A Review of the Emergency Response in Maban, South Sudan 2012

Analysis of the Humanitarian Aid System – Case study 1

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Executive Summary

As part of MSF's on-going analysis of emergency response capacity within the humanitarian aid system, we undertook a case study review of the Maban county emergency in South Sudan which peaked over the summer of 2012.

This was, in many ways, a 'classic' emergency – a large number of refugees fleeing conflict, crossing an international border into a sparsely populated and isolated rural area, requiring the full spectrum of humanitarian assistance and almost entirely dependent on it. Although the emergency should not have come as a surprise, and in a part of the world that has a long-term presence of humanitarian and development actors, it still caught many humanitarian agencies unprepared to mount a large scale, logistics- and human resource-heavy operation.

The first wave of refugees arrived in November and December 2011 and were housed in the Doro and, later, Jamam camps[1]. From January, concerns started to be expressed by MSF, Oxfam and others about the adequacy of the response, including in particular the quantity of water supply and the location of the camps. However, little progress was made to address these flaws before the second wave of refugees arrived in May and June 2012. This wave arrived unexpectedly, and in very poor condition, requiring a scramble by many actors to respond. Two new camps were opened, first Batil and then later Gendrassa. Once these camps started to reduce the pressure on the assistance effort in the two older camps, the situation somewhat stabilised – however, this was not until mid-August or September, at least 12-16 weeks after the second wave of refugees started to arrive and after a catastrophic peak in mortality.

For MSF, two operational centres (MSF Holland and MSF Belgium) covered health needs and other urgently needed gap-filling emergency assistance activities in the four major refugee camps plus outreach towards the border with inpatient and outpatient care including vaccination campaigns, maternal care and nutrition, a very significant emergency water and sanitation intervention, underpinned by a very significant investment in logistics and international and regional staff. The entire operation has so far cost MSF approximately €20 million in 2012.

Being a refugee crisis, the situation fell within the legal mandate of the UNHCR who managed the overall operation, setting up a 'pseudo-cluster' system, with its own people managing key sectors such as watsan and health. It did not bring in other UN agencies to support the response, but rather relied on a patchwork of implementing partner NGOs working to UNHCR

[1] A map is provided in Annex 5.

contracts. Most of these NGOs struggled to cope with the scale of the operation and the logistical difficulties, and the watsan response in particular was slow and inadequate, along with important deficiencies in shelter and food supply. This had a significant impact on mortality and morbidity. In July, MSF conducted a retrospective mortality study in Batil camp, finding a crude mortality rate of 1.75 and an under-five rate at 4.2/10,000/day; household surveillance in Jamam showed similar results and only normalised at the start of September. Using these reports, MSF lobbied other actors directly and through the media to improve the response and targeted, the ICRC, to contribute to the response with their watsan expertise and capacity. This mobilisation effort was done independently of the UN and other actors (UNHCR did not attempt the same kind of effort) but was later seen as having made a significant change in the overall response, in particular the ICRC's construction of boreholes and a 15km pipeline.

MSF was a key player in the response with UNHCR emphasising the importance for them to have 'an MSF in every camp.' Yet MSF's relationship with the formal system was ambiguous, playing both an 'insider' role, covering the majority of the health needs and also some key emergency water and sanitation needs, and was yet also an 'outsider'. Many actors felt MSF was very critical and did not contribute enough to solutions, that it did not share its data consistently, and that it didn't share its plans with others.

The response revealed important failings in humanitarian emergency capacity. UNHCR struggled to set up and then was unable to provide clear guidance and a strategy for the response. The NGO partners sub-contracted by UNHCR, many of whom have a long experience in South Sudan, were unable to respond with the required speed and scale to an emergency. Some agencies appear to lack the size, logistical and HR capacity and flexible funding to be effective within an appropriate amount of time (say, within 4-6 weeks of the second wave of refugee arrivals). For others, emergency response seems to have been undermined by their own efforts to work on long-term issues with a local-partner model.

It seems that MSF should revise its expectations of what other actors are capable of in such an emergency. One possible implication for MSF's own response appears to be an investment in a larger emergency capacity of its own, in sectors other than health (watsan in particular), so that it can respond appropriately itself within the first 4-6 weeks of an emergency, without counting on significant timely involvement of other organisations. Another implication would be to deploy advocacy and communications efforts aimed at the humanitarian system earlier, from the very beginning of an emergency, before the inevitable gaps and failings become truly life-threatening, rather than being reactive. Both of these paths were attempted during the Maban emergency, and met some success, but greater progress would require longer-term efforts.

Introduction

In October 2011, aerial bombardments of villages in Blue Nile state in Sudan led to the first of a large number of refugees crossing the border into South Sudan to seek refuge[2]. By the end of the year there were approximately 30,000 refugees in Upper Nile state. By April, the number was up to 80,000 and by July, it had increased to 100,000[3]. Although South Sudan only gained independence in July 2011, many humanitarian agencies seemed well positioned to respond – some having been in country since the 1980s. Sudan has been the largest recipient of humanitarian aid in the past ten years[4], and South Sudan currently hosts 149 INGOs[5].

Despite these factors, the emergency response in Maban county had serious short-comings, pushing MSF to conduct extensive lobbying and advocacy at field, capital and international levels. This case study was undertaken in order to understand what the problems in the response were and how they came about. It aims to shed light on how the humanitarian aid system in South Sudan performed in responding to the Maban county emergency from November 2011 to November 2012. This case study is part of a wider analysis of the emergency response capacity within the humanitarian aid system.

Methodology

This case study involved a field visit to South Sudan (including Juba, and Jamam, Batil, and Gendrassa camps in Maban county) and a review of documents from MSF and other humanitarian actors. Interviews were carried out with 42 key informants from MSF, NGOs (ACTED, Oxfam, Save the Children, IMC, GOAL and the NGO Forum), UN agencies (UNHCR, WHO, WFP), ICRC, DFID and ECHO; they were conducted in South Sudan but also in Geneva, Amsterdam and Brussels. A full list of interviews is provided in the annex. For data and documentation, a comprehensive review was performed of the e-desks' own files, plus a search was done for all publicly available material on the Maban response available on Reliefweb, and the UNHCR, OCHA, WHO and WFP websites. The focus of the study was on the peak of the emergency from April to September 2012, although the preceding period from November 2011 is also looked at.

The case study used a qualitative methodology, aimed at drawing on the insights and judgements of a broad set of actors, rather than a detailed reconstruction of the whole response using quantitative data. This is both due to the case study's focus on qualitative phenomena such as planning and decision-making and due to significant gaps in the documentary and data record especially of the external non-MSF response. Further, the case study looks at the overall response, and does not attempt an in-depth review of MSF's medical operations, which is beyond the capacity of the authors.

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[2] This paper focuses on the Blue Nile/Upper Nile crisis. Bombardments in South Kordofan state (Sudan) started earlier, in May 2011 and led to a large influx of refugees into South Sudan, of whom the majority were settled in Yida Camp.
[3] UNHCR data: http://data.unhcr.org/SouthSudan/region.php?id=25&country=251
[4] Global Humanitarian Assistance report, 2012 http://www.globalhumanitarianassistance.org/report/gha-report-2012
[5] Interview, NGO Coordination Forum, South Sudan

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Context

Maban county is an isolated region close to the new border with Sudan, with a host population of agro-pastoralists numbering only 36,000. It was sparsely inhabited because it is a low-lying area that floods regularly. Despite an abundance of surface water in the rainy season, the water table is very deep and there is very little water available in the county. This part of Upper Nile State has not previously received such an influx of displaced people and this emergency was the first time for them to receive *refugees*. Life in Maban is hand-to-mouth; there are few local markets and those that exist sell very little. Local authorities are not strongly present; the seat of the regional government is in Malakal. This meant that throughout the emergency, the role of the Government of South Sudan was not particularly prominent and the task of assisting the refugees fell to the humanitarian system. To date there have been few security problems for aid workers and very few serious protection issues have been reported, although there has been some (until-now resolvable) tension between local communities and the refugee population.

