than a failure to meet contractual duties.

Empathy can engender personal accountability and ethical behaviour (Munro et al., 2005). One UN official in Myanmar, for example, explicitly said that her empathy for, rather than formal accountability to, the affected communities motivated her to act. Hugo Slim (2010) suggests that empathy can avert global death and suffering if it is used to shape global political consciousness and institutions (p. 1206). Indeed, lack of empathy, according to Levinas, allows a reductionist distancing process in which a label such as “refugee” defines a person rather than seeing someone as a complex, feeling human being like oneself (Bergo, 2013). This separation is one of the primary roots of violence.

The *capacity* for individuals to cultivate empathy, which strengthens accountability processes, should be recognised. Empathy cannot be forced, but it can be facilitated through teaching or training (Davis, 1990; Stover, 2006). It can be argued that psychological distancing is a beneficial coping mechanism in severely stressful

environments such as humanitarian work. However, empathy does not require the dissolution of boundaries with self and Other (Connolly, 2006). Emotional and psychological boundaries are essential for “true empathy” (Connolly, 2006). Establishing these boundaries and engaging in self-care can contribute to the development of empathy and is important for the mental health of aid workers.

In addition, empathy can fuel social competence as well as forge supportive relationships (Prati et al., 2003). For example, a Phase III respondent described how fostering empathy among aid workers for refugees increased group cohesion as well as more effective interventions, reinforcing the interconnectivity between intra- and interpersonal accountabilities.

10.3.4 Hybridisation

This research questions a fundamental claim by some scholars that a lack of synchronisation between formal accountability and personal ethics creates a moral-strategic split. Roberts (1991) argues that “contemporary organisational accountability is constructed around an untenable and destructive split of ethical and strategic concerns to the detriment of both” (p. 355). Dubnick (2003) similarly suggests that the absence of alignment between personal and work-related accountabilities creates “an existential conflict” (p. 424).

Everett & Frieson (2010) explore this tension in the context of international relief, and conclude that the conflict between personal values and formal accountabilities, particularly in relation to donors, creates a grotesque culture of humanitarian performativity. Humanitarian actors, they suggest, behave as though they are moral agents based on the social narrative that relief agencies are inherently ethically driven; in reality, however, their moral underpinnings are subsumed by technical requirements from donors and others. Roberts (1991, 1996) further suggests that formal accountability processes undermine socialising accountability in addition to personal ethics. He argues that vertical and horizontal accountabilities are, to a large extent, mutually exclusive: individualising, hierarchical accountability processes by nature erodes interpersonal, social accountabilities. He asserts that organisations do not value or recognise ethical or social accountabilities, thus forcing employees to privilege formal obligations. Although both Everett and Frieson

and Roberts acknowledge some ambiguity and interdependence in their analysis, they present a bifurcated picture of formal and informal accountabilities.

The findings from the two case studies reveal a more complex story of the interplay of personal, socialising, and formal accountabilities. Certainly, cross-pressures and competing accountabilities, particularly balancing organisational and inter-agency commitments, manifested in both settings. In Haiti some respondents expressed frustration at their desire to provide RH care with the conflicting priorities of their organisation, thus reflecting strains at a moral-strategic level.

However, in both case study settings, formal and informal accountabilities were not inherently pitted against one another. They sometimes aligned and, counter to Everett & Frieson and Roberts, reinforced each other. The majority of informants received funding specifically for the implementation of RH services, which coincided with their personal ethics and commitments. Technical processes such as the establishment of coordination mechanisms provided designated spaces in which to socialise and develop interpersonal connections with partners; this demonstrated how formal accountability systems reinforced and enhanced socialising accountabilities.

Some informants said that *more* formal accountability mechanisms for RH implementation were needed. Respondents complained that the lack of a pre-designated lead RH agency within the Cluster system contributed to the neglect of RH service provision. Although WHO is technically accountable for ensuring RH is addressed, it is not held accountable by Health Cluster members if RH is neglected.

