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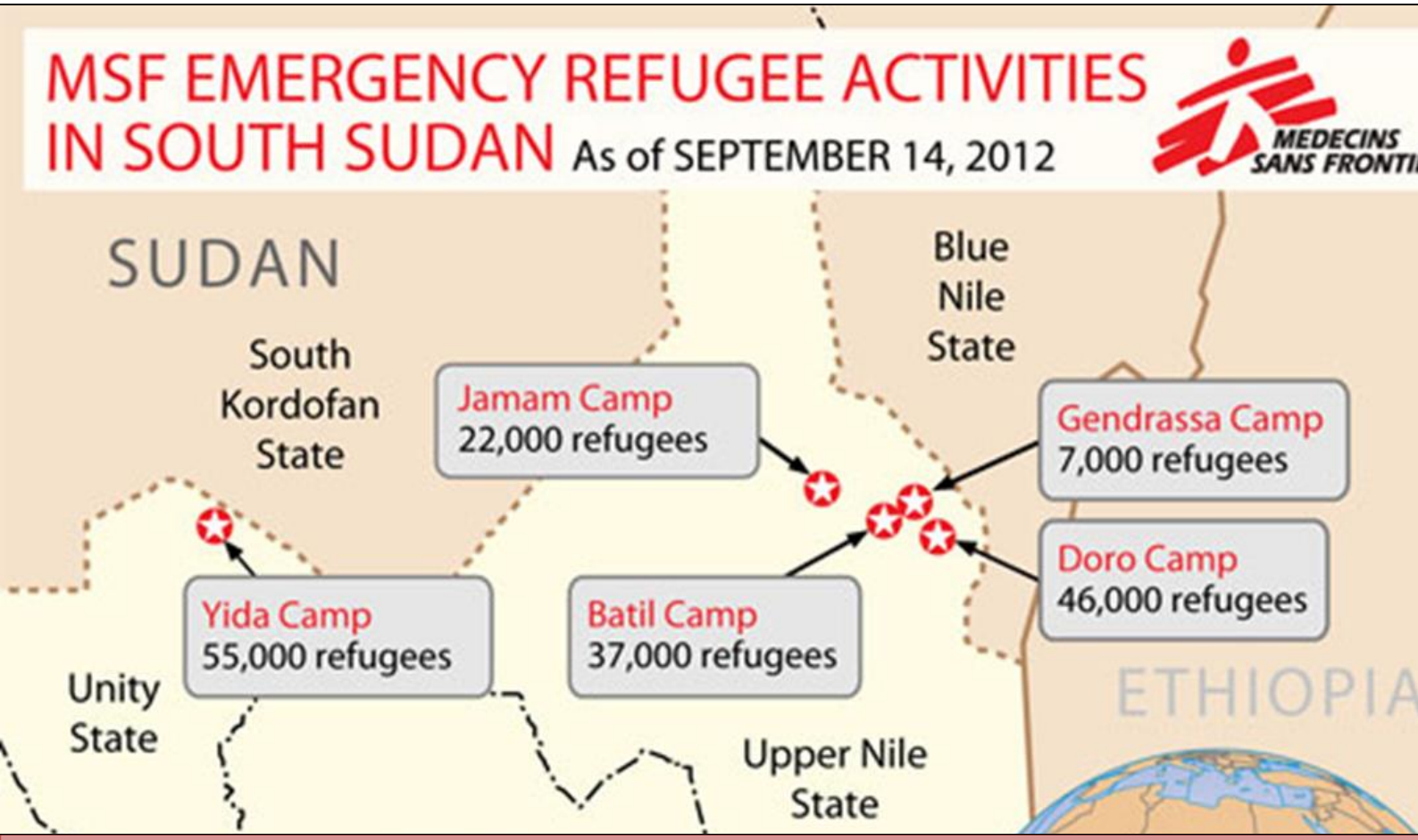

Evaluation

Summary

Maban, South Sudan, MSF-OCB, 2012

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EXECUTIVE SUMMARY

This report covers the evaluation of the Médecins Sans Frontières-OCB emergency refugee intervention in Maban County, Republic of South Sudan (RoSS). The evaluation was conducted during September and October 2012 and covers the period of November 2011 till June 2012. The methodology included both qualitative and quantative components and included a field visit during September 2012. Interviews were conducted with MSF staff, beneficiaries, external organisations and authority representatives. This evaluation was originally requested by the cell to provide a lessons learnt perspective from an emergency managed by a call and mission.