The emergency

The emergency started in October 2011 when bombardments of locations in Blue Nile State, Sudan caused an influx of refugees[6], arriving at approximately 1000 persons a day. By December 32,000 refugees had settled in Doro camp, mostly arriving via two border crossing points in the vicinity. A third border-crossing point at El Fuj, some 40 km to the northwest, also started to see an influx of refugees, who settled in Jamam camp. In January, further groups of refugees came over the border, bringing the total number up to 60,000 by February.

The second wave of refugees began to arrive in May and June, just before the rainy season began. Most crossed the border at El Fuj and then stopped at a transit site at K43 and then another further on, K18. It was at this point that a new site, Batil, was identified and opened; initially intended for refugees relocated from Jamam, which had recently been identified as dangerously overpopulated given the limited availability of water, it then repurposed to host the May influx of 35,000 refugees. In August, a fourth camp, Gendrassa, was opened, to take refugees from Jamam. It was at this point that the situation began to stabilise in the camps.

The response

As this was a refugee crisis (a first for the new nation of South Sudan), and given the UNHCR holds an international legal mandate to protect and assist refugees, the UNHCR had an obligation to respond. It was rather quick to take the lead role, mounting its first assessment

[6] Figures from UNHCR data: http://data.unhcr.org/SouthSudan/region.php?id=25&country=251

within a week of the first wave of arrivals in November 2011. It set up its own sectoral management with technical specialists as 'leads' for health, watsan and other sectors from within UNHCR. It did not call upon any other UN agency to support the response, and largely bypassed the existing cluster system. A regular coordination meeting was held in Juba and there were also meetings chaired by the UNHCR in Maban.

UNHCR assigned NGO 'partners' to various sectors in camps. The main NGOs working as partners for UNHCR were ACTED, Oxfam, Relief International, DRC, Intersos, Solidarites, GOAL, IMC and Samaritan's Purse. There was no presence of any local NGOs, churches or the South Sudanese Red Cross. ICRC initially only had a limited presence through its sub-delegation in Malakal; focussed on protection and believing that needs in the camps were covered, it was not until August that it conducted an assessment mission to look into the water and sanitation situation and then intervened. NGOs provided service in health, water and sanitation, and nutrition in all four camps of Maban County. Some also provided services for the host community.

MSF's intervention

MSF first responded in November 2011, as the first wave of refugees were arriving in Maban county. MSF Belgium was the first section present, with MSF Holland conducting its explo on request from MSF Belgium in April. The MSF Belgium operation was managed by the regular desk until May, and then handed over to the emergency desk. The MSF Holland operation was managed throughout by the emergency desk. The expansion of operations was rapid and large-scale: at the peak of the crisis in late May and June, the two MSF sections had 270 international staff present.

Findings

Water and sanitation: the critical failing

The major issue which plagued the Maban emergency response was provision of water and sanitation to the camps. In the area around Jamam, there were serious problems in finding water sources and extracting and distributing water to an adequate level; this was known by all watsan actors and communicated clearly by them as early as December 2011. When MSF Holland conducted its initial explo in April, the explo team characterised the water situation in Jamam as already 'grossly inadequate' (6.65 l/pppd)[7]. Discussions began in January on identifying a third site at Batil, to reduce the numbers in Jamam, with water needs as the primary consideration; however no viable location was even in initial preparation until May.

The group of refugees which began to arrive in May and June arrived exhausted from many days (in some cases, weeks) of walking, and in very poor condition with few, if any, resources. Many died en route or on arrival, especially of dehydration and diarrhoea. Most crossed the border at El Fuj and then stopped at a transit site at K43. Water was the critical problem and was initially limited to 2.6 litres per person per day, with MSF the sole provider, from the *haffir* (surface

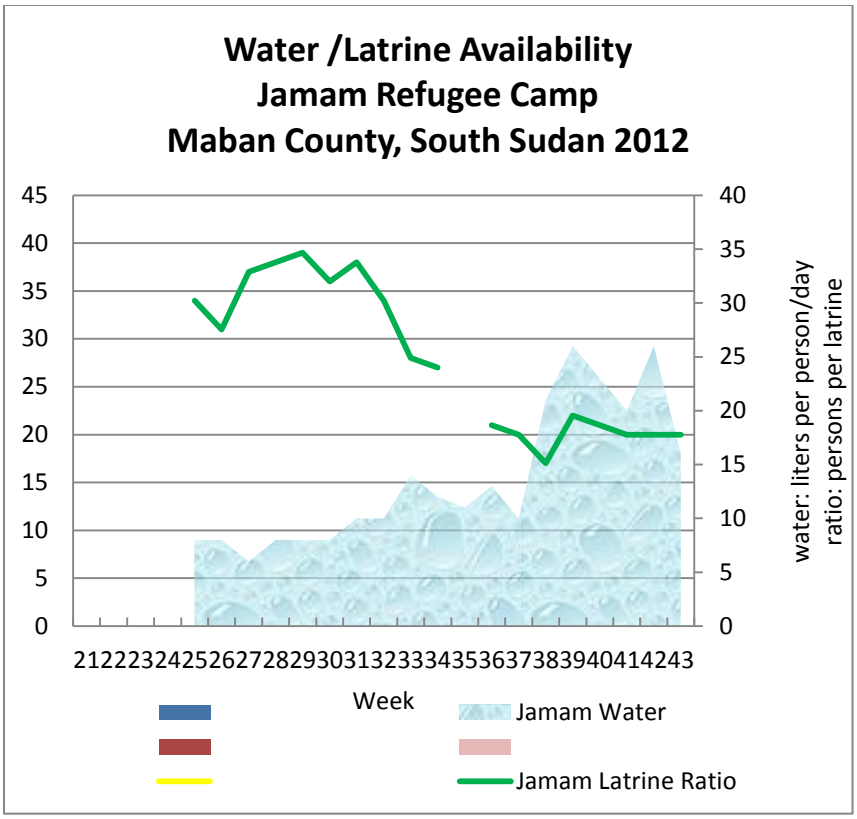
[7] "Discussion paper: MSF Holland involvement in Jamam camp", April 2012.

water source)[8]. By May 31, some 34,000 refugees were registered at this transit site. Refugees thus began moving to a second transit site, K18, which was similarly water-poor (initially 2.5l/pppd, then 5l/pppd from June 15)[9]. At this point, realising the crisis, UNHCR seems to have made a hurried decision to open the Batil site and move the transit refugees there, leaving the Jamam situation to be dealt with later. Due to the urgency, the site was approved before water supply there was guaranteed and it initially did not have the water available to house all the new arrivals (it could provide 15,000 people with 6l/pppd in the week of June 11[10]). Relocation was a difficult, stop-start operation, hampered by the rains and flooded roads. At one point, watsan engineers were racing to ensure there was enough water at Batil before the water sources at the two transit sites was used up. When the water did finally run out, it sparked a horrific night exodus on foot from K43 to K18; the next morning, MSF field teams found refugees dying on the roadside and in their arms as they tried to triage the most urgent cases.

The operation became extremely difficult following heavy rains which continued throughout June, July and August, greatly exacerbating the already poor water and sanitation situation. Some parts of the camps flooded and there were many pools of standing, stagnant ground water – this posed a particular hazard because some refugees turned to drinking the dirty water. Further, successive borehole constructions failed in the Jamam area, but also in Batil camp. As a result, water supply remained a serious problem throughout June and July in Jamam camp, hovering around 6-7 l/pppd throughout and only improving to 14l/pppd with the opening of the Gendrassa camp in August and the reduction of Jamam's population[11].

In August (following lobbying by MSF) ICRC conducted an assessment visit to Batil to appraise the possibility of building a pipeline, dig boreholes and install various water and sanitation equipment as well as to make two distributions of NFIs in all four camps. The provision of adequate water (to SPHERE standards) was only achieved by September – and even then perhaps only on paper.

