WHERE IS EVERYONE?

RESPONDING TO EMERGENCIES IN THE MOST DIFFICULT PLACES

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A review of the humanitarian aid system's response to displacement emergencies in conflict contexts in South Sudan, eastern Democratic Republic of Congo and Jordan, 2012-13

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CREDITS

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FOREWORD

The international humanitarian aid system has more means and resources at its disposal and greater know-how than ever before. But, on the ground, whether in Syria, DRC, South Sudan or the Central African Republic, MSF teams have repeatedly seen that:

- Humanitarian responses are slow and cumbersome, and lack impact.
- UN agencies and INGOs are increasingly absent from field locations, especially when there are any kind of significant security or logistical issues.
- In acute emergencies, when assistance is most needed, international staff of humanitarian agencies are rapidly evacuated or go into hibernation, and programmes downgrade to skeleton staff or are suspended.
- Many agencies are concentrating only on the easiest-to-reach populations and ignoring the more difficult places.
- Many humanitarian actors are now working at arm's length through local NGOs or government authorities, acting more as technical experts, intermediaries or donors than field actors.
- These local organisations have enormous burdens placed on them to respond, but often do not have the skills and experience required to conduct technically difficult interventions; further, it can be difficult for them to operate in contested areas and to be seen as neutral and impartial.
- Some humanitarian agencies simply wait until the emergency passes to continue their usual, long-term programmes.
- Technical capacity in sectors such as water and sanitation or health also seems to be declining in emergency settings.

The result of all of this is that people in desperate need of lifesaving assistance are not getting it – because of the internal failings of humanitarian aid system. The findings in this report are based on research into three major displacement emergencies of recent years, but are also corroborated by our field staff all over the world. We are seeing these conclusions reinforced in the major crises of the day. In the Philippines response to Typhoon Haiyan, for example, where there is good access, funding and visibility, the UN and INGO community has deployed a massive response which has been largely effective, although very costly. Yet in the Central African Republic and South Sudan, countries with considerable security and logistical challenges, persistent problems remain with the scale up of the UN and INGO response, which is characterised by bureaucracy and risk aversion. What assistance there is in these contexts is largely concentrated on the capital cities and/or in a small number of very large, officially recognised refugee camps; very little reaches the periphery.

In this report we level criticism at the UN for its lack of flexibility and effectiveness.In particular, we highlight the way the current UN system inhibits good decision-making, in particular in displacement crises where a number of UN agencies have a responsibility to respond.

We also put the choices made by INGOs, our peers, in the spotlight: to profile themselves as emergency responders, but without building the technical and human capacity to respond quickly and effectively; to work as implementers for the UN agencies, and become trapped in their bureaucracies; to avoid risk to the extent that they won't work where people most need them; and to become dependent on the geopolitical interests in play in various conflicts and crises.

Donors should also examine their contribution to the atrophy of the humanitarian system, in particular their funding systems which are slow, inflexible and not suited to emergency situations. The "value for money" of a late, badly targeted and ineffective response is surely close to zero.

Refugee camp in Doro, South Sudan.

Some of the problems identified in this research are also challenges for MSF. In some conflicts and emergencies, our emergency medical capacities can be almost monopolistic. In camp settings we can be too focused on hospital care and not do enough community outreach. We are reviewing our approach to vulnerability.

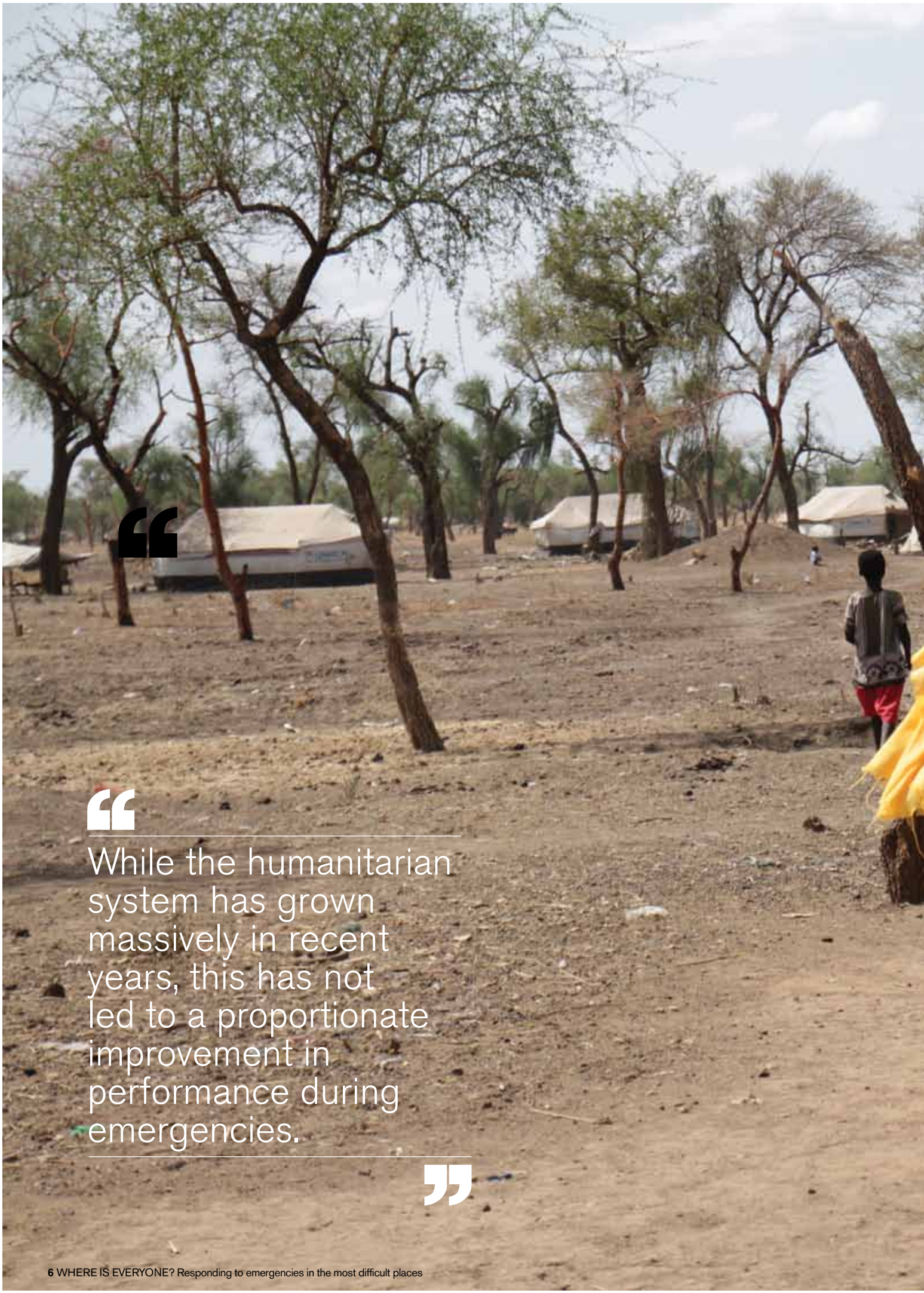
We will undertake a review of our own emergency response capacity, and continue to examine the evidence of the system's response in key contexts such as the Central African Republic and South Sudan. We also will engage with donors, and take a special look at how to improve our engagement with Emerging Actors.

Although we keep our distance from the formal institutions of the UN, MSF is part of the humanitarian aid system. And for all of its 'smartness' and wealth, it is not able to respond to the needs of the most vulnerable people affected.

For MSF this poses a huge challenge; in places like CAR and South Sudan our operations have grown enormously to respond to the massive needs caused by the crisis. We risk being the de facto substitute for the Ministry of Health. This exposes our teams in areas where there is great insecurity and we are the only health care providers. It also makes it a real challenge to scale down and to exit. Should we encourage or enable others to scale up? Or should we increase even more to fill the gaps? Presently, we are stuck with a strategy which vacillates between the two.

We put our conclusions forward at a time when the humanitarian system is taking the opportunity to review how it functions, in the lead up to the World Humanitarian Summit in Istanbul in 2016. We hope that this will be a time of reflection leading to changes, rather than a reaffirmation of the status quo. MSF is ready to contribute to making these changes.

Dr. Joanne Liu
MSF International President



> While the humanitarian system has grown massively in recent years, this has not led to a proportionate improvement in performance during emergencies.

© Robert Hoglund/MSF 2013, Maban South Sudan.

EXECUTIVE SUMMARY

Responding to emergencies in conflict areas where people are displaced is a difficult task. Often working at very short notice, in remote areas, requiring complex technical responses, NGOs and UN agencies are faced with daunting challenges.