Informants also desired effective leadership from a formal RH Working Group focal person who would enrol others and facilitate the RH response. In this way, they could facilitate informal accountabilities. Indeed, the *lack,* rather than the presence, of certain formal mechanisms contributed to the failures in MISP implementation.

At the same time, some formal accountability mechanisms discouraged meaningful accountability processes as explored in the previous section. As Roberts (1991) suggests, many formal accountability processes are rooted in exclusion, specifically, the exclusion of the “wrong-doer”. This begets a fear-driven culture in which individuals are terrified of being

held accountable and thus retreat into self-absorption, self-preservation, and even dishonesty. This fear-inducing form of accountability is embedded and continuously reinforced in the wider world. For example, after the 2013 Boston Marathon bombings, headlines around the globe referred to a prominent quote from U.S. President Obama, "We will find out who did this, and we will hold them *accountable*" (Holland & Mason, 2013, emphasis mine). While these perpetrators should indeed be held accountable for their crimes, the term itself is wielded like a stick. Applying this traditional, punitive conceptualisation of accountability to (non-criminal) humanitarian accountability processes can produce fear and encourages people to retreat rather than disclose.

Both the technocratisation of accountability systems and the lack of effective formal accountability mechanisms compromised the development of robust accountability processes. Socialising and personal accountability helped to fill these gaps. This research demonstrates the ways in which actors negotiated and managed various accountability processes in order to achieve programmatic, personal, and inter-agency commitments. As such, these findings challenge Roberts' (1991) claim that "obligations that come with a commitment to the hierarchy threaten the loyalties of informal, whilst informal commitments risk compromising and subverting functional responsibilities" (p. 364). The findings suggest a more dynamic, dialectical approach to conceptualising accountability. Other scholars (Bourguignon et al., 2010; Koliba, Zia, & Mills, 2011; Lindqvist & Llewellyn, 2003; Munro & Hatherly, 1993) have similarly criticised a dualistic discussion of accountability, advocating a hybrid approach.

10.4 Theoretical implications: an ecological approach to accountability

Humanitarian accountability needs rethinking. Despite increased attention by humanitarian actors and scholars, the discourse has given limited consideration to socialising and personal aspects of accountability. Calls for reform have challenged traditional understandings of accountability, yet many new permutations still appear rigid and constrained. HAP's (2008a) redefinition of accountability, for example, as "the responsible use of power" was welcomed as a clear and fresh approach, particularly given the lack of accountability towards affected communities. Yet is accountability really just about power? This redefinition continues to reinforce a vertical conceptualisation of accountability that may evoke a sense of threat and fear. As explored above, punitive understandings of

accountability “work backwards” (Strathern, 2000), ultimately obscuring what they seek to reveal. Who wants to be accountable if it is equated with criticism, punishment (such as through loss of funding), and shame? A performativity of accountability ensues.

Informal accountabilities are also clearly no panacea or antidote to the pitfalls of technocratisation. A diffuse or overly holistic approach can erode accountability processes if expectations are vague: people may not feel accountable or behave ethically if responsibilities are unclear (Baucus & Near, 1991 in Dowse, 2011).

One anonymous humanitarian blogger, who criticises the use of simple accounting tools to manage complex humanitarian systems, writes: “An organisation shouldn’t have to prescribe what accountability must look like, but instead leave it to the capacity of the individual responding to find how best to apply that accountability principle in the midst of the chaos” (MoreAltitude, 2010, para. 33). While the discourse should move in a principled direction, a more complex, integrated understanding of accountability may better foster effective formal, personal, and socialising elements. This transcends opposites and embraces a dialectical, hybrid approach.

I suggest a reconceptualisation of accountability and propose an *ecological approach*. Ecological approaches have been applied to public health (cf. Kickbusch, 1989; Novilla et al., 2006; Nurse & Edmondson-Jones, 2007) among other disciplines, but were not identified in accountability literature.