[8] Interview with MSF Holland Watsan Coordinator, June 10.
[9] "Update June 15". Email.
[10] "MSF Holland sitrep, June 11-17".
[11] "MSF Holland Maban sitrep, 16-22 August".



A key constraint for getting adequate water supply to the camps was logistical: only three drills were on-site, one shallow and two deep, and they were in constant demand. Good quality hydrogeological surveys, to assess the sustainability of the water aquifers, were particularly difficult to accomplish. Another issue appears to be the need for high-level technical staff with experience of responding in this kind of context. Experienced staff were deployed late, or not at all, and not in sufficient numbers. Some tasks, such as introducing a more equitable distribution of water points in Jamam and Batil, were simply never carried out, despite being a priority for months.

However, besides logistical constraints, agencies also appear to have struggled to change gears from a development to an emergency approach, and suffered from a lack of urgency at certain points. For example, there were disputes over the sustainability of particular water sources during the height of the emergency and over how the refugees should be involved (as volunteers or as paid attendants) in latrine construction and maintenance. Development approaches, prioritizing long-term activities in resident communities and emphasising the use of local staff and local contractors, were inappropriate in this emergency setting where there was only a very limited existing market, and the majority of refugees lacked basic numeracy and literacy skills. This led to delays in response time. As the coordinator of the response, UNHCR itself took too long to assert leadership in the watsan sector.

Oxfam was one of the only organisations to already be established in Maban. Agency staff stated frankly though that they had not planned ahead for the coming emergency and gotten funding in place. The Oxfam team pulled out of Doro as it seemed too close to the border and therefore too dangerous for them. They then were contracted to provide water for refugees

being temporarily housed in Jamam camp. They lobbied for a change in location from December 2011 due to the lack of available water, and waited for UNHCR to relocate refugees. When it became clear that this wasn't going to happen, they were already behind schedule. There were disputes between the water and sanitation engineers of different agencies: those of MSF thought that Oxfam's hydrogeological survey had been "neither conclusive nor successful" and that Oxfam had not lived up to its responsibilities; while Oxfam engineers felt singled out by MSF for criticism when they'd made great efforts in a difficult situation.

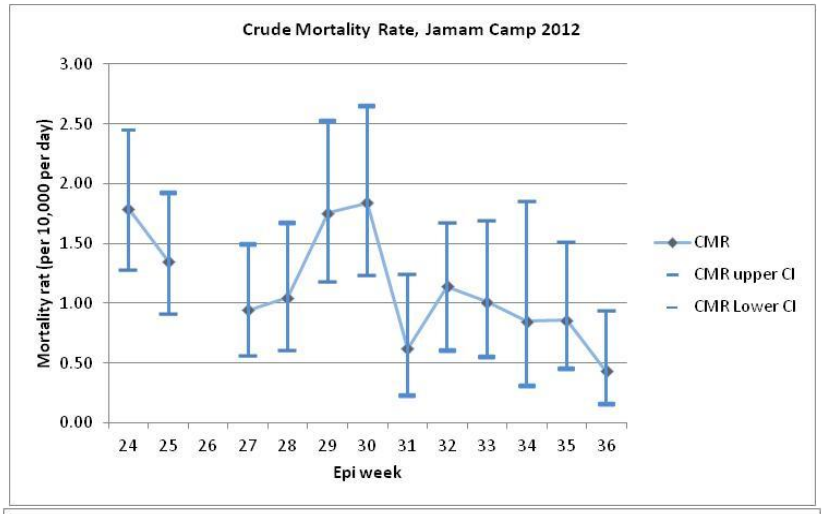
From November 2011, MSF was counting on other agencies with the responsibility and expertise to respond to the water needs, partly in the (mistaken) belief that other agencies' presence meant needs would be covered and partly out of concern about the size of its own burgeoning operation. This "wait and see" approach was critiqued within MSF, with some (especially the MSF watsan specialists themselves) arguing convincingly that this attitude of waiting for others to step up delayed our own response. When the capacity and supply constraints and their health consequences on the population became clear, however, MSF did begin emergency water supply and distribution interventions. One of MSF's key interventions was provision of drinking water in Doro, with more than 40 percent of the water for some 45,000 refugees still provided by MSF, more than a year after the start of the intervention and despite discussion for all that time with IOM concerning handover. In Jamam, MSF was initially providing more than 50 percent of the water in the camp, and continued to treat and distribute surface water as borehole after borehole failed owing to the huge hydrogeological challenges. The idea was that these could be handed over to other actors in time. In one case, Doro, this proved overambitious, as a long-planned handover of water supply from MSF to IOM failed due to the latter's capacity problems; the handover was still under discussion at the time of writing although there are very few signs of a swift expansion of capacity of IOM to be able to take on this workload. A rapid and large-scale response became even more critically important with the arrival of the second wave of refugees in May: in the transit camps K18 and K43, MSF was the principal provider of water.

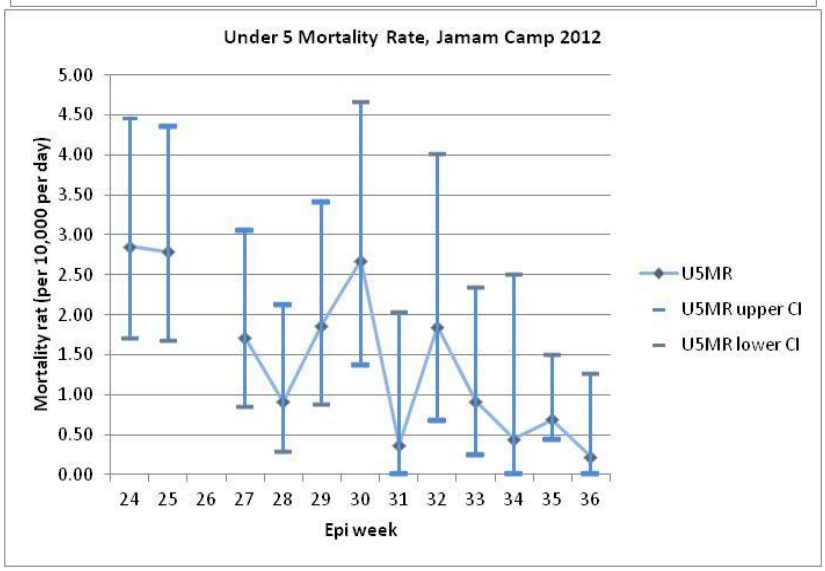
Frustrated by the scale of the crisis and what it saw as a slow and inadequate response, MSF began from February to lobby hard for others to deliver on their responsibilities. MSF became increasingly critical and vocal towards actors that it felt had not been able to respond adequately to the challenges posed by the Maban environment, in particular watsan actors. In August, MSF met with ICRC in Geneva and in Juba, presenting the results of its mortality surveys. In response, ICRC sent out an assessment team which eventually resulted in a short term but large-scale intervention: in Jamam, the ICRC built a 15-kilometre water distribution pipeline, and in Batil, ICRC installed piping, storage tanks, tap stands and pumps. Questions do have to be asked about why the ICRC did not intervene until MSF started its lobbying.

High mortality rates lasting months

The initial rate of mortality among refugees of the second wave seems to have been very high. One factor which may have played a role was the differing backgrounds of the refugees: the first wave passing through the Yabus/Guffa border area were mainly Uduk, "experienced refugees" since at least the 1980s fleeing pre-emptively, and this second wave of (mainly) Ingessana people from Baw farther north who had never been displaced before and had far fewer coping mechanisms.

Teams reported many deaths each day among the newly arrived from dehydration and diarrhoea. MSF established a prospective surveillance system to monitor mortality[12], among other indicators; its first rapid survey was conducted in Jamam in week 24 of the crisis (mid-June, covering a recall period of 7 days) and identified a crude mortality rate of 1.79 deaths per 10,000 per day, and an under-five mortality rate of 2.85 deaths per 10,000 per day. Both figures exceeded the relevant emergency thresholds of 1 death per 10,000 per day for the general population and 2 deaths per 10000 deaths per day for under-fives. The main cause of mortality identified was diarrhoea (65% of deaths), but it was considered that underlying malnutrition was also a major contributing factor to the high death rate, especially among under-fives.