The refugee crisis was caused by the conflict within Blue Nile State in Sudan reigniting and tens of thousands of refugees crossing the border into RoSS. Maban County is an isolated region close to the border between the two countries with limited access, poor road network and often cut off during the rainy season as it is prone to flooding.

MSF-OCB conducted an assessment in November 2011 which concluded the need for an emergency intervention providing medical support to refugees who had settled in Doro Camp, close to Bunj town and at the border crossings, most notably El Fuj. The project began in December 2011, supported initially by the E-Prep team of South Sudan mission. The intervention quickly grew as the number of refugees increased and in late December the project expanded to support refugees settling in Jamam camp, closer to El Fuj border crossing.

The refugee population quickly grew to over 60,000 by the end of January in the two camps combined. A third wave of refugees began arriving in April and May and these were resettled in June in a third camp, Batil, 1 hour from Doro camp, taking the refugee population to over 100,000. A fourth camp opened in July with the relocation of over 50% of the Jamam camp population to Gendressa camp, located 4 kilometres from Batil camp. MSF OCB handed over the responsibility for Jamam camp in June to MSF OCA and subsequently handed over responsibility for Batil camp as well in November.

The MSF intervention was managed by the mission and the cell responsible within headquarters for South Sudan until June, when the responsibility was transferred to the emergency pool. The response started with the provision of medical care in Doro camp and at the border crossings but quickly extended to include provision of drinking water and non-food item distributions. While a nutritional survey was conducted in Doro in March, which showed a relatively stable setting, subsequent surveys conducted in Jamam and Batil camps showed alarming levels of mortality above the recognised emergency thresholds.

FINDINGS

The evaluation finds that, as the emergency developed and the number of refugees rose, the needs of the refugees went largely unmet or delayed as the international response was slow to scale up. MSF was consistently recognised externally as having been able to invest resources (both human and financial) quickly and adequately. The number of refugees seems to have been continually underestimated by UNHCR and other actors, which was given as one reason for the collective failure.

The registration of refugees was often slow and took weeks and sometimes months before they were provided non-food items or food distributions. The location of the camps made providing minimum standards for access to clean water extremely difficult. Availability was often limited to between 7 and 11 litres per person a day against the

recommended 20 litres per person per day. In addition the provision of acceptable number of toilets and hand washing points again failed to reach minimum standards.

The isolated location of the camps contributed to the difficulties experienced by MSF and other organisations. For example the transport of goods was often slow and very expensive with the World Food Programme particularly hit when transporting food stuffs. The window of opportunity for organisations to be ready before the rainy season added extra strains and stresses. It was recognised that many of the organisations working with UNHCR did not have the capacity to meet the needs and were reliant on their funding.

For MSF, the main critiques focused on the decision making structure within the organisation, the lack of a decentralised health care approach, the lack of an adequate home visitor and health promotion follow up, the failure in the supply system, and finally the lack of adequate human resources in the capital and project to implement all the activities required. There are other findings included in the report relating to the role of water and sanitation, construction choices (tents, prefabs, and inflatable tents), medical reporting and mapping and communication channels, amongst others.

1. A Committee de project (Copro) was held in January to confirm the response decision. No further Copros were held other than financial. The Copro system is an opportunity to incorporate participation from the house when defining and finalising operational decisions and strategies. While the final decision lies with the Operational Director, the possibility is there for strategies to be developed, proposed, challenged and have responsibilities and needs clarified. However, there appears to have been a breakdown in the Copro system for Maban. Perhaps in part due to the rapidly developing context or perhaps due to a more general breakdown in trust in the process.