The humanitarian aid system is growing and expanding, and so surely its capacity to meet these challenges should also be growing.

Yet despite the enormous resources, in the more complex, less high-profile and difficult contexts, MSF teams in the field have seen that humanitarian responses to displacement emergencies have not occurred in a timely and effective way. This is especially the case in conflict areas.

These observations have prompted MSF to conduct this review, to better understand how the humanitarian system is responding to acute displacement emergencies. The review is based on three case studies:

- the refugee emergency in Upper Nile state, South Sudan, starting in November 2011 to November 2012;
- the emergencies related to the M23 mutiny in North Kivu, DRC, from April 2012 to April 2013; and
- the massive influx of Syrian refugees into Jordan from July 2012 to June 2013.

The review confirms that emergency response suffers from several recurrent problems which need to be addressed. Rather, while it is core business for the humanitarian system, emergency response capacity has been undervalued and under-prioritised.

In all of the problems identified in the three cases, the main issue appears to be the level of prioritisation attached to emergency response and in particular the level of willingness to try to address the needs of people who are the most difficult to reach.

The following common themes stood out:

- While **external constraints** on emergency response, as security, access and cost, were certainly significant, in all cases, there was more than could have been done to reduce the external constraints that did exist. Further, it cannot be said that the main barrier to better response is lack of funding – in all three cases reviewed, the funding situation was adequate.
- The **UN was at the heart of the dysfunction** in each of the cases reviewed. There, historical mandates and institutional positioning have created a system with artificial boundaries (for example, between the coordination roles of UNHCR for refugees and OCHA elsewhere), to the detriment of those needing assistance and protection. Further, the triple role of key UN agencies, as donor, coordinator and implementer, is causing conflicts of interest, especially in recognizing and correcting mistakes. Funding systems, in particular, are problematic, slow, cumbersome and not fit for emergency situations.

Zaatari Camp in Jordan, home to more than 100,000 Syrian refugees.

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- NGOs make their own choices about how to respond in emergencies – and so **must also bear their own responsibilities for how they respond**. In some cases, we found that technical capacities were not as they should be, for example, in health, water and sanitation, or assistance to victims of sexual violence. Many agencies had great trouble reorienting longer-term humanitarian programmes to re-adapt to emergency needs. Risk aversion was pervasive within the NGO community, not only in relation to security but also to programming, meaning that agencies were choosing to prioritise the easiest-to-reach over the most vulnerable.

- **As for MSF**, we found that, while the organisation has made significant efforts to prioritise emergency response, it was not immune to many of the same criticisms. In all three cases, in MSF, just as everywhere else, much came down to the nimbleness and reactivity of field leadership, of how well they were able to see changing needs and react accordingly.

INTRODUCTION

Over the past few years, in Haiti, Pakistan, Somalia and elsewhere, MSF (amongst many others) has been highly critical of the performance of the collective body of humanitarian agencies in major emergencies – with a perceived "failure of the system" to provide assistance which is rapid, appropriate and at scale. But these emergencies have themselves been exceptional – so how far can we generalise?

To address this question, we have undertaken a review of emergency responses, comprising:

- A series of three case studies of recent emergencies, specifically related to conflict and displacement, based on field visits, interviews with key informants inside and outside the humanitarian community, and review of available data, namely:
  - The refugee emergency in **Maban county**, South Sudan, November 2011 to November 2012;
  - The emergency in **North Kivu**, Democratic Republic of Congo, following the formation of the M23 rebel group, April 2012 to April 2013; and
  - The refugee crisis in **Jordan** caused by Syrians fleeing their country, July 2012 to June 2013.
- A systematic review of evaluations conducted between 2008-12 of emergency operations in situations of conflict and displacement from throughout the humanitarian system, including all the relevant inter-agency real-time evaluations, but also evaluations made by individual agencies (found in the databases of ALNAP, UNICEF, WFP, UNHCR among others), as well as MSF's own evaluations.

The principal questions the review addresses are:

- What is our assessment of the performance of the humanitarian system[2] in such displacement emergencies, including what impact does it have, how well does it cover needs, and how effective is it?
- What difficulties are encountered in such emergencies, and what explains them? In particular, are they attributable mainly to external constraints on humanitarian assistance, to systemic or structural features, or to agency-level decisions and constraints?

This paper summarises the principal findings and conclusions from the review. The case studies are summarised at the end of the report.

METHODOLOGY

The three emergencies in this review were chosen using the following criteria: the presence of an ongoing emergency, a significant operational input from both MSF and the wider humanitarian system, and sufficient security to allow for a visit by the reviewers. Three separate visits were made by the reviewers to study sites in the DRC, South Sudan, and Jordan, during 2012 and 2013.

A total of 116 key informant interviews were conducted with MSF field and headquarters staff, a wide variety of national and international humanitarian organisations, a large number of UN agencies, the ICRC and national Red Cross societies, donor agencies, national government personnel, and representatives of local and displaced communities. A detailed review of existing literature further augmented the information collected during the interview process, and facilitated the critical comparison of findings, common themes, and conclusions. A review was also conducted of available and relevant quantitative data, especially those which might shed light on the impact of the humanitarian operations. This data was taken from sources both published and unpublished (e.g. internal assessments conducted by individual agencies).

FINDINGS

Assessing humanitarian performance in three emergencies

The core criterion for judging the success or failure of a humanitarian operation should be impact:[3] in particular, how many lives were saved? The data on mortality trends in the

Mugunga III, North Kivu, DRC.
An official camp for IDPs.

> Status was the principal determinant of assistance, rather than need or vulnerability

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three emergencies is incomplete, so no definitive answer can be given to this question. Further, in Jordan especially, it was not at all clear that lives saved would be the most appropriate yardstick, as the health status of the refugee population was generally good on arrival, and the principal risk factors facing populations were more associated with destitution and exploitation, rather than with high levels of excess mortality.

However, enough was seen to make some judgments:

- In the refugee camps of **Maban**, very high levels of mortality persisted during the period May-August 2012, after which they began to reduce to less high (but still alarming) levels. Given the setting, and the absence of any other actors, the reduction in mortality is attributable to international humanitarian assistance.
- In **Jordan**, there is no available mortality data on refugees in the cities, but in Zaatari refugee camp, mortality rates were low and falling after winter 2012-13, during which conditions were at their worst. Generally good background health status, low levels of malnutrition, the relatively low risk of epidemic diseases, but also the assistance provided by humanitarian actors can all be considered the most significant contributing factors in this.
- In **North Kivu**, assessing humanitarian impact was the most difficult of the three cases. The only evidence on mortality rates during the period under review comes from the Walikale territory, which showed mortality rates above the emergency threshold. Walikale suffered a malaria epidemic during this period and also had hardly any governmental or humanitarian presence during the period of the survey, both of which would likely have elevated the death rates. Conversely, the areas around Masisi, Kitchanga and Goma suffered less malaria but more violence, and received more assistance from humanitarians and government. While no data is available on mortality rates in those zones, most of our informants thought they would likely be lower than in Walikale – and it seems reasonable to consider that humanitarian assistance in those areas was a contributing factor, although probably far from the major one. More work is needed in North Kivu to really understand what contribution humanitarian assistance makes to reducing mortality.[4]

Whose lives, where and when?

So humanitarian assistance did save lives – but whose lives were saved, where and when? All three operations did achieve considerable scale, serving in each case hundreds of thousands of people, and addressing many needs in a relevant and appropriate fashion. But coverage issues were very significant in two of the emergencies: in both the North Kivu and Jordan cases, the level of assistance that a displaced person received was very strongly influenced by their registration status with UNHCR and by their location.

Further, it was evident that in the more rapid-onset emergencies (Maban, North Kivu), *reactivity* was weak and response times before assistance arrived were below what should be expected. Logistical considerations were significant in both settings, while security was a major constraint in North Kivu. But in Maban, there were significant failings in contingency planning and then in reacting quickly to new needs, which prolonged the high mortality levels. In North Kivu, reactivity varied wildly: for example, in one town, Kitchanga, the same displaced population received a general food distribution from ICRC within days of major violence, but waited four to five months for food and NFIs from UNHCR and its implementing partners. Even in Jordan, where the onset of the crisis was slower and steadier, the first six to nine months including winter in Zaatari camp were very difficult for the refugee population, due to an underestimation of the crisis, the weak capacity of responding agencies and a relatively long scale-up process.