[12] MSF (2012), Household mortality surveillance in Jamam and Gendrassa camps, Maban Country, South Sudan [internal].

In July, a retrospective mortality survey in the Batil camp[13] covering the entire period from March found a crude mortality rate of 0.91/10,000/day and an under-five mortality rate of 2.1/10,000/day; the rates since arrival in the Batil camp were almost two times higher than for the entire period (1.75/10,000/day and 4.19/10,000/day respectively) – meaning death rates were higher once people arrived in the camps. An exhaustive retrospective survey[14] conducted in the T3 transit camp at the end of June 2012 and covering a recall period of 300 days (i.e. the entire period of displacement, of which only the last several weeks were spent in the refugee camps), also found that the mortality rates prior to arrival in the camps had been lower: in that case, under-five and crude mortality rates were below the emergency threshold (0.52 and 0.45 per 10,000 per day respectively). It found that one-third of the deaths had occurred during the initial bombing and a further half of them between their home villages and the border.

Household surveillance conducted in Jamam from week 24 onwards shows a slow decline in mortality rates among under-fives and the whole population, as well as elevated death rates among over-50s (see graphs[15]). Only by the beginning of September had the mortality rates in the camp returned to a level that could be considered normal (in week 36, the crude mortality rate was 0.43/10,000/days and the under-five mortality rate was 0.23/10,000/day).

The poor water and sanitation situation in the camps appears to have been the major contributing factor to the persistently high death rates. In the household surveillance, diarrhoeal diseases were found to be the cause of the majority of deaths in the majority of weeks, as well as being a (lethal) factor in other cases of dehydration, malnutrition and other conditions. Further, in September, a Hepatitis E outbreak was confirmed in Jamam, and then in the three other camps, again seemingly connected to the poor hygiene situation. Between the first cases in week 21 and week 39, 609 patients met the clinical case definition, while 17 people died of the disease in a facility[16]. The first cases of the disease (initially considered jaundice) began to appear from week 21, but the presence of the disease only became suspected by medics from approximately week 27 and extensive efforts began to tackle the outbreak from week 28[17]. MSF provided outbreak investigations, active screening of all pregnant women and case management, and supplied most of the urgency to tackle the epidemic. Other humanitarian actors, including UNHCR, Oxfam, did also respond on the watsan and health promotion side. Hepatitis E cases continue to rise in the Maban camps, and the outbreak has been a focus for medical action and advocacy by emergency teams.

Reliance on MSF to 'cover' health in all camps

MSF initially set up a hospital with in- and out-patient services in Doro camp, which was later complemented by outreach clinics in the camp offering out-patient consultations. MSF then set

[13] "Retrospective mortality, nonfood items and nutritional survey: Batil refugee camp, Maban County, Unity State, South Sudan." July 2012

[14] "Exhaustive Retrospective mortality survey in transit refugee camp (T3), Maban County, South Sudan." Preliminary report: 30 June 2012.

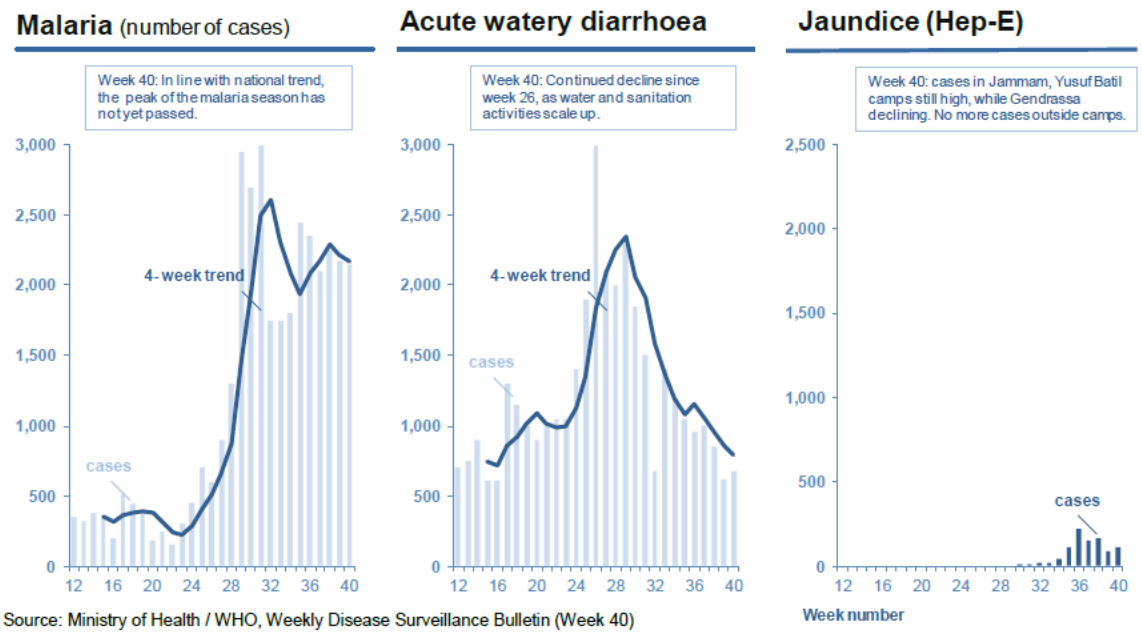
[15] "Maban Refugee Response Medical Report: South Sudan, MSF MSF Holland. Epidemiological Weeks: 36 – 39/2012." 23 July – 26 August 2012.

[16] "Maban Refugee Response Medical Report: South Sudan, MSF MSF Holland, Epidemiological Weeks: 36 – 39/2012". 23 July – 26 August 2012.

[17] "Hepatitis E Medical Response Jamam and Gendrassa Refugee Camps: Epidemiological weeks 25 – 36." 15 September 2012.

up a hospital in Jamam in January, providing in-patient and out-patient services to 35,000 refugees. Nutrition support was also set up through an intensive and an ambulatory therapeutic feeding centre, and vaccination campaigns were carried out in all of the camps. MSF Holland managed the operation in this camp from April, adding a response in the transit camps K43 and K18 from May. In Batil, when it opened in June, MSF set up a field hospital providing in- and out-patient care, nutrition, maternity and mental health services, supported by over 60 expatriates. In August 2012, in Gendrassa MSF set up a clinic providing in-patient services, while next door International Medical Corps (IMC) started providing out-patient consultations.

In comparison, in terms of medical response all other agencies were working at a smaller scale. All actors said they considered that when MSF was there 'it's covered'. UNHCR stated that it would be happy if there was 'one MSF in every camp'. The main difficulty for other actors in the camps was that they couldn't scale up beyond a certain point and provide the range of services required. For example, International Medical Corps, which has been in South Sudan for 25 years, couldn't start up without external funding and their operation was small, with only five international staff. Other NGOs were overstretched: GOAL was performing health promotion, primary health care, nutrition, and water and sanitation in three camps. This meant their services were only partial: maternity services in Batil were only open 8am-5pm, for example.



Source: Ministry of Health / WHO, Weekly Disease Surveillance Bulletin (Week 40)

Food needs difficult to cover

The rainy season closed off much road access and required everything to be sent in by plane or by boat from Juba to Melut and then by road, with serious effects on logistic pipelines for food. WFP was only able to supply the first monthly ration in September; until then, only week-long or 15-day rations could be provided, and with delays. At a certain point in August, WFP had to airdrop food because of flooding. These difficulties had serious implications for the nutritional status of the population, given their total dependency on external assistance: in July, a

nutritional assessment in Batil camp found severe acute malnutrition rates of 10% (measured by MUAC) and global acute malnutrition at 27.7%[18].