Ecological, in its broadest sense, refers to the relationship between organisms (in this case, people) and their surroundings (Hurst, 2012, p. 5). An ecological approach is inherently contextualised and addresses multiple influences and factors at the individual, interpersonal, community, and societal levels (WHO, 2014a). It recognises that no one factor causes an outcome and that individuals adapt to their environment to maximise survival and success. Notions of interdependence and interaction are key to an ecological approach (Kickbusch, 1989).

Applying an ecological approach to accountability highlights the socialising and personal components and reframes it as an ongoing, interconnected, interdependent, contextualised process and practice rather than a static system of measurement. I situate accountability

against Nurse and Edmonson-Jones' ecological public health frame, which outlines five key elements to explore applicability and fit (Nurse & Edmondson-Jones, 2007, p. 557).

1. Each component is part of a cyclical system

Accountability *emerges* from diverse components working together, like an ecosystem, influencing, reinforcing, as well as eroding each other. Enactment itself becomes an enabler and advances the reproduction of accountability ties. As a dynamic process, it includes cyclical aspects at the micro level, such as feedback loops from crisis-affected communities which, in turn, influence the behaviours and practices of humanitarian actors towards affected populations. At the macro level, within the humanitarian sector context, crises can be seen as cyclical in nature: prevention → crisis → response → recovery → and then looping back to prevention or crisis. The production of accountability is inherently tied to its environmental context and thus mirrors this broader cyclical pattern. The manifestation and relevance of different forms of accountability are dependent on timing within the cycle. In terms of formal accountabilities, the MISP, for example, is critical to the prevention and crisis phases but less so at other points in the cycle (after implementation).

2. Each part influences the other

Accountability is not comprised of discrete components, but arises through the interaction of different aspects. Formal, socialising, and personal forms of accountability are symbiotic. For example, in the story told by a Phase III informant, programme staff working on adolescent family planning who became more empathetic to their clients—thus enhancing accountability to the clients—also became more connected to each other, which fostered socialising accountability. Other examples in this research demonstrate how personal accountability to RH and affected communities augmented and reinforced socialising and formal aspects, contributing to an overall culture of accountability.

3. A balance of different components is needed to maintain a healthy ecosystem

An effective, or healthy, accountability system includes a balance of formal, socialising, and personal accountabilities. Too much or too little of one form can undermine the system. At an organisational level, overly bureaucratic systems can become unwieldy and ineffective, eroding accountability processes. A lack of formal mechanisms can promote reckless behaviour or incompetent interventions. Effective leadership, confrontation, and "intelligent" or meaningful consequences for actions are tools to maintain balance.

4. Clear pathways between components allows a cycle of energy to flow

A productive accountability culture requires clear roles and responsibilities, open channels of communication and spaces for engagement, as well as an alignment of accountabilities. When accountabilities are out of sync or contradictory, individuals may be forced to abandon one form. In the two case studies, many informants gave priority to personal over formal accountabilities. In other settings, individuals may prioritise technical accountabilities that counter personal values and thus may disengage or even work robotically without reflection. Under both circumstances, accountability stagnates. A culture of accountability flourishes when accountabilities are aligned and reinforce one another.

5. The overall system needs to be sustainable

An effective accountability system emerges when it is sustained over time at the micro and macro levels. For example, at the micro level, low staff turnover supports socialising accountability, strengthening the entire system. From a broader perspective, when a cohesive accountability system straddles the humanitarian and development divide, the system is sustained and reinforced.

The theoretical underpinnings of the ecological approach to accountability are based on "intelligent accountability", to draw from O'Neill's language (O'Neill, 2002). The principles of this intelligent accountability encompass integrity, shared responsibility, and justice. Accountability shifts from a judgmental, punitive approach of "holding someone to account" to helping people achieve goals and meet responsibilities; sanctions become the exception rather than the rule. As Roberts notes (1991), the goal of accountability is not conformity or consensus. Rather, the objectives involve the augmentation of mutual understanding, trust, and supportiveness.