However, if poor coverage implies that outcomes were worse for people and places not reached by the humanitarian responses, the Maban case demonstrates that, even where the response was present, *effectiveness* was not a given. The performance by humanitarian agencies in Maban was the worst of the three cases – as shown not only by the mortality

curves but also by the very considerable difficulties in water provision and response capacity, site planning and emergency preparedness. The responses in North Kivu and (more strongly) Jordan were more effective in meeting the most crucial needs.

External factors do play a considerable role

Humanitarian assistance occurs in a given context, whose specific characteristics heavily influence the performance of a humanitarian response. The following factors were notable in the three cases under review:

- **Logistical constraints** associated with the geography of an emergency were very significant in Maban, making every facet of the intervention much more difficult, as well as in the peripheral zones in North Kivu.
- **Insecurity** and associated restrictions on access to populations were a very real constraint in North Kivu, significantly endangering communities and the humanitarians seeking to service them, as well as reducing the presence of the aid organisations. (This has also been a major factor in the Syrian conflict, which underlies the Jordanian refugee crisis.)
- **The role of the government** was the decisive factor in Jordan, both in service provision and in decisions on refugee status, but was less significant in North Kivu and Maban.
- **Civil society actors** were also a very significant factor in Jordan, providing some of the most relevant assistance, and were a factor in North Kivu too.
- **The visibility of the emergency** in the international community – and associated with that, the political interests of the great powers – also played a major role in both Jordan and North Kivu, pushing greater humanitarian efforts. This could be seen in the negative in Maban, which could be categorised as a neglected crisis.

It should be noted that **insufficiency of financing was not identified as a major constraint** on performance in any of the three emergencies reviewed. Of course, more resources would have meant more assistance – but all three responses were

LIST OF ACRONYMS

ALNAP	Active Learning Network for Accountability & Performance in Humanitarian Action
DRC	Democratic Republic of Congo
IASC	Inter-Agency Standing Committee
ICRC	International Committee of the Red Cross
INGO	International non-governmental organisation
IOM	International Organisation for Migration
FARDC	Armed Forces of the Democratic Republic of Congo
MONUSCO	UN Organisation Stabilisation Mission in the Democratic Republic of Congo
NFI	Non-food items
NGO	Non-governmental organisations
OCHA	Office for the Coordination of Humanitarian Affairs
RRMP	Rapid Response to population movements
SGBV	Sexual and gender-based violence
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
watsan	Water and sanitation
WFP	World Food Programme

Arman, Jordan 2011
Reconstructive surgery hospital

relatively well-funded, in the range of 50-60% of the various UN appeals, and in the hundreds of millions of dollars.

It should also be noted that, in all the above cases, **humanitarian agencies did have the possibility to influence these external constraints** – which they sometimes did, and sometimes did not. For example, humanitarian agencies were able to forge good relationships with Jordanian authorities, although they were not always so successful in influencing their decisions; while in North Kivu, some agencies were capable of negotiating access with armed groups and thereby maintaining humanitarian presence during conflict episodes, while others were not. While there will always be constraints imposed on humanitarian operations by the external environment, these are not always insuperable – in fact, a key consideration in a successful operation must surely be the capacity to overcome, or at least adapt to, these constraints.

The UN is at the core of many of the system's dysfunctions

There is no basis to conclude that the humanitarian system as a whole failed in any of the three cases examined. However, where major problems in each of the responses were identified, UN agencies and structures were a central factor in them.

One common theme in the three emergencies was the crucial role played by how particular displaced populations were categorised by the humanitarian community. **Status was the principal determinant of assistance, rather than need or vulnerability**. Partly this is a function of legal mandate, and partly a function of administrative systems. In Jordan, there was a significant gap in assistance between refugees in the camp settings and those in the urban centres, and an even more significant gap between those registered with UNHCR and those (15%) who were not. In North Kivu, where the displaced were internal and not refugees, there was an even

clearer gap between those in official camps (assisted and protected by UNHCR), those in unofficial camps (assisted by IOM) and those in host communities (who received targeted assistance from very few agencies and negligible protection). In North Kivu, substantial machinery had been built to register and classify all displaced people, in order to deny assistance to those deemed not genuinely displaced; meanwhile, displaced populations could wait months for assistance. In all three locations, the host communities themselves received very little assistance of any kind, despite mounting needs and vulnerabilities.

In all three cases, UNHCR played a crucial role: in Maban and Jordan, it was the lead agency, while in North Kivu it took the lead in the official camps. However, in no case was this role unproblematic. **Rather, the triple role of UNHCR, as coordinator, implementer and donor, led to considerable conflicts of interest**. In Maban, UNHCR did not perform very well in any of the three roles: there was a very late recognition of the scale of the emergency and a poor reaction to it; there were enormous difficulties in mobilising qualified staff to respond in the relevant sectors;[5] and the triple role made it difficult both for subcontracting NGOs to share their problems and difficulties in implementation, and for UNHCR itself to admit to bigger problems or to ask for technical assistance from other UN agencies, for fear of losing out on funding or credibility. This weakened the quality of information available for sound decision-making. In North Kivu and Jordan, the wide differences in assistance to different categories of displaced person were also directly attributable to UN system (in particular UNHCR and OCHA) decisions and processes.

Emergency response requires flexible, rapidly disbursable and unearmarked funding to be effective and to respond to changing needs – **but the current emergency financing mechanisms fail** to provide this. The emergency funding mechanisms in South Sudan, North Kivu and Jordan were inflexible, bureaucratic, and required long lead times.[6] In North Kivu, it was estimated that the process from concept note to funds hitting the field took a minimum of three months to get through the clusters which means it cannot be properly considered "emergency response". Three months was also a recurrent figure in Maban and Jordan, as it was the minimum length of time it took agencies to get to proper scale and impact in both settings. There were some examples found of better practices, such as humanitarian INGOs which had standby funding agreements with donors for emergencies in North Kivu, or the Rapid Response to Population Movements (RRMP) mechanism in North Kivu, which funds joint assessments and the first three months of interventions – but the fact that such initiatives are necessary at all is itself an indictment of how ill-adapted the major mechanisms are to responding to emergencies.

Weaknesses in the leadership and technical capacity of particular sectors (or clusters), especially in health and watsan, were also notable. In Maban, UNHCR had many difficulties in mobilising the right technical capacity for


Maban, South Sudan

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the watsan sector it led, either internally or from within its implementing partners. In North Kivu, the health cluster was (according to many informants) the worst performing of the clusters (although here the relative absence of the major health responder, MSF, surely played a significant role). In Jordan, by contrast, the performance and the leadership in both the watsan and health sectors were strong, but were focused on the camp settings.

Choices made by NGOs play a decisive role

As important as the external or systemic and structural constraints are, the three cases also demonstrate that NGOs have their own capacity to respond and react, and make their own choices about how to do so – and so **must also bear responsibility for how they respond**. We saw both positive and negative examples of such choices, which enabled or retarded good emergency response.

Firstly, in several cases there appeared to be **genuine capacity issues**, that is, a lack of sufficient human, financial and especially technical resources to get the job done. The most significant examples of this are from Maban, surprisingly, because of all three, this was the kind of response in which humanitarian agencies are surely most experienced. Not only was there a lack of sufficient technical capacity in watsan, but there were also significant failures in contingency planning (especially as new refugee arrivals were predictable), in site planning, in information sharing, in redirecting programmes to respond to new needs, among others – all basic tools of the art. In North Kivu, there were similar examples of weak capacity in health (very few actors were able to provide medical services during moments of emergency), in response to sexual and gender-based violence (especially in medical and psychosocial treatment for survivors), watsan, NFIs, and in security management (negotiating access with rebel groups in particular). Agency-level capacity issues appeared to be considerably less significant in Jordan, although errors were made at the establishment of Zaatari camp in site planning (the location of all key services at one end of the camp) and in security and protection (the decision not to establish policing within the camp), which took over one year to rectify.

A major theme to emerge in all three cases was **a very strong risk aversion by NGOs**. This was most obvious in relation to the management of security risks in North Kivu, but it applies much more broadly to the way agencies make decisions, identify priorities and implement programmes. In Jordan, everyone was aware of the imbalances in the response, but most agencies gave higher priority to their larger, more visible and more straightforward camp operations than to their smaller, more complicated and more likely to fail urban ones. One effect of this was noticeable in all three emergencies: a principal determinant of the level of coverage and effectiveness was the level of difficulty (and, conversely, convenience). Populations received assistance in large part based on how easy they were to target and reach – in North Kivu, aid declined dramatically from Goma to the periphery where needs were

greater; in Jordan, needs in Zaatari were over-covered, while urban refugees received considerably less despite their greater vulnerability; while in Maban, it seemed that many agencies found the whole emergency too hard. The more a need lent itself to a solution which resembled engineering, the more likely it was to get addressed. In contrast, there appeared to be a shortage of agencies willing and able to do the "difficult things" – to react immediately in Maban, to keep working during the bush war in North Kivu, to find a way to get to the 70,000 unregistered refugees in Jordan's cities who were not receiving humanitarian assistance.