Like all others, WFP was slow to set up and faced significant planning and logistical difficulties. Initial planning for the year was for 75,000 refugees, so the final figure of 110,000 refugees was much larger than anticipated. By May, they reported being able to preposition 14,000 tons of food, enough for 140,000 refugees for six months in Upper Nile and Unity state[19] – at the time, there were already 150,000 between the two states, and the second wave of 35,000 refugees was still to arrive. WFP also suffered from the high cost of transportation and lack of road access. The operating conditions of the country called for exceptional measures (in this case an airdrop of 2000 tons of food in August[20]). The cost was so large that it required using WFP's financial reserves. In addition, the logistics cluster was overstretched with many other commitments around the country. As a result, the pipeline was precarious, with many delays and last minute deliveries. There was also some contamination of the stock with weevils, and the food type was not always appropriate.

Agencies also struggled to distribute food. There was no system of decentralised distribution so in some places distributions took days. NGOs found that at every level money was charged: porters charged to carry the food, local committees required 'taxes' to be paid, and there were informal 'mafias' charging exorbitant rates for key commodities like plastic sheeting. Without any significant local authority in place, it was difficult to address these issues.

Shelter provision and site selection weak

The provision of shelter meeting minimum requirements was complicated by the poor state of the refugees on arrival (as few had any shelter of any kind) and by logistical difficulties, including ruptures in essential items such as tents: in mid-June, some 10,000 refugees were living in several of the established camps without tents. In the week of June 18-24, an airlift was able to cover vital shelter needs, including 2,000 family tents, 5,000 kitchen sets, 13,000 blankets, 194,000 bars of soap, 12,000 plastic sheets, and 20,000 sleeping mats, jerry cans and mosquito nets, targeting the 50,000 new arrivals[21].

Site selection was not done well. It became clear as early as January that Jamam would not be able to cope even with existing numbers once the rains arrived. And yet it was only months later and after the second wave began that a third site, Batil, was made available. Precious time was lost in deciding where the refugees would finally be located. Once the decision was made in May, the actual site identification and the moving of refugees was also difficult. The new influx of refugees was transferred to Batil first, and with great logistical difficulty, as they were the priority, but this left the Jamam refugees in significant difficulties of their own. Then Jamam camp was flooded and almost entirely under water, while Batil was full of the new influx of refugees, requiring the swift identification and preparation of the Gendrassa site. The relocation process itself was frustrated by the water situation: at the moment that the two transit camps

[18] "Retrospective mortality, nonfood items and nutritional survey: Batil refugee camp, Maban County, Unity State, South Sudan." July 2012
[19] "WFP Operational Update", May 1 2012.
[20] "WFP plans airdrop to continue lifesaving food assistance to refugees in South Sudan". August 2, 2012.
[21] "OCHA South Sudan weekly humanitarian bulletin", June 18-24, 2012.

were running out of water, sufficient supply of water had not yet been secured at Batil. Flooded roads also meant confusion and delay in moving the refugees, with many needing to walk the distance.

There was no real site planning so the camps ended up looking like villages, with white UNHCR tents dotted here and there. Nevertheless, camp management was not cited as a major problem. The NGOs responsible for camp management took on a variety of additional tasks. ACTED, for example, was also covering health promotion, food distributions, shelter provision, relocation, and even started getting engaged in the vaccination of cattle. They did so with only a small number of international staff, and found themselves overstretched.

Poor planning, coordination and strategy

Poor contingency planning slowed the response to the second wave of refugees in mid-May. While information from Blue Nile state, on the other side of the border, was certainly limited, this should surely not prevent response plans being drawn. Since early 2012, information had been provided by sheikhs, who knew who was still left on the other side, that some 30-120,000 people could possibly flee from Blue Nile. But still humanitarian actors were caught flat-footed by the scale and timing of the influx. No one (including MSF) actually made plans and prepared operationally for that foreseeable influx.

In addition to the lack of preparation, there was a lack of a strategic overview. Coordination meetings in Juba and Maban were showing two different realities. In Juba, meetings lacked structure; figures were bandied about without context, making them meaningless. Many NGOs overstated their activities and minimised problems. They also overpromised. Often numbers were cited and then just not corrected. There was confusion about what was going on. Once it became clear that the challenges of the response were too much for these NGOs, UNHCR 'doubled up' on partners, allocating more than one NGO to a camp or sector.

UNHCR tried continuously to show that it was dealing with things and doing well. Yet as well as being a donor, UNHCR was also constantly looking for funding. In November 2012, UNHCR reported of the $186 million needed, still 40% was unfunded[22]. NGOs were entirely reliant on funding from UNHCR; those that tried to launch their own appeals only received minimal amounts (Save the Children raised $300,000 but it was for the whole of South Sudan). Because it was looking for funding and also trying to keep other UN agencies out, this meant that it was difficult for UNHCR to admit problems. The Humanitarian Coordinator in South Sudan was barely involved in the operation and OCHA was kept out of the picture.

Outside the immediate context of the Maban response, the situation in Blue Nile state, from whence the refugees fled, went largely unattended. MSF did conduct several explos to get an idea of what exactly was going on which found a population either highly dispersed or in embattled enclaves, but this never rose to the level of actual assistance. It does not seem like any other humanitarian actors mounted serious efforts either.

[22] UNHCR Press briefing note, South Sudan: *UNHCR warns that hepatitis E risk is growing*, 9 November 2012 http://www.unhcr.org/509cedcd9.html

The advantages of size and scale – and logistics

Scale and capacity were primary factors in determining the level of success of an agency's operation. The Maban emergency required a high level of technical competence, experience and skills and yet most NGOs struggled to get experienced staff in sufficient numbers. MSF was able to scale up relatively quickly, surmounting local human resources constraints by using a very large number of international staff (including many from the region). Regional staff from Juba, Uganda and Kenya were mobilised to perform frontline tasks such as nursing and even driving and cooking. MSF's human resources advantage was clear in the numbers: in Batil camp, MSF had 60 international staff, whereas IMC had 5, for example.

Logistics was key: agencies reported from 30% to 80% of costs on logistics, which is somewhat typical for South Sudan. Locally, there were many difficulties. With local markets which had very few items and almost no local suppliers, it was difficult to procure even basics like bricks or wood. As soon as the operation started, prices started to rise. UNHCR lobbied the local government to control pricing but without much success. Set up costs for NGOs were up to €1 million, as compounds had to be set up, vehicles, equipment and materials all had to be airlifted. One small mistake (for example, a wrong part) could cause a delay of two weeks or more for small organisations which relied on chartering planes or on the logistics cluster. Both MSF Holland and MSF Belgium hired planes, which set up regular bi-weekly flights with equipment and provisions, providing the 'backbone' of the operation. MSF's already substantial logistics set up in-country, in place for the regular mission, allowed for quick mobilisation and scale-up. There was also a substantial investment in logistics capacity at project level: whereas IMC might have one or maybe two logistics persons per project, MSF had 5 or more.

The very high costs had significant ramifications for all agencies. Overall, the cost of the operation for MSF was proportionately lower than for smaller NGOs as MSF benefitted from economies of scale. UNHCR's 2012 appeal for refugee response South Sudan (including both Yida and Maban) is €151million.[23]The estimated expenditure for MSF in 2012 was €20 million. Smaller NGOs, claimed to be running operations worth approximately €5million for fewer services, but with €1million in average set up costs.

MSF possessed two significant advantages that other INGOs did not necessarily have. Firstly, the lack of infrastructure in this part of South Sudan meant supply chains were long and very expensive – which was easier for MSF, with its financial reserves and independence, to manage. Secondly, the lack of skilled human resources in the labour market was especially difficult to manage for smaller agencies with less funds and for more development-focussed agencies which had difficulties with the idea of bringing in large numbers of international and regional staff.