10.5 Practical applications of the ecological approach

Applying the ecological approach has the potential to enhance a culture of intelligent accountability at all levels of the humanitarian architecture. Multi-level approaches are essential to engender change. At an individual level, the ecological approach could help humanitarian staff recognise the value of socialising and personal accountabilities. It brings interdependence to the fore and encourages people to recognise their influence and power in an interconnected, interdependent system. Indeed, it has the potential to empower staff

to embrace individual responsibility and promote interpersonal cooperation. Further, the ecological approach recognises the value of confrontation in developing a meaningful culture of accountability. Confronting another person is intimidating and requires courage, discipline, and commitment to the principles of accountability. The approach impresses upon individuals the value of constructive confrontation, which is rarely mentioned in discussions of creating an accountability culture, and the importance of a climate of safety and trust to enable the confrontation process. Further, the ecological approach has the potential to help people reflect on their ethical framework, the value of empathy, and humanitarian principles. It highlights the importance of balance and spotlights addressing, or at least recognising, alignment disparities, paradoxes, and contradictions.

At the organisational level, agencies are the locus for promoting the ecological approach and encouraging a culture of intelligent accountability. This requires organisations to commit to changing the discussion and enactment of accountability from a set of activities to an ongoing process and overall approach to work. Agencies can promote the normative underpinnings of the ecological approach—justice, integrity, and shared responsibility—and cultivate a culture of enquiry through institutionalising space for ongoing discussion, reflection, and learning (which some agencies have initiated). The approach emphasises harmonisation of accountabilities in which agencies can explicitly identify and negotiate accountability tensions to establish flexible, aligned systems. Organisations can create rewards and incentives for peer supportiveness and promoting trust and participation with communities, which contributes to building a climate of stewardship and cohesion. Agencies can specifically promote trust-building—an essential component for a culture of accountability as well as an effective response—by encouraging a climate of safety that allows vulnerability to be revealed and resilience promoted. The After Action Review, for example, which was first developed by the U.S. military, is an interactive debriefing process in which troops discuss what happened during an event or exercise, why it happened, and how to improve collective performance in the future (Morrison & Meliza, 1999). The ecological approach can stimulate these and similar efforts.

Furthermore, institutions that apply the ecological approach and are guided by principles of intelligent accountability engender learning organisations, which, simply put, make people feel good. People enjoy working in an environment in which they feel connected, valued,

and rewarded for principled behaviour; this decreases staff turnover, increases performance and efficacy, and supports a sustainable accountability ecosystem.

The application of the ecological approach requires agencies to invest in their staff, specifically the development of interpersonal skills and personal values. Through training and mentorship programmes, organisations can help cultivate empathy, leadership skills, and social and cognitive skills such as situation awareness, decision-making, teamwork and trust-building, and effective communication including active listening and constructive criticism. Constructive confrontation in particular needs to be taught and rewarded, and often requires unlearning ineffective interpersonal communication habits (Toomey, 2000). In addition to augmenting accountability, these skills have additional benefits, such as, within the RH context, increasing patient safety and streamlining service delivery (Flin, O'Connor, & Crichton, 2008).

Applying the ecological approach at the humanitarian sector level can help actors recognise the personal, institutional, and socialising dimension of accountability and support more holistic, interconnected humanitarian action. With its emphasis on a sustainable overall system, the ecological approach supports knitting together the disparate elements of the emergency management universe.

Within the RH context, this requires integrating humanitarian response as an essential piece of health systems work and RH as an essential component of health. Indeed, the ecological approach can be employed as a tool to bridge the humanitarian and development divide and reinforce partnerships, coordination, and cohesive programming. It encourages engagement—long before a crisis—between international actors and government agencies, national and community-based organisations, health workers, and communities themselves to assist them to establish trusted partnerships to lead and manage an effective humanitarian response.

Changes in financing are essential for the development of a resilient, sustained sector-wide culture of accountability. The ecological approach could be leveraged to call upon donors to support national capacity building, organisational development and learning, and inter-agency collaboration, which funders have traditionally neglected in favour of direct service implementation. By recognising that overly technical accountabilities may constrain

effective humanitarian action, the ecological frame can provide support to donor reform efforts that advocate flexible, dynamic, adaptive approaches rather than generic solutions.