Further, it was evident that **redirecting long-term programmes towards addressing emergency needs** can be very difficult for many agencies. This is the "problem of shifting gears",[7] which was raised by informants in all three settings as being a key difficulty, especially in the two more rapid-onset settings. In Maban, particular agencies came under withering criticism from others for not being ready to respond to predictable crises and being too focused on their long-term programmes to spot coming storms. In North Kivu, the same agencies had large emergency teams and surge capacity, pre-programming funding in case of emergencies and were ready to go, while others (notably in health) which had longstanding primary health programmes in the periphery did not have the capacity to switch them to emergency needs and instead had to watch them evaporate. The relative prioritisation by individual agencies of emergency response was crucial, as was the role of proper management systems and capable leadership and the willingness to take the initiative.

Emerging actors and the humanitarian system – different worlds?

Despite growing discussion about connectedness and inclusiveness, the humanitarian system continues to be difficult to access for non-western responders. Some changes are underway: Turkey, Kuwait and other Middle Eastern countries are now significant donors to UN appeals, while the UNHCR appeal in Jordan does include Jordanian national NGOs.

In the three cases reviewed, it seems that the humanitarian system is not currently adapted to provide much direct assistance to local civil society actors, despite their growing role as responders in emergencies.[8] In Jordan, many of the more effective programmes were implemented by small-scale local NGOs, which were able to reach some of the most vulnerable urban refugees. But many of the small 'start-ups' reported lacking the organisational capacity to attend the numerous UN meetings and fulfil onerous reporting requirements and as a result, they generally operate outside the parameters of the UN-centred humanitarian system. In North Kivu, although the capacity of local NGOs was quite limited, there was a civil society which was well-informed (and critical) of the humanitarian aid system's response – and largely excluded.

Further, there were a wide range of "emerging actors", especially from the Middle East active in the Syrian crisis response, including diaspora groups, Red Crescent societies and NGOs from the region. Working mainly outside the humanitarian system (but participating occasionally in some meetings), they are in some ways freed from its constraints. Several have developed well-funded and relevant programmes which meet real needs, for example funding medical procedures for Syrian war-wounded in Jordan. However, they are also subjected to individual or government donors who prefer projects with good visibility that produce obvious results. Also, many of the larger emerging actors are required to work under the aegis of their governments or have chosen to align themselves with their government's policies.

Emerging actors, however, are not present in some of the direst humanitarian crises: for example, none were present in the North Kivu or Maban emergencies.

And MSF?

MSF was not immune to any of the constraining factors identified in this review. While distinct, many of the same criticisms apply.

In the three emergencies under review, MSF was able to provide relevant medical assistance, and it was able to provide it at large-scale to tens of thousands of people. In Maban and North Kivu, it was able to respond quickly during the crucial first weeks of displacement. It was also able to cover several highly technical areas of needs – such as reconstructive surgery in Jordan and medical response to the hepatitis E epidemic in Maban. It was also able to provide assistance in some of the most difficult areas, such as rebel-held zones in North Kivu or cross-border into Syria.

But responding to more hard-to-reach needs or switching gears from long-term programmes to emergency response was not easy for MSF in any of the three contexts, and required considerable efforts, and sometimes good fortune. MSF teams found it significantly easier to respond in the camp setting than to target the more vulnerable but more dispersed refugees in Jordan's cities, just as many other agencies did. Nor did MSF direct much attention to identifying the most vulnerable in the open displacement settings in North Kivu; rather, it hoped that accessible health provision offered to the general population would be sufficient.

MSF's 'gap-filling' approach to water provision in Maban essentially consisted of a wait-and-see stance, which meant that when it stepped it, it was already late in its response. The Maban emergency (and the parallel Yida emergency further west along the Sudan-South Sudan border) also kicked off internal discussion within MSF emergency teams about whether the organisation had lost touch with some of its earlier capacity and technical know-how in closed camp settings. Certainly, it was noticeable that MSF programmes in North Kivu, Jordan and Maban concentrated heavily on the secondary level of care – although, in Maban, there was a greater concentration on primary and community levels of care, but from somewhat late in the emergency.

As for its public voice and advocacy, in Jordan and North Kivu, it was a much more restrained, more "insider" and more "diplomatic" MSF on show. The upside of this was much better relationships with government and with other humanitarian actors, but it did mean some loss of impact – the best example being MSF's silence on the mass rapes allegedly committed by FARDC soldiers in Minova. Perhaps less dramatically, MSF's 'head down' approach meant it shared little technical expertise in topics such as epidemic response or treatment for survivors of sexual violence, both areas in which MSF teams were critical of a lack of capacity of other actors.

The exception to this picture of studied restraint was the Maban emergency, where MSF played heavily on its confrontational "outsider" role in publicly criticising perceived failings by the humanitarian community. While the public advocacy achieved its goals in this case, it possibly could have achieved similar results but with fewer burnt bridges if it had invested more in strategic engagement with the humanitarian community in Juba.

All this is to demonstrate that there is nothing inevitable about good emergency response. In all three cases, in MSF, just as everywhere else, much came down to the nimbleness and reactivity of field leadership, of how well they were able to see changing needs and react accordingly.

CONCLUSIONS

The humanitarian system can deliver a relevant and large-scale package of assistance – provided it is not too difficult to do so. This means that the humanitarian system does have positive impact in emergencies. But it is not good at responding to hard-to-reach needs, has low levels of reactivity, has poor capacity to deliver good coverage (especially of the most vulnerable), and can sometimes lack proper effectiveness and technical capacity. Any degree of difficulty seriously diminished the value of any given response: those populations who were easy to reach were assisted, those who weren't were assisted much less. There is a strong disconnect between the state of the art (i.e. what is known about

humanitarian contexts and how to deliver effective assistance) and the actual capacity to deliver.

While the humanitarian system has grown massively, this had not led to a proportionate improvement in performance during emergencies. Rather, while it is core business for the humanitarian system, emergency response capacity has been undervalued and under-prioritised. **In all of these issues, the core issue appears to be the level of prioritisation attached to emergency response and in particular the level of willingness to try to address the most difficult to reach needs**. This needs to change, through the introduction of a series of system-level and agency-level reforms:

- Leadership in emergencies is key, in particular at country level, to ensure appropriate strategic-level decisions are made about responses, and in order to reorient them as the context evolves.
- Greater investment needs to be made in building better (management, financial, human resources and logistical) systems for responding, in order to improve preparedness, reactivity and effectiveness.
- Assistance in displacement emergencies needs to be reoriented to be more based on need and vulnerability than status and location, in particular by concentrating more efforts on reaching more difficult-to-reach populations and needs.