MSF's loud voice: the role of advocacy and communications

MSF sought to address gaps in the response through concerted lobbying in Maban, Juba and Geneva, as well as through significant international media publicity. From March 2012, and especially throughout the summer, MSF met with UNHCR, WFP, OCHA and ICRC at Juba and Geneva level in an effort to push an improved overall response, particularly in water and sanitation, and shared its concerns with Emergency Relief Coordinator Valerie Amos. MSF

[23] UNHCR Global Appeal, South Sudan 2013 (Figure for revised budget 2012) http://www.unhcr.org/50a9f8220.html

representatives also gave more than 100 interviews to different international media outlets, including Channel 4, BBC, CNN, Al Jazeera and the New York Times. MSF was highly critical and confrontational, pushing others to fulfil their obligations. These endeavours had at least one clear result in the decision of ICRC to undertake a large-scale water and sanitation intervention. This attitude did help put some 'urgency' in the response, although it did also contribute to tensions.

Nevertheless, many of the actors felt that there was a lack of clarity about MSF's roles and relations with other actors. The UNHCR complained that MSF didn't really understand the way the UN system worked: "MSF were putting ultimatums to NGOs and then having bilaterals with NGOs and not including UNHCR, and not understanding that UNHCR will have to be part of the solution that they agree. This caused a lot of tension and confusion in the planning."[24]

Relations with UNHCR were also complex, with UNHCR treating MSF as a 'partner' in its official bulletins, and also sometimes presenting MSF's data as its own. Yet it also did not engage in more strategic discussions with MSF about the operation. When MSF went to ICRC to lobby for their involvement, it did so independently of UNHCR, yet UNHCR did not go to ICRC itself. It treated the ICRC entry into the operation as a 'timely offer'.

MSF's role towards the rest of the system was ambiguous. It sometimes stood back and criticised, only then to come forward to fill a gap. Some external agencies complained that there wasn't regular sharing of data (medical and watsan) at the Juba level although within MSF this is disputed. MSF's strategy was also not clear to others, and was not shared at a high level; some agencies expressed concern about not knowing how long MSF would remain committed to Maban and what the effects of its departure would be. Yet, as such a major player, MSF was heavily relied-upon. The UNHCR representative in Maban said: "MSF is the last resort. Like UNHCR."[25]

When others failed to show that they could really fulfil their commitments, MSF was able and willing to take over, especially during the height of the emergency in late May and early June 2012. However, it is clear that MSF's gap-filling approach, especially on watsan, caused delays and uncertainty. In a situation in which other actors were having difficulties mobilising the capacity to respond quickly, it would have been better if MSF had utilised its greater capacity for speed to step in, and then hand over, watsan activities earlier.

Analysis

The response to what was an foreseeable refugee influx, in a country that humanitarian aid actors knew well and understood[26], in a context without significant problems of acceptance and access, must be considered inadequate. Mortality levels, water supply, food provision and other needs only reached acceptable levels by mid-August or September, some 12-16 weeks after the

[24] Interview with Paul Spiegel, Deputy Director, Division of Programme Support and Managment, and Marian Schilperood, Chief of Public Health Section, UNHCR, 21 November 2012.
[25] Interview with Frederic Cussigh, Head of Field Office, Maban, 3 November 2012.
[26] Operation Lifelife Sudan operated for many years in South Sudan, including in Upper Nile state, and was capable of delivering large quantities of assistance. The Maban emergency seems to show that much of this former capacity has now evaporated.

second wave of refugees arrived and some 10 months after the first wave arrived. The difficulty of the terrain, the rain and the remote location made it a very difficult operation, requiring significant HR, financial and logistical investment. Nevertheless, the humanitarian system in South Sudan failed to respond in a timely and sufficient way. Further, quality of services in all sectors was not consistently adequate.

These failings can be attributed to several flaws in the humanitarian system. These can be summarised as:

Lack of preparedness: This should have been a crisis foretold, especially for the second refugee wave in May and June when death rates reached catastrophic levels. Yet the humanitarian aid system in South Sudan did not prepare itself properly and therefore was unable to respond in a timely fashion. The UNHCR showed that, despite its extensive knowledge and experience in the area, and its early warning systems, it was unprepared for this emergency. The ICRC, despite also having a legal mandate to provide assistance and protection for victims of armed conflict, needed extensive lobbying before finally deploying. Other agencies were likewise caught short and unprepared. The failure to plan for any new influx of refugees was particularly great, as the scenarios were already clear from January.

Overpromising and under-delivering: Overall, there was a real distance between what was promised and what was actually done on the ground. Coordination meetings were rife with wishful thinking, part-reporting and problem-minimising; a culture of blame and suspicion rather prevailed in which "collective" accountability meant no accountability. There was little checking of whether standards were being met and little monitoring of quality. There was also little ability within the system to adapt to changes in the environment and to be responsive to new needs.

Ideological divide: There was a clear distinction in approach between multi-mandate NGOs and MSF's focus on rapid emergency response. NGOs in Maban believe that some of MSF's emergency measures undermined the longer-term approaches, such as draining water sources. On the other hand, MSF found that NGOs were too slow. They were unable to switch from a development approach to an emergency one, and were still persisting with longer-term (and hence slower) approaches when the situation called for more urgency.

UNHCR: In this case at least, the UN's refugee agency was not able to fulfil its obligation to assist and protect refugees. It appears to have lost much of its capacity to deliver assistance and to enforce standards. UNHCR took control of the operation, but was not able to scale up and respond in an appropriate way. It didn't have sufficient operational capacity of its own, or the speed and decisiveness required, or the strategic overview and leadership. This weighs particularly heavily on the agency because it worked to exclude other UN agencies, such as the OCHA and the HC, who might have helped them address these shortcomings.

NGO capacity for humanitarian response is limited: In Maban, notwithstanding their long-time experience in South Sudan and the ease of access, international NGOs were slow in responding and achieving scale. Some had significant capacity issues – especially not enough qualified people on the ground. Smaller agencies especially suffered from their size, and the consequent high start-up costs, lack of quick and ready financing and the constant juggling of budget lines.

But even larger agencies, such as Oxfam, also showed problems in their emergency response capacity.

MSF's own response raises some questions: While MSF did manage to provide extensive medical, water and sanitation and other services to a population of 110,000 refugees, this intervention had its flaws for the organisation as well. While response was relatively swift, contingency planning was weak. The logic behind the terms of the handover and division of labour between the two sections, MSF Holland and MSF Belgium, was not always clear: for example, the new section took over existing services rather than establishing new ones, while camps right next to each other were managed by different sections. Several emergency team members, and external informants, critiqued the tendency to focus too much on work within health facilities at the expense of community-level outreach, surveillance, contextual analysis or networking with other actors. There were also tensions between competing priorities, such as how much effort to put into cross-border operations into Blue Nile state, where populations went largely unassisted. Further, while the scales of their operations were significant, during the height of the emergency both MSF Holland and MSF Belgium seem to have reached their maximum capacity.

MSF's strategies, adopted pragmatically, to solve problems in the broader response in Maban were twofold: firstly, it advocated directly, and in quite a confrontational manner, for better response from other humanitarian agencies; and secondly it expanded its own operations outside the health sector, especially in watsan, to cover capacity problems there. These strategies are in some way contradictory and lead to uncertainty and delays.

Regarding the advocacy efforts, the most obvious question perhaps is why MSF focused its lobbying on external actors, and did not call earlier on other MSF sections to become more involved in the response. In terms of the lobbying itself, the points made by other agencies, that our lobbying was overly aggressive and showed a lack of awareness of how other agencies work, have some merit. In particular, it is notable that advocacy was conducted strongly at both Maban and Geneva levels in particular at the peak of the emergency in August, but was weaker in Juba, where many of the decisions about the wider system response were being made. More resources and effort could have gone into engagement at Juba level, where most NGOs and UNHCR decisions were taken. However, it should also be noted that MSF's confrontational approach, in its lobbying and in public through the media, did significantly increase pressure on the major responders, and contribute to a larger response.