For a systematic shift to occur, sectoral buy-in is essential and must include explicit commitment and visible, ongoing involvement by political administrative elites (Boin & 't Hart, 2010, p. 368). If only a single agency embraces honesty about their operational challenges without the support of the broader field, it could face negative repercussions (Hoffstaedter & Roche, 2011). Just as organisations must create a culture of safety for individuals to be honest and vulnerable, so too the humanitarian sector must cultivate a suitable culture for organisations.

10.6 Directions for future research

This study highlights a number of areas for future research that can inform further knowledge about socialising and personal accountability processes and advancement of RH care in humanitarian emergencies. Firstly, the ecological approach to accountability requires further exploration and input from academics and practitioners. Are the practical applications outlined above realistic? Do practitioners find it useful? How can the approach be extended and refined? What are its limitations? How does it fit with the emerging field of complexity theory as applied to humanitarian response?

Secondly, the political dimensions of aid require further exploration in regards to the development of socialising accountability. In many conflict-affected settings, for example, authorities representing an oppressive government regime or even a party to conflict are involved in the response. How can socialising accountability be strengthened under these circumstances? How does one build this trust amongst agencies with differing perspectives on the politics, alongside differences in influence and power?

Third, the role of national and local cultures on socialising accountability processes also warrants further exploration. Were the successes in advancing socialising accountability in Myanmar largely due to cultural norms? If so, how can socialising accountability be cultivated in other settings with very different norms, behaviours, and expectations?

Fourth, the gendered intersection between RH implementation and socialising accountability throws up important questions. To what extent did the strong sense of socialising and personal accountability among RH actors have to do with their personal connection to RH as women, given that almost all the actors engaged at this level and emphasising socialising accountability were women? Can socialising and personal accountabilities be strengthened in other sectors, and amongst men, or were the findings from this research specific to RH?

Fifth, personal accountability emerged in Phase II and was not fully explored. Deeper examination of personal accountability in the advancement of RH care as well as its interface with socialising and formal accountabilities may provide further insight into developing intelligent accountability cultures.

Finally, the "dark side" of socialising accountability—destructive social norms, behaviours, rewards, sanctions—merit study. A 2013 paper on Nazi Germany, for example, explored the ways in which social capital, civic networks, and strong interpersonal relationships fuelled the rise of the National Socialist Party (Satyanath, Voigtlaender, & Voth, 2013). Given this, if and how can positive permutations of socialising and personal accountability be ensured in humanitarian settings?

10.7 Concluding remarks

The Nobel Prize-winning economist Elinor Ostrom imagined the ideal aid system as one that would "reward people for developing imaginative ideas that draw on the complexity of the real world, that leave people in developing countries more autonomous, less dependent, and more capable of crafting their own future" (Ramalingam, 2013, p. 363). She proposed that, in a rapidly evolving global society, the nature of change is non-linear and is achieved not through pre-fabricated solutions but through creating flexible, dynamic systems. A step toward realising Ostrom's vision involves replacing pre-set accountability mechanisms with an adaptive, ecological approach that is grounded in the local context and local communities. As the effects of climate change manifest in increasing displacement and migration, addressing the RH needs of displaced, conflict- and crisis-affected people becomes more urgent than ever. It is hoped that applying the ecological approach to

accountability can help humanitarian actors enhance affected communities' well-being and assist in realising their right to healthy and fulfilling sexual and reproductive health lives.