CASE STUDY 1

THE HUMANITARIAN RESPONSE TO THE REFUGEE CRISIS IN MABAN COUNTY, SOUTH SUDAN, 2011-12

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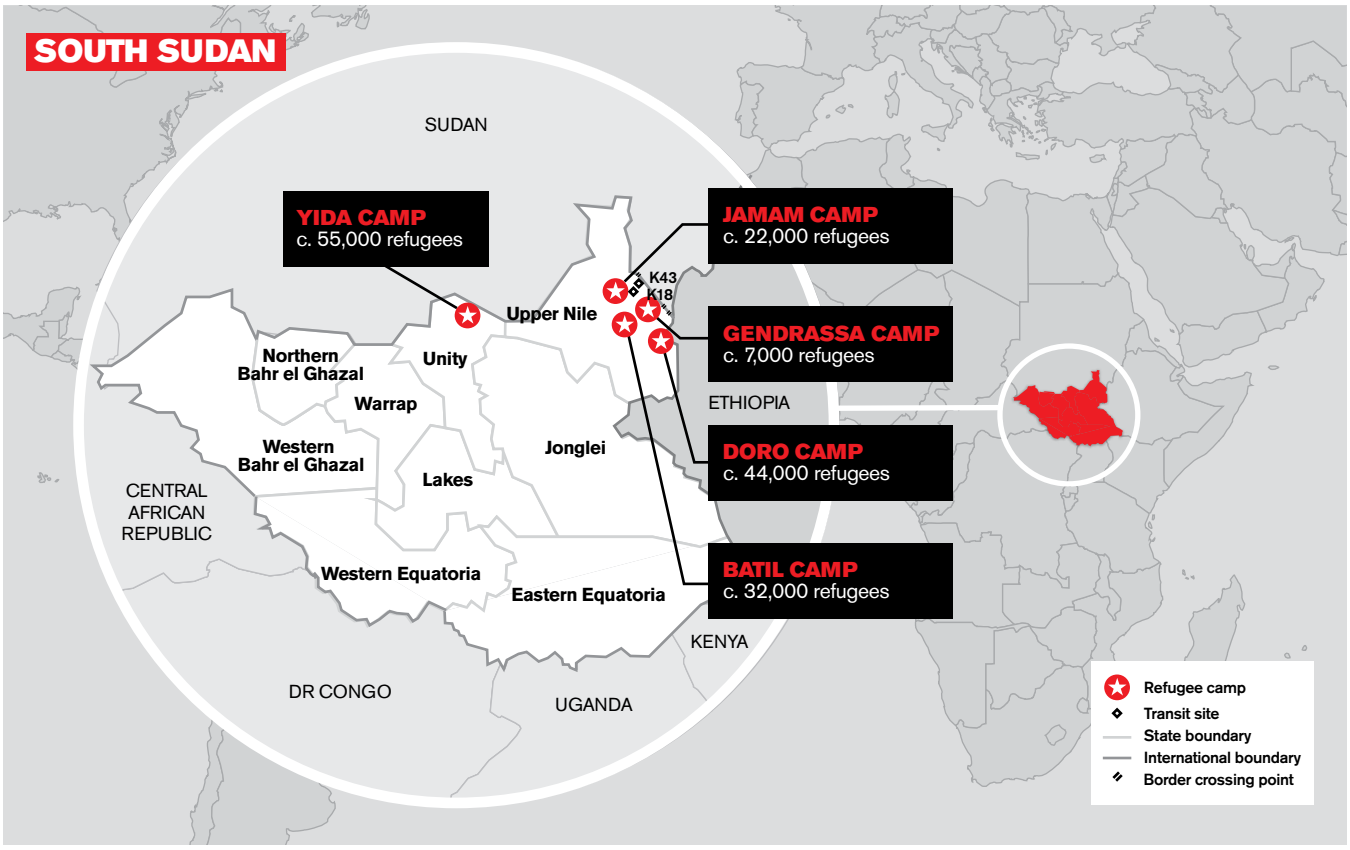
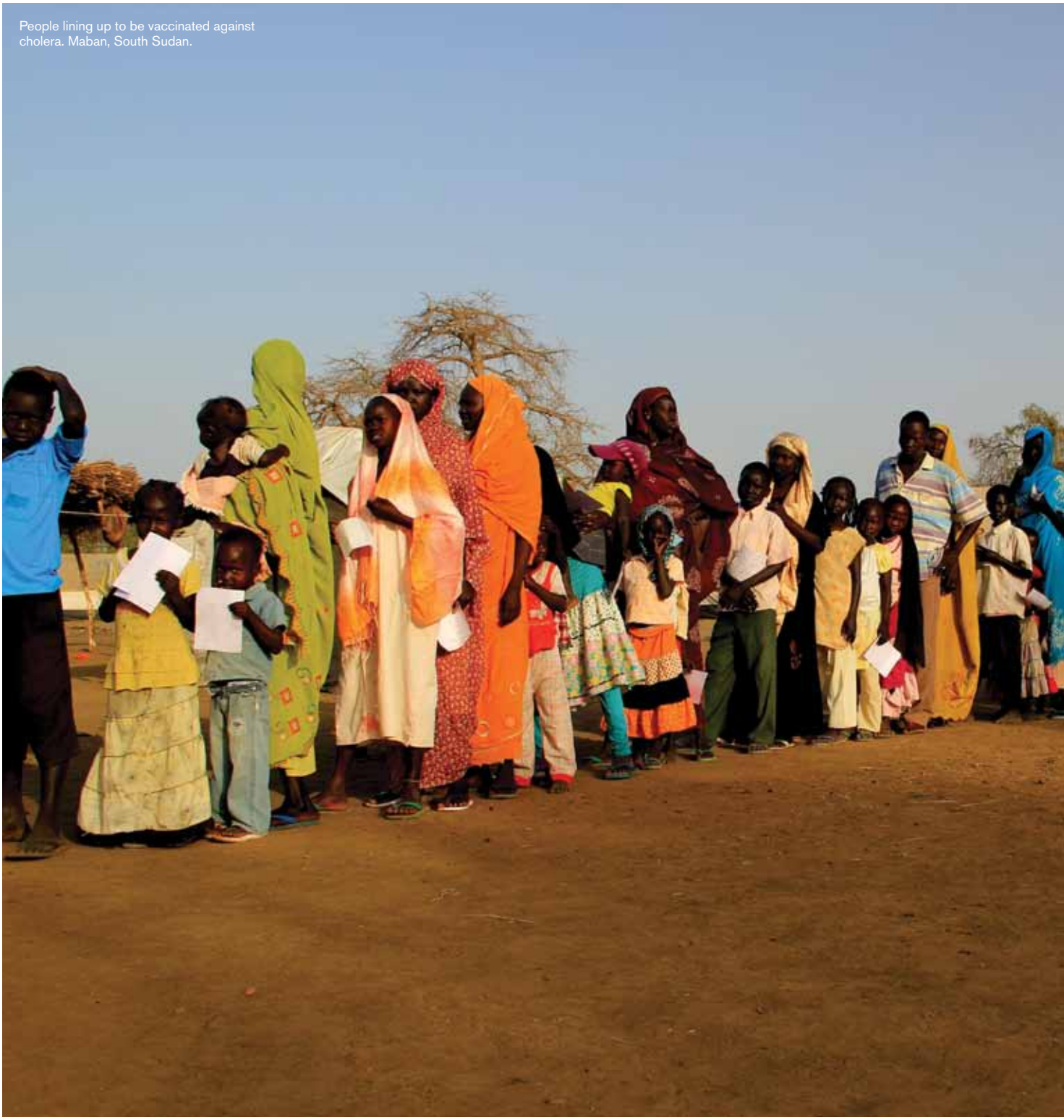


Figure 1: Refugee camps of Upper Nile State and estimated total population

The emergency in Maban county, South Sudan, unfolded in two distinct phases. In October 2011, the aerial bombardment of a number of villages in Blue Nile state, southeastern Sudan, triggered a mass influx of refugees into South Sudan via two border crossing points in the vicinity.[9]