MSF's watsan intervention was based on a concept of "gap-filling", that we are a health actor and will only intervene if no other more specialised watsan actor can do so adequately. But this was based on unrealistic expectations: it should have come as no surprise that other agencies would not be able to act in the manner and with the speed required. MSF held several very specific advantages and strengths in this emergency response which no other responder had: logistical, human resources and financial size, capacity and autonomy allowed it to expand to fill gaps, in particular in watsan, as needed, when other NGOs were not capable of meeting their obligations. This was most clearly seen in May and June, when MSF's emergency water responses for the new arrivals in the transit sites and the camps were vital. MSF could have considered going into watsan activities earlier and more whole-heartedly and investing in some longer-term solutions, without an attitude that it would only do so if it had to.

Conclusions

Given these deep flaws within the system and in the delivery capacity of humanitarian agencies, **MSF will have to revise downwards its expectations of what other humanitarian agencies can actually deliver in such rapid-onset refugee crises.** MSF should expect that assistance will be slow in arriving and it will be more difficult to achieve proper scale and technical quality. Certainly, MSF needs to stop considering that other organisations are our other-sector equivalents, in capacity, speed or approach. We cannot judge other organisations by our own yardstick: our emphasis on speed and scale, regardless of cost, is not shared by (or even possible for) other emergency responders.

Rather, the lesson from the Maban emergency should be to rely more on our own capacities and less on those of others. We do this already in health; we will likely need to take a similar approach in watsan, at least in the first 4-6 weeks of an emergency and perhaps longer. Otherwise, we set ourselves up for confusion, delay and frustration.

In its positioning within the humanitarian system, MSF seemed to want to have it both ways: to be both an insider negotiating with NGOs, the UN and others around key operational issues and seeking to determine the strategy for the overall response, and yet also be an outsider, free from obligations to the rest of the system (such as sharing information or planning) but able to name and blame others if they don't fulfil their obligations. It takes no responsibility for addressing longstanding problems within emergency response, and yet still expects that responders will be able to perform their core functions to its own standards. **Being both an insider and outsider can offer the best of both worlds, but it can also mean that we cannot address problems in a wider response until they arise.** Better would be to deploy advocacy and communications efforts aimed at the humanitarian system earlier, from the very beginning of an emergency, before the inevitable gaps and failings become truly life-threatening (by analogy, this would be the same way that we don't wait for measles cases before starting measles vaccination in a closed refugee setting).

Of course, specific advocacy in specific interventions will continue to have a role. Such efforts can be cooperative or confrontational depending on the exact situation – certainly the Maban case shows again that confrontational approaches can have a significant impact. But many of the problems of the humanitarian system in the Maban emergency could not be fixed on the spot, and should not be expected to be. Rather, **a deeper engagement needs to be sought with the major humanitarian agencies (including UNHCR in particular) in an effort to understand better why such problems come about and to prevent them in future.** This will require MSF to invest in a more significant dialogue with the humanitarian aid system, both at international level and in certain key countries like South Sudan.

Annex 1: Timeline Maban Emergency November 2011 – September 2012

Nov 8: Bombardments of Yafta and New Qufta, Blue Nile state causes the first wave of refugees to Maban county.

Nov 13: UNHCR conducts an assessment mission to the county.

Nov 28: MSF sets up a temporary clinic and starts providing emergency latrines. MSF has 15 international staff and upwards of 70 locally hired staff working

Dec 9: UNHCR starts working on a second camp (Jamam), as Doro approached its 25,000 capacity. New arrivals estimated at 1000 per day.

Dec 14: Oxfam arrives, with plans for water and sanitation, including drilling boreholes. WFP is distributing food. Refugee population in Maban country estimated at 32,000.

Jan 16 and 23: The Blue Nile town of Rom was bombed, causing hundreds more to flee. Refugee population is estimated at 60,000.

March 16: Oxfam is working on improving water supply in Jamam, trucking from boreholes further away. Search is on for a new site, away from the border, with water and unlikely to flood.

April 24: Pace of new arrivals has slowed, but water problems are significant. Jamam's population are receiving 6.65 litres per day, while those are Doro receive 12 litres per day, leading to plans for moving Jamam's population to another site. Shelter is inadequate, with only 30% under UNHCR tents.

May 19: The second major wave of refugees begins with an estimated 30,000 refugees crossing the border in a three week period, fleeing violence and food stock depletion. The first group is sent to the newly opened Batil camp.

June 1: Many new arrivals are relocating themselves 30kms to a transit site at K43. Meanwhile, Doro camp has 37,000 refugees, while Jamam is grappling with a lack of water (estimated at seven litres per person per day). The relocation of 15,000 refugees from the transit sites to Doro and Batil is underway. Total refugee population is 100,000.

June 12: Eight thousand refugees are moved by UNHCR from K43 to K18, with others walking. The population is arriving in very poor state; MSF is providing health and water there (but only at two litres pppd). Total numbers of refugees are in excess of planning scenarios (for only 75,000, versus an estimated 110,000 in reality).

June 22: Water remains a major problem, with average provision only 7 litres pppd in Jamam and similar problems in the others. Water sources in Batil are improving, with more water points discovered. Relocation of refugees from Km 18 to Batil is underway, but 14,000 remain there, as roads get flooded. Surveys by MSF at Jamam in this period show crude mortality rates at

1.8/10,000/day, with 65% of deaths from diarrhoea, while those at Batil were lower at 0.9/10,000/day.

July 7: Visit to Batil camp by "elders" including Desmond Tutu and Mary Robinson.

July 10: Conditions are worsening due to torrential rains. Four drilling rigs are now operational, but needs are very high, given the 110,000 refugees in the camps.

July 17: MSF meets ERC Amos, warning of critical unmet needs.

July 24: Jamam is partly flooded by rains, relocations of refugees from Jamam to Batil are underway, and a new camp at Gendrassa is also established. Batil has reached its capacity with 34,500 refugees; current water provision is 13 litres pppd. Gendrassa has two new boreholes and a provision of 15 litres pppd.

August 29: Malnutrition and mortality rates among the population in the camp remain very high during this period. Water provision in Batil is down to nine litres per person per day, while there is one latrine for 28 people.

September 12: UNHCR reports that only US$73 million, out of $183 million required, has been pledged.

September 13: The South Sudanese Ministry of Health declares an outbreak of Hepatitis E in the camps, first at Jamam and then in the three others, although cases had begun as early as June.

September 20: ICRC launches a water project in Batil, including pipes, tanks and pumps. A similar project in Jamam is almost complete. Total refugee population is at this time estimated at 109,046 persons.

Annex 2: List of interviewees

MSF

- **MSF Holland:** 11 people interviewed in Maban, Juba and Amsterdam
- **MSF Belgium:** 8 people interviewed in Maban, Juba and Brussels
- **International Office**

NGOs

- **Oxfam**: 3 people interviewed in Maban and Juba
- **NGO Coordination Forum**
- **ACTED**
- **IMC**: 2 people interviewed in Maban
- **Save the Children UK**: 2 people interviewed in Juba and Maban
- **GOAL**

UN

- **UNHCR**: Five people interviewed in Maban, Juba and Geneva
- **WHO**
- **WFP**

Red Cross movement
ICRC: 4 people interviewed in Maban, Juba and Geneva

Donors
- **ECHO**
- **DFID**

Notes:
a) The Relief and Rehabilitation Commissioner, Peter Lam Both was travelling the week of the review and so it was not possible to interview him. Ministry of Health staff were unavailable due to internal planning meetings.
b) Attended the Maban Coordination meeting on Nov 9th chaired by UNHCR and attended by all NGOs participating in Maban response.
c) Met and shared reflections with MSF France team evaluating Yida response on 10 Nov.

