Evaluation: **MSF-OCP project in Yida camp, South Sudan**
Nov 2011- Dec 2012

Summary

On August 2nd, 2012, a press release by MSF declares a health catastrophe in Yida refugee camp, South Sudan where MSF-OCP is working since November 2011. Three months later, in October, MSF-OCP's Operations Department requests an evaluation of the intervention in Yida refugee camp to draw lessons learned. This review analyses the operations developed by MSF-OCP in Yida camp within the global scope of the entire humanitarian response, with a special focus on the emergency phase.

Methods
The evaluation was conducted at both MSF-OCP headquarters and in the field (visits to Yida and Juba) using a multidisciplinary approach. It is based on interviews with some 50 people who have been involved with the project in a variety of roles at different stages. The evaluation addressed all health related priorities to meet in emergency situations. Some limitations affected the evaluation: uncertainties around population figures; inconsistencies in global nutrition data; gaps in specific information and priority indicators from other actors' activities.

Context
In July 2011, fleeing fighting and bombing in the Nuba Mountains (NM), South Kordofan, a first wave of refugees crossed the border and settled in Yida, a small Dinka village in South Sudan. Because of the short distance to the border (12 km) the camp is not considered safe by the UNHCR that does not recognize it officially as a refugee camp, limits the assistance and tries to relocate the refugees. Following an exploratory mission around the new Sudan/South Sudan border, MSF-OCP E-Desk opens a small project in Yida (OPD and 15-beds IPD) in December 2011. The project returns to the regular desk in March 2012.

Results

Development of an emergency
From April 2012, the population in Yida grew dramatically and the situation deteriorated quickly. The basic resources became severely overstretched especially water and sanitation. It translated into an increase of diarrhoeal diseases, which in turn contributed to SAM among children and led to global excess mortality in June-July. Admissions doubled at MSF's field hospital and IPD mortality jumped. From July, aid agencies scaled up their response. MSF-OCP set up 3 new OTPs and increased its hospitalisation capacity to > 100 beds. These efforts significantly improved the situation in the camp and led to decrease previous months' excess mortality down to normal figures (for the area) as of August 2012.

Current situation and perspectives
The humanitarian situation has stabilised but remains precarious – for example, an outbreak of Hepatitis E in November highlighted the poor sanitation level: achievements in WASH contributed to control the situation. Daily surveillance of cases with CHWs was efficient (MSF/Epicentre). Current increases of new arrivals are observed and further surges are expected.

Resources
The resources – human and financial – increased sharply from July to support the operations.

Discussion

Delay in understanding the emergency

If, from April, information on Yida's situation was known at all levels, without a mortality surveillance system in place, it took weeks to realize the magnitude of the crisis and to convince decision makers. MSF-OCP also chose to focus on the medical response, refusing to engage in non-medical relief – i.e. 'emergency' WASH. This leads to question a certain 'loss' in MSF's know-how while managing IDP/refugee crises. Also, with limited insight into the situation in the NM, MSF-OCP, normally used to face such emergencies, was not prepared and anticipated poorly such an influx of refugees.

Delay in addressing to the emergency

Yida's location, potentially dangerous, has limited mid/longer-term investment at the early stages: UNHCR has repeatedly tried to relocate the refugees, and some donors have refused to fund assistance inside the actual camp. In face of agencies with funding issues and limited expertise in emergencies, MSF-OCP hesitated pushing to create its own space. This raises the question of the adequate timing for switching from lobbying to doing and more generally on MSF specific positioning within the aid system. In a climate of budget restrictions, the Reg. Desk was reluctant to scale-up operations. Finally, once the decision to scale up was taken, logistics constraints slowed down the response.

Recommendations (Cf. report p. 32-33 for full text)

Yida project

1. Develop understanding/knowledge on Yida camp's evolving situation
2. Develop understanding/knowledge on the situation in the NM and anticipate impact on Yida camp refugee population
3. Develop contingency planning now for 2013 (and way before rainy season, May 2013)
4. Ensure proper handover between E-Desk and Reg. Desk (NYC) and vice/versa if needed

MSF-OCP in general

5. Reinforce reflexes & maintain 'in-house' know how/10 health priorities at all levels
6. Reinforce the concept of emergency preparedness: making use of early diagnosis, early warning systems, timely data interpretation, context analysis, etc.
7. Include (re-introduce) WASH component in needs assessment in IDP/refugee emergency situations at least and in ad-hoc 'life saving' activities
8. Encourage 'early' field visits by HQ decision-makers: closer follow-up and exchange of perspective (institutional responsibility)
9. Maintain the early input of emergency specialists (MSF or Epicentre) = necessary added value in such emergency situations
10. Clarify decision making for handover to E-Desk earlier (triggers?)
11. Debate and develop institutional positioning /global aid system: necessary clarification, notably for the field teams, confronted to the international community daily.

Conclusion

Given the health needs of the population, the relevance of MSF-OCP presence in Yida refugee camp, the biggest one in South Sudan, makes no doubts.

But the main shortcoming of the intervention appeared in the delay in scaling up the project during the emergency phase (April-August 2012). If the response finally ensured adequate coverage of needs, turned out to be appropriate and efficient, lessons must be drawn from this intervention. Omitting to set-up surveillance system and refusing to engage in non-medical activities constituted

strategic failures. MSF, which has built most of its experience in IDP/refugee crises, must reinforce institutional reflexes and know-how on health priorities in such settings. Also, the analysis of the reasons behind the delayed response highlights a series of key issues for MSF including its positioning within the humanitarian system.

Today, the population's status has just stabilised in Yida refugee camp but the situation could quickly turn into another emergency as the war continues in the Nuba Mountains and as new influxes of refugees were witnessed during the evaluation and again reported at the time of the writing. MSF-OCP should capitalize on the past emergency: stronger preparedness plans and enhanced surveillance - notably for mortality, potentially epidemic diseases and possible pockets of malnutrition in Yida camp – are needed to avoid repeating the crisis scenario of July 2012.