2. The lack of a decentralised health care approach resulted in a centralised provision of health care through a Primary Health Care Centre with an inpatient capacity. Additional Primary Health Care Units were not established until June and July, some 7 months after the start-up of activities. MSF policies and guidelines state the importance of extending health care access and providing ambulatory therapeutic feeding, ante-natal services, mental health, vaccination and consultations through this approach.

3. An inadequate home visitor and health promotion network impacted on MSF's presence and awareness within the camp outside of the medical structure. It is the first line in the early warning and monitoring of the conditions within the camp. The importance of having 'eyes and ears' within the community cannot be understated. In Jamam home visitors were not employed and in Doro they were grossly underestimated. The apparent lack of awareness or use of refugee health knowledge by MSF in the field contributed to this. The expected standards and requirements are available in a variety of sources including MSF Refugee Health.

4. The supply system was crucial to the response but failed for a variety of reasons. Ruptures in stocks were common and inadequate support provided in both the capital and field to be able to manage the system. Orders were processed through the normal system leading to longer lead times for delivery than required for an emergency response. Additional capacity was added 'piece-meal' and the mission struggled to implement standard operational procedures.

5. During the initial start-up, human resources were mobilised quickly but as the emergency grew and the needs increased the human resource component did not keep up. Sufficient resources were neither identified nor mobilised to provide adequate 24 hour medical care or faster decentralisation of services. Human resource requirements were not always agreed between project, capital and headquarters slowing down the system. There is a perception that there were a high number of 1st missions but in reality the level is within the usual ratio.

MAIN RECOMMENDATIONS

The main recommendations are included below but additional recommendations are included in the full report and the above is expanded upon.

Operational Management

1. Reinforce the use and trust within the Copro system and implement correctly the policy and procedures. Encourage active participation in the Copro from all departments and ensure that middle management take their responsibility within the system.
2. Establish trigger mechanisms within the Copro system defining when subsequent Copro decisions are required.
3. Review and justification of relevant emergency experience in the cell and mission is required prior to deciding management through a cell or E-Pool.

Medical

1. Ensure implementation as per MSF refugee health standards of a decentralised health care approach.
2. Ensure priority given to a Home Visitors Network, Health Promotion and Population Mapping Incorporate in the activities the distribution of shroud material for burying the dead to monitor mortality

Supply

1. Ensure emergency supply authorisation is given to the cell or mission supported by or through the E-Pool.
2. Reinforce the Logistix 'Lite' (Excel) approach in emergency situations to ensure that basic supply administration is in place from the beginning e.g.) ins and outs, inventory and order overview.

Human Resources

1. Based on a needs revue, separate the management and follow up of HR in an emergency managed by a mission from the normal follow up of the mission. Ensure adequate resources in field and capital with additional back up by the mission.
2. The development of a HR strategy within a mission, including a section on emergency support would provide important information for future responses.
3. For emergencies with a significant number of regional expatriates, recruit a HR position from Kenya as part of the emergency coordination team to manage the regional expats, contracts and briefings.

CONCLUSIONS

The overall response from MSF OCB while fulfilling many of its operational goals did not meet the expectations and high standards expected of the organisation. The reasons for this are not solely the responsibility of MSF but were impacted upon by the activities and poor response provided by other organisations. MSF was required to extend the scope of its activities and response on a regular basis, over and above that of the core medical activities. Feedback from beneficiaries, authorities and other actors was predominantly positive towards MSF and appreciative of the investment made.

In order to learn lessons from this intervention, there is a need to address the structural decision making processes especially when deciding if an emergency should be managed by a cell or emergency pool. It is beneficial that emergencies are managed through the cell structure and that experience and knowledge is gained but constant monitoring and checks and balances need to be in place to ensure the quality of the response.

It must be stressed that while this evaluation is intended to provide a lesson learnt perspective, it must not take away from the hard work and lifesaving activities which were provided by the teams in a difficult environment. While improvements can be made, many successes were achieved due to the hard work of all involved. The presence of MSF did have a positive.