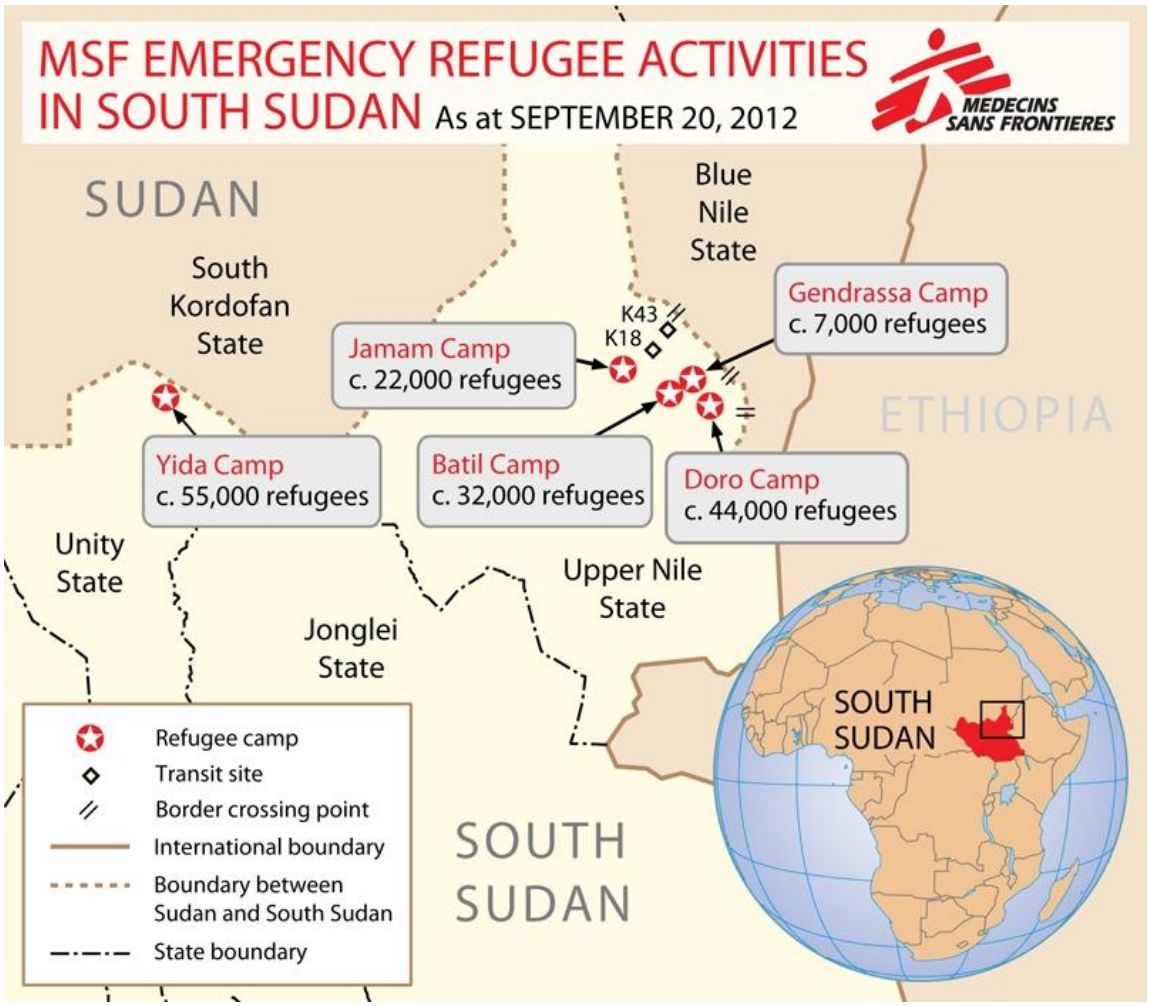
Annex 3: Review programme/itinerary

Field Visit: Nov 2-6 Jamam, Gendrassa, Batil visits; Nov 7-10 Juba
Desk Study and HQ interviews: December 2012

Annex 4: Key reference documents

Documents reviewed include:
- MSF weekly sitreps, medical reports, explo reports.
- MSF external communications, press releases and statements, and crisis updates.
- MSF briefing papers for the humanitarian community.
- MSF and Epicentre retrospective and prospective mortality surveys.
- Public reports and press statements of UNHCR, IOM, Oxfam, Goal, International Medical Corps, ICRC, Danish Refugee Council and ACTED, as found on Reliefweb between November 2011 and September 2012.
- Data, maps and reports on the UNHCR data website.
- Data, maps and reports on the WFP website.
- Humanitarian bulletins and updates on the South Sudan website of UN OCHA.
- Weekly epidemiological bulletins from the WHO, published on Reliefweb.

Annex 5: Map



Annex 6: Terms of Reference

Emergency response capacity in the humanitarian aid system
Case study: Maban, South Sudan emergency
October 2012 – Final

Problem statement
In a paper prepared for the MSF ExCom in June 2012, a conclusion was reached that "the humanitarian aid system is expanding and yet is manifestly unable to respond to emergencies in a timely, relevant and acceptable way". This paper was based on a comprehensive review of published reports and articles from MSF, the wider humanitarian system and researchers, but

was conducted at a high level of generalization, without a detailed assessment of specific emergencies.

This paper lays out a proposal for a case study review to test this conclusion at field level in a particular emergency – specifically that in Maban, South Sudan. The case study would map out the evolution of the emergency, looking specifically at the response of the humanitarian system (including MSF) and assessing the extent to which there were weaknesses or failings in that response and why those weaknesses or failing arose. This case study would constitute part of a broader process of analyzing the emergency response capacity of the humanitarian aid system, which was commissioned by the ExCom.

Working hypotheses (to be proved/disproved by the review)
Was there a lack of emergency response capacity that negatively impacted the refugee and host population in Maban between May and September 2012 at the onset of the second wave of people crossing the border due to violence in Blue Nile?
a. Criteria: Timeliness? Relevance? Acceptability?

Methodology
The review will map both the needs of the refugee and host population and the actual and promised provision of emergency aid in time, starting from a baseline at the beginning of May 2012. This will reveal the evolution of the emergency and facilitate the comparison between demand and supply in time. The comparison of demand and supply determines if the aid provided was timely. Once the emergency response is mapped it will enable us, through beneficiary and host population enquiries, to determine if the response was relevant and acceptable.

The following methods will be used:

- Desk review of medical, epidemiological, watsan and other data from MSF and external sources.
- Desk review of all MSF and other agency (where available) reports, such as sitreps, assessment and explo reports.
- Interviews and/or focus group discussions with:
    - HQ emergency and regular desk, including specialists, in Amsterdam and Brussels.
    - Mission emergency coordination team.
    - Project team.
    - Members of the refugee population in Maban.
- Key informant interviews with:
    - Key emergency team members no longer on site.
    - Humanitarian agency staff in Juba (including at least: Oxfam, WFP, UNICEF, OCHA, ICRC, and any other relevant agencies).
    - Humanitarian agency staff in Maban.
    - Representatives (chiefs, community leaders) of the refugee population in Maban.

Deliverables

The following analytical products will be drafted:

- Case study report summarizing the results of the enquiry, including assessment of accuracy or not of the working hypothesis.
- Timeline of the response.
- Presentation of the results to MSF Holland Ops Platform (and others).

Timeline

September: Draft initial concept and protocol.
October: Internal consultations (Ops, PHD, MSF Belgium). Approval of concept (Ops Platform? MT?).
November: HQ-based interviews.
November: Field visit.
December: Draft case study. Consultations/feedback round.
January: Approval. Dissemination.

Researchers

Sean Healy for Desk Study and Sandrine Tiller for field and HQ activities.

Programme

In Juba: Focus group discussions and key informant interviews with:

o Mission emergency coordination team. (MSF Holland and MSF Belgium if possible.)
o Other humanitarian agency staff in Juba (including at least: Oxfam, WFP, UNICEF, OCHA, ICRC, others).

In Maban: Focus group discussions with:

o Project team.
o Other humanitarian agency staff in Maban.
o Representatives of committees within the refugee population in Maban (eg. water committee, camp management committee).

In UK/Berlin/Amsterdam:

Desk review of medical, epidemiological, watsan and other data, and desk review of all MSF and other agency (where available) reports, such as sitreps, assessment and explo reports.

- Interviews with returned MSF and external agency staff.