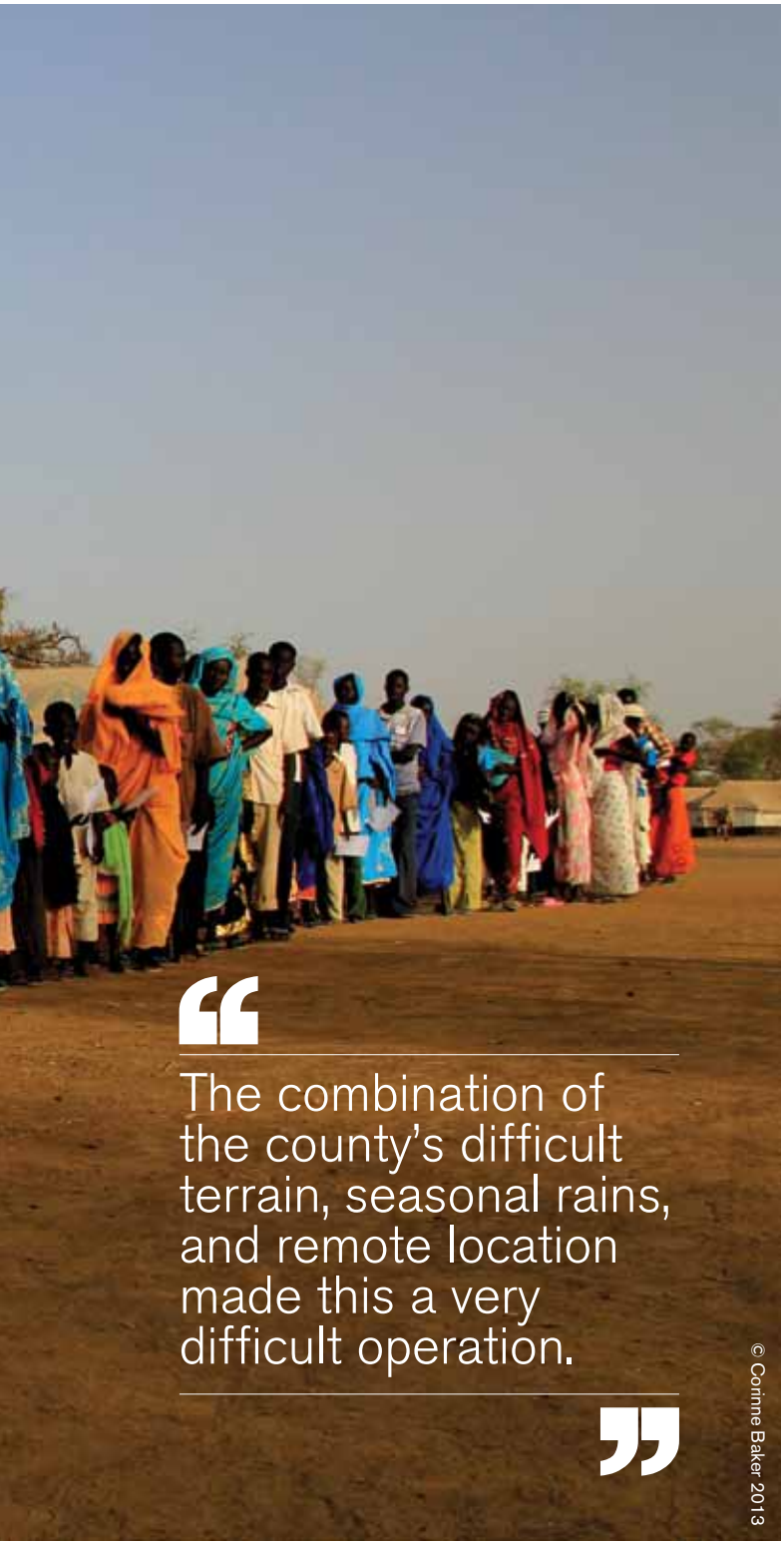
By January 2012, 28,000 refugees had settled in Doro camp, Upper Nile state; these refugees arrived in relatively good health but, as we will see, deteriorated after arrival. The total number of refugees doubled in the subsequent two months (see **Figure 1**), compelling UNHCR to establish a second camp at Jamam in February. Then, a second wave of refugees arrived between May and June, immediately prior to the rainy season, in very bad health. The majority crossed at El Fuj border crossing before passing onwards to the K43 and K18 transit sites. A third camp was opened at this time at Batil, followed by a fourth in August at Gendrassa. By this time the total refugee population had increased to over 105,000.



People lining up to be vaccinated against cholera. Maban, South Sudan.

Maban county is an isolated region close to the new border with Sudan. The region is sparsely inhabited with difficult access to natural water sources. As this was primarily a refugee crisis – a first for the new nation of South Sudan – UNHCR took a lead role, as per its mandate to assist refugee populations. The emergency response faced a wide range of difficulties and suffered from a series of shortcomings:[10]

- **Water and sanitation was the critical failing**. 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. Water provision levels in the transit camps in April and May dropped as low as 2.5 litres per person per day, and 6 litres per person per day in the established camps, far below minimum standards for survival. Heavy rains in June, July and August led to



flooding in several areas of the camps, contributing to high levels of diarrhoeal diseases and a hepatitis E outbreak. The water and sanitation situation only stabilised with the opening of a fourth camp at Gendrassa in August 2012.

- **Mortality rates were catastrophic in April and May and remained high for many months**, in large part due to the water and sanitation situation. Prospective surveillance[11] in week 24 of the crisis (mid-June, covering a recall period of 7 days) 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. Only by the beginning of September had the mortality rates in Jamam dropped sufficiently below the emergency threshold. Two retrospective mortality surveys[12 13] were done subsequently, which seemed to indicate that mortality rates might actually have risen after arrival in the camps, at least initially. Far from fulfilling a protective and rehabilitative function, camp conditions precipitated further problems.

- The combination of the county’s **difficult terrain, seasonal rains, and remote location made this a very difficult operation**, requiring a heavy investment in human resource, logistical, and financial capacities by even the largest agencies. All this had a serious impact on the reliability of the food relief supply chain. WFP was only able to supply its first full monthly rations in September. In the preceding months, only week-long or 15-day rations were supplied, and often with delays. Given the total dependency of the population on food aid, it is unsurprising that nutrition assessments in Batil in July reported global acute malnutrition in 27.7% of the population.

- There were significant gaps in planning, coordination and strategy. The transition from a longer term, development-oriented approach to emergency programming was a struggle for some agencies, presenting as a lack of urgency and an insistence on longer-term approaches (eg with watsan) which were inappropriate during the emergency phase. Contingency planning and site selection were arranged poorly, as it was known in January 2012 that Jamam would be unsuitable for the resident population during the rainy season and community leaders had signalled that a large influx of refugees could occur.

- Coordination in Juba and Maban described two different realities. A number of NGOs were reliant on funding from UNHCR, which itself was significantly underfunded throughout the crisis. The need to solicit more funding,

along with the efforts made by UNHCR to keep other UN agencies from participating in the response by largely circumventing the existing cluster system, meant that it was difficult for the agency to be open about the problems in Maban. Agency representatives described coordination meetings rife with wishful thinking, part-reporting, and the minimisation of problems; a culture of blame and suspicion prevailed, while collective accountability disguised an absence of individual agency accountability.

- MSF's strategy in Maban was threefold: firstly, it acted principally as a specialist medical responder; secondly, the organisation expanded its own operations beyond the health sector to cover gaps in service provision elsewhere; and thirdly, the organisation advocated directly for a better response from other humanitarian agencies. MSF's water and sanitation intervention was based on the notion of 'gap-filling' but it should have come as no surprise that other agencies would find it difficult to act with speed and technical competence in such a setting. MSF's advocacy approach was highly confrontational as the organisation pressed others to fulfil their obligations. While it had some positive outcomes, and did inject some urgency into the international response, it also contributed to inter-agency tensions. The organisation would sometimes stand back and criticise, only to then come forward to fill a gap.

MORTALITY RATES AND EMERGENCY THRESHOLDS

In the absence of a baseline mortality rate (often impossible to estimate in emergencies), humanitarian agencies have established "emergency thresholds". Below, see a comparison between those thresholds and the results in Maban county.

	Crude mortality	Under-five mortality
Emergency threshold	1 death per 10,000 population per day	2 death per 10,000 population per day
Initial survey, previous 7 days, Jamam camp, June 2012	1.79	2.84
Exhaustive retrospective survey, previous 300 days, T3 transit camp, June 2012	0.45	0.54
Retrospective mortality survey, previous 137 days, Batil camp, July 2012	0.91 *whole period* 1.75 *since arrival in camp*	2.1 *whole period* 4.19 *since arrival in camp*
Mortality among over-60s, Jamam camp	3.45	

REFUGEE NUMBERS, MABAN COUNTY, 2012

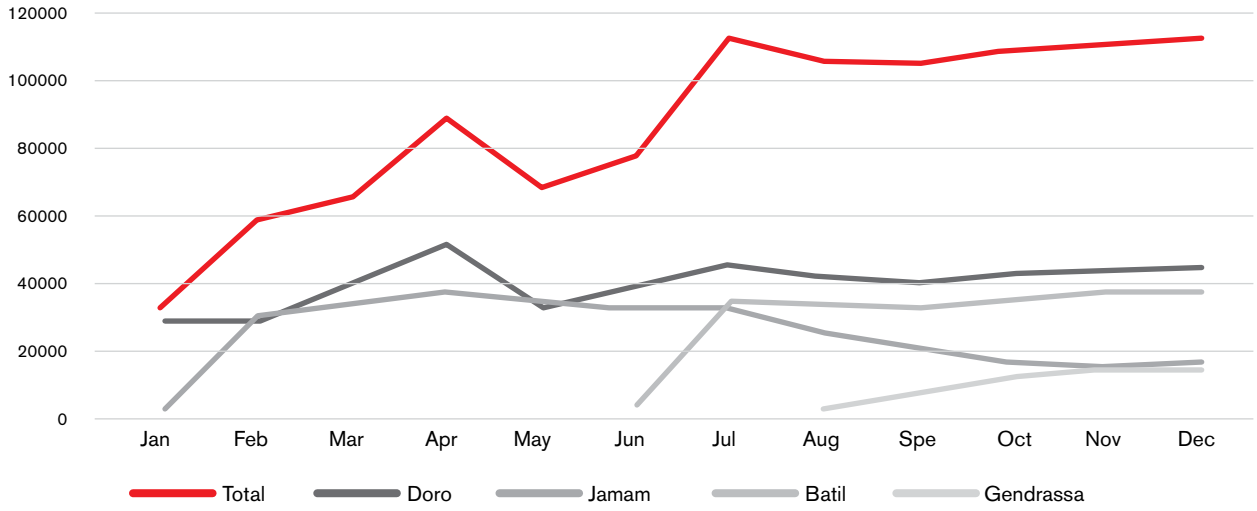


Figure 2: Population change in Batil, Doro, Gendrassa, and Jamam camps during 2012.[14]