Appendix A: UNFPA Myanmar MISP training and orientation sessions, May-Nov 2008

1. MISP orientation sessions

No	Date	Participants				
		Gov	UN	INGO	Local NGO	Total
1	May 17	0	0	0	21	21
2	May 22	59	7	5	2	73
3	July 1	0	13	13	1	27
	Total	**59**	**20**	**18**	**24**	**121**

2. MISP training at Central Level (Yangon) and Township Level (Mon and Kayin States)

No	Date	Participants					Participating organisations
		Gov	UN	INGOs	Local NGOs	Total	
1	Aug 7-9	1	1	27	8	37	UNHCR, CARE, MMA, AFXB, MSI, PSI, Alliance, MDM, JOCHF, Burnet, World Concern, DMR
2	Aug 22-23	7	0	0	14	21	DoH, MANA, MMA
3	Nov 4-5	0	0	10	0	10	ADRA (Laputta)
4	Nov 10-11	23	4	6	5	38	Mawlamyine: DoH, UNICEF, UNHCR, IOM, Care Myanmar, WVM, FXB, SC, MSI, MNMA, MRCS, MMCWA, USDA, Fire Brigade Kyaik Hto Township: DoH Thahton Township: INGO; World concern, DoH Bilin: DoH Yae: DoH
5	No 13-14	12	0	2	3	17	Pa-an: DoH, WVM, SC, MMCWA, MRCS, Fire Brigade Hlaing Bwe: DoH
TOTAL		**43**	**5**	**45**	**30**	**123**	

3. MISP 0rientation sessions							
No	**Date**	**Participants**					**Participating organisations**
		Gov	**UN**	**INGOs**	**Local NGOs**	**Total**	
1	Jul 22	1	11	4	5	21	MWEA, UNDP, UNICEF, UNIAP,UNHCR, IOM, UNAIDS, UNFPA,JOICFP, Burnet Institute, ARMURT, Thingaha, NGO Gender Group
2	Sep 8	0	10	6	2	18	IOM, UNDP/UNOPS, UNICEF, PACT, Alliance, MSF Holland, AMI, OXFAM
3	Sep 10	0	12	3	3	18	UNHCR, UNDP, UNFPA, Care, MSF, AFXB, Ar Yone Oo, NGO Gender Group
TOTAL		**1**	**33**	**13**	**10**	**57**	

4. General MISP training at Central (Yangon) and Township Level (Ayeyarwadi, Yangon Divisions and Rakhine State)

No	**Date**	**Participants**					**Location/Townships**
		Gov	**UN**	**INGOs**	**Local NGOs**	**Total**	
1	Jun 16	0	0	0	150	150	MMA (GPs)
2	Aug 24-25	44	0	0	0	44	Kungyungone
3	Sep 8-9	68	0	0	0	68	Bogale
4	Sep 9-10	77	0	0	0	77	Mawgyun
5	Sep 11-12	100	0	0	0	100	Maubin
6	Sep 13-14	56	0	0	0	56	Pyapon
7	Sep 8-9	56	0	0	0	56	Kawmu
8	Sep 10-11	92	0	0	0	92	Kyauktan
9	Sep 12-13	73	0	0	0	73	Thonegwa
10	Sep 16-17	72	0	0	0	72	Twante
11	Sep 17-18	89	0	0	0	89	Dedaye
12	Sep 11-12	119	0	0	0	119	Myaungmya
13	Sep 13-14	87	0	0	0	87	Ngaputaw
14	Sep 18-19	96	0	0	0	96	Wakema
15	Sep 15-16	97	0	0	0	97	Laputta
16	Oct 1	65	0	0	0	65	Laputta
17	Oct 7-9	1	8	14	1	24	Rakhine – Maung Taw

18	Oct 20-21	0	0	0	46	46	Yankin MANA
19	Oct 23-24	0	0	0	49	49	North Dagon MANA
20	Nov 17-18	0	0	0	50	50	Shwe Pyi Thar MANA
21	Nov 21-22	0	0	0	50	50	Than Lyin MANA
22	Nov 24-25	0	0	0	50	50	Kyauk Tan MANA
23	Nov 27-28	0	0	0	50	50	Kungyangone MANA
24	Nov 2-3	0	1	18	5	24	WHO, ADRA, MRCS (Laputta), MRCS
25	Nov 17	0	0	0	15	15	MMA (Mobile)
26	Jul 16-20	0	0	0	6	6	MDM
27	Aug 25-26	0	0	0	13	13	IOM
TOTAL		**1192**	**9**	**32**	**485**	**1718**	

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