CRUDE MORTALITY RATE, JAMAM CAMP 2012

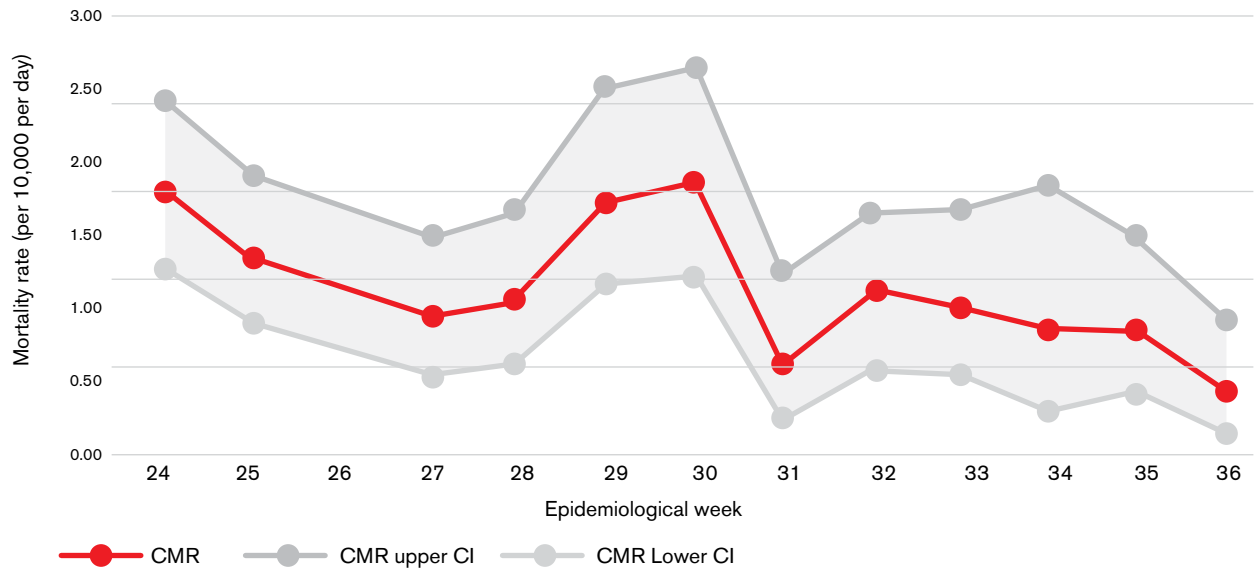
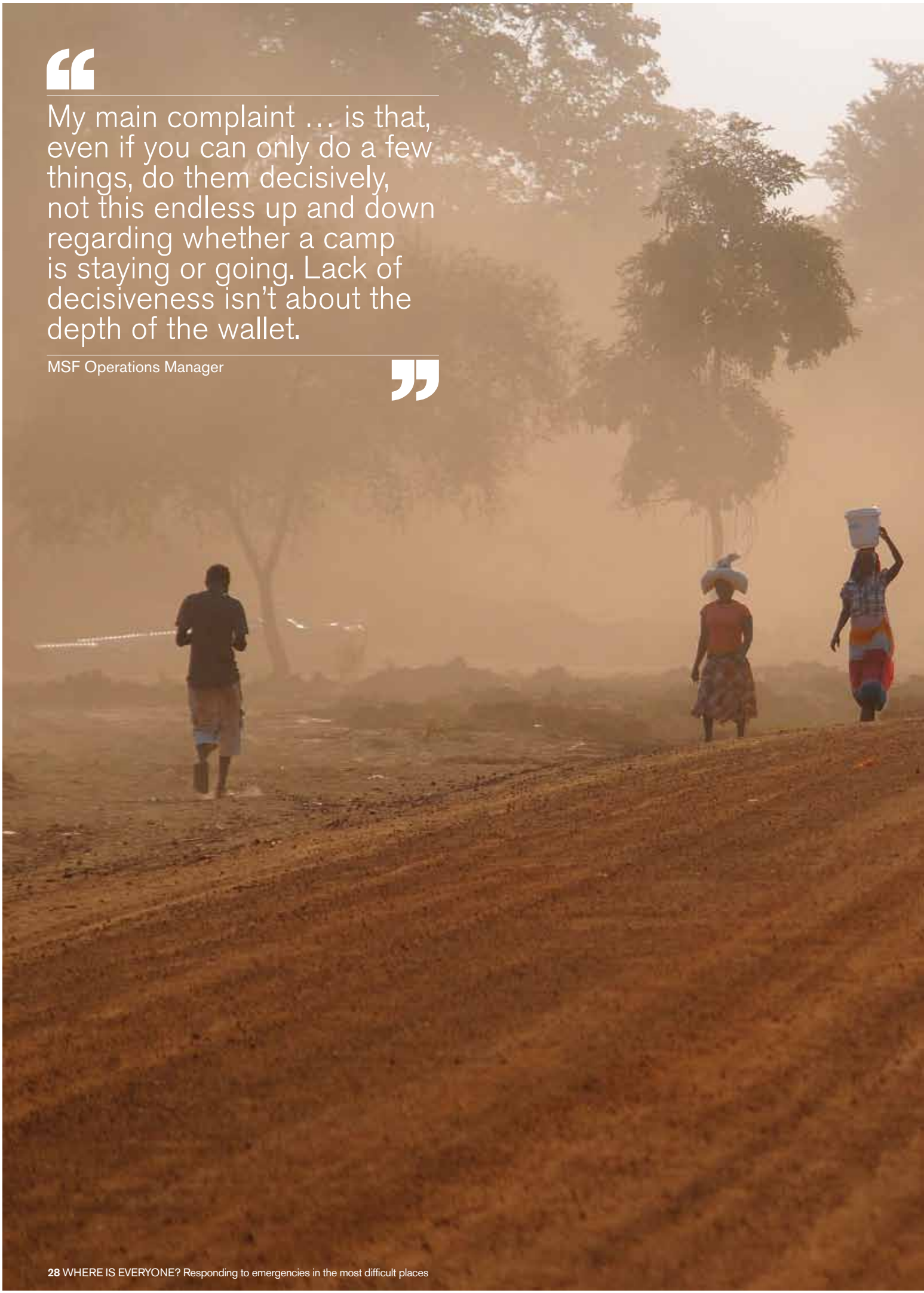


Figure 3: Crude mortality rate, Jamam Camp, 2012, from prospective surveillance system.



> My main complaint … is that, even if you can only do a few things, do them decisively, not this endless up and down regarding whether a camp is staying or going. Lack of decisiveness isn't about the depth of the wallet.
>
> MSF Operations Manager

Refugee camp.
Doro, South Sudan

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CASE STUDY 2

THE HUMANITARIAN RESPONSE TO THE 2012-13 EMERGENCIES IN NORTH KIVU, DEMOCRATIC REPUBLIC OF CONGO

2

Figure 3: Map of North Kivu.

In April 2012, units of the Armed Forces of the Democratic Republic of the Congo (FARDC) mutinied, named themselves the M23, and moved to take control over the eastern province of North Kivu, briefly seizing the capital, Goma, in November that year before turning to the negotiating table.

This sparked realignments by other armed groups in the province, as some took advantage of the withdrawal of FARDC units to fight the mutiny to move into new territory.

All of these actions by armed actors had significant impacts on civilian populations, including killings, sexual violence, looting of villages and enormous displacement. Between March 2012 and March 2013, it was estimated that the number of people displaced in North Kivu almost doubled from 554,949[15] to 920,784[16], or 16% of the total population of 5.7 million people.

The beginning of the M23 crisis and the widespread displacement prompted a shift towards more emergency programming by the humanitarian community. In assessing this response, we found:

- What the people of North Kivu want above all is **security and protection** from armed violence – but there is no one capable of stopping pillages, robberies and attacks. For the Congolese state and MONUSCO, whose main responsibility it is to protect civilians, this remains the central failing.

- Assistance to **internally displaced people** is overwhelmingly concentrated on the 14% living in "official" recognised camps. The 16% of displaced people living in spontaneous sites receive significantly less protection and assistance, including in food, non-food items, water and sanitation and health services, while the remaining 70% have sought shelter with families and host communities and generally do not receive targeted assistance of any kind. Further, assistance is heavily concentrated on the camps close to Goma, while those in the worst-affected periphery receive significantly less help. Location and "status" are more important determinants of assistance and protection than need.

- Claims by humanitarian agencies to have **"covered" humanitarian needs** in certain zones or sectors (such as health) were poorly founded during the 2012-13 crisis; rather, we found that many agencies' programmes evaporated as soon as the emergencies occurred. In health, many agencies have adopted a model which prioritises geographic "coverage" at primary level, providing 'top ups' to Ministry of Health salaries, and a few key drugs as well as some training. In reality, due to persistent stock ruptures and a lack of adequate supervision, primary health care centres were infrequently open even outside emergency periods. In trying to cover "everybody" with patently insufficient resources, major gaps have appeared, affecting the most vulnerable.

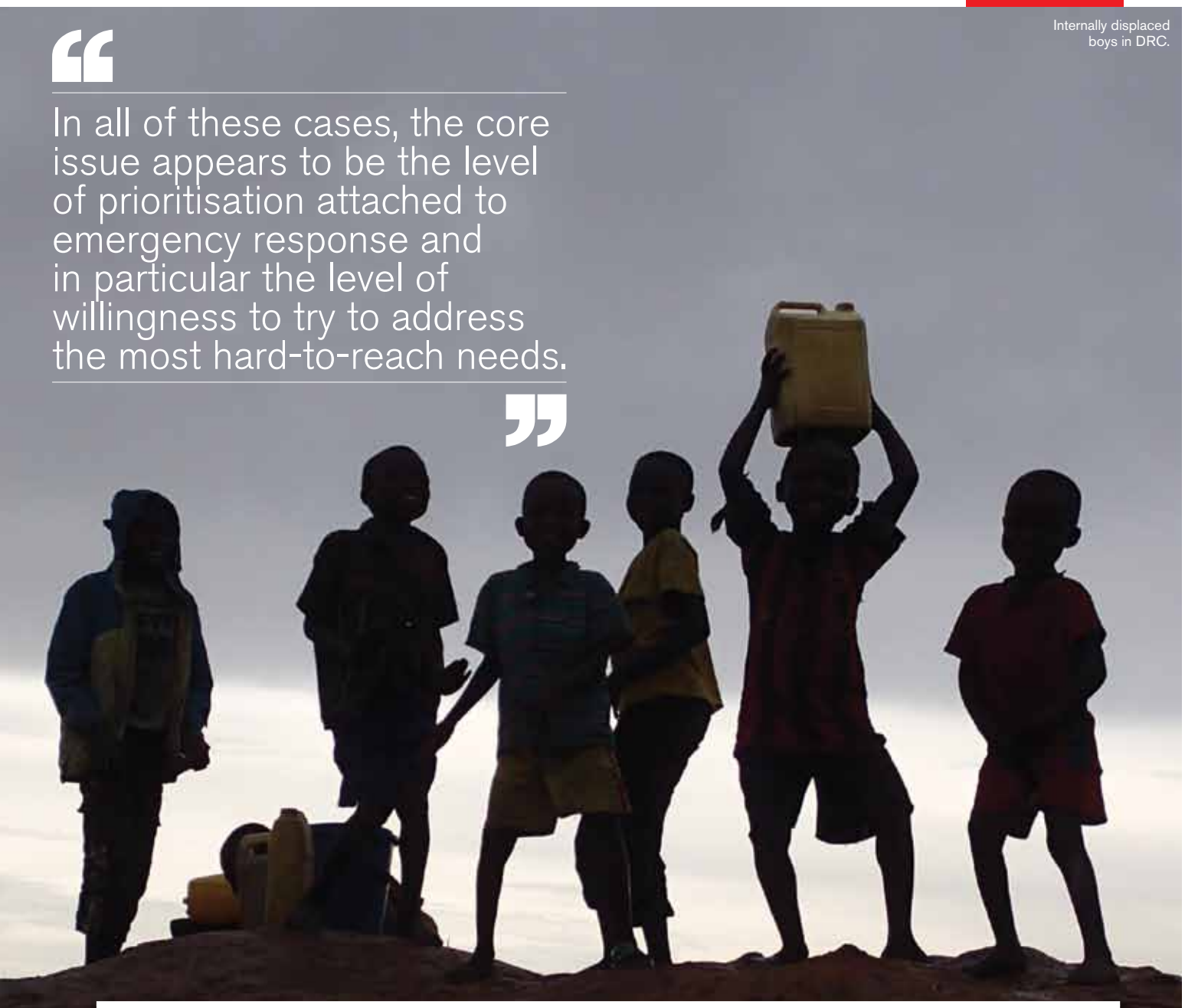
- The widespread **incidence of sexual violence** attracted much attention from the humanitarian community, but little in the way of medical or psychosocial services – even in Goma, let alone in the periphery. Further, serious breaches of medical confidentiality by MONUSCO and FARDC, in ostensible pursuit of justice against perpetrators, went largely unchallenged.

- Humanitarian agencies have adopted a **stance on security which is risk-averse** and which has led, in more than a few cases, to populations being without emergency assistance when they most needed it. Further, it seems that many agencies have allowed the practice of negotiating access with all armed actors to fall into disrepair, limiting their presence to those zones patrolled by MONUSCO.

- The humanitarian community's programming was generally **too cumbersome and inflexible** to allow for quick reaction to the emergencies that occurred during the 2012-13 crisis, despite readily available funding. Rather, only a very few larger agencies (ICRC, MSF, Oxfam, WFP etc) possessed serious emergency response capacity. The UN's RRMP mechanism does add some relatively smallscale additional flexibility in the sectors of NFIs, watsan, education and (to a lesser extent) health.

- While capable in its emergency response, **MSF constrained itself to a withdrawn role**, focusing on its day-to-day work in projects, and did not try and influence the larger humanitarian community. While it did communicate about some of what its teams witnessed and advocated directly in a small number of instances, it did not respond publicly to the mass rape in Minova and generally did not seek to exercise a significant mobilising role, even in areas of its technical competence such as health provision and medical response to sexual violence. Internal coordination issues and the lack of a wider DRC advocacy and positioning strategy appear to be key causes.

The humanitarian response to the needs generated during the 2012-13 crisis in North Kivu was successful in several respects, but was also limited. The assistance was relevant and appropriate – but only for those "lucky" enough to be in a location which received it. Poor coverage of needs was the most significant limiting factor for the impact of humanitarian assistance. Timeliness and quality also receded further away from Goma.



Internally displaced boys in DRC.

> In all of these cases, the core issue appears to be the level of prioritisation attached to emergency response and in particular the level of willingness to try to address the most hard-to-reach needs.

THE ASSISTANCE CASCADE IN NORTH KIVU

Populations receiving assistance in descending order

Status and location	IDP caseload	Agency responsible
Displaced persons registered in official camps near Goma	1.7%	UNHCR
Displaced persons registered in the official camps in the (government-held) periphery	7.5%	UNHCR
Displaced persons in unofficial camps near Goma	10.1%	IOM
Displaced persons registered in the official camps in the (rebel-held) periphery	4.8%	UNHCR
Displaced persons in unofficial camps in the periphery	5.9%	IOM
Displaced persons in the host communities in the periphery	70%	?
Host communities in the periphery	unknown	?

“

These spontaneous sites attract insecurity. It’s a bad choice, either you are outside the camp and have to fend for yourself or in the camp and have to deal with insecurity.

MSF Head of Mission

”

Cecile (name changed), from Kashuga, has five children and lives in Bulengo makeshift displaced camp in North Kivu, DRC.

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RESULTS OF RETROSPECTIVE MORTALITY SURVEY IN WALIKALE

MSF conducted a survey to estimate the crude and under-five mortality rates in select communities in Walikale in June 2013, along with the frequency of displacement and violent attack. From a sample size of 4,157 respondents, with a long recall period:

Crude mortality rates were estimated at

1.2/10,000/day

(95% confidence interval: 1.0-1.4).

Under-five mortality rates were estimated at

1.8/10,000/day

95% confidence interval: 1.3-2.4).

Malaria/fever was cited by survey respondents as the principal cause of death in

34.1%

of cases, of which intentional violence accounted for

7.5%

of deaths.

24.9%

of respondents classified themselves as displaced, while

43%

considered themselves returnees from displacement.

6.4%

of respondents had directly experienced violence during the 12-month recall period, of which in

81.9%

of the cases the perpetrator wore a military uniform.

In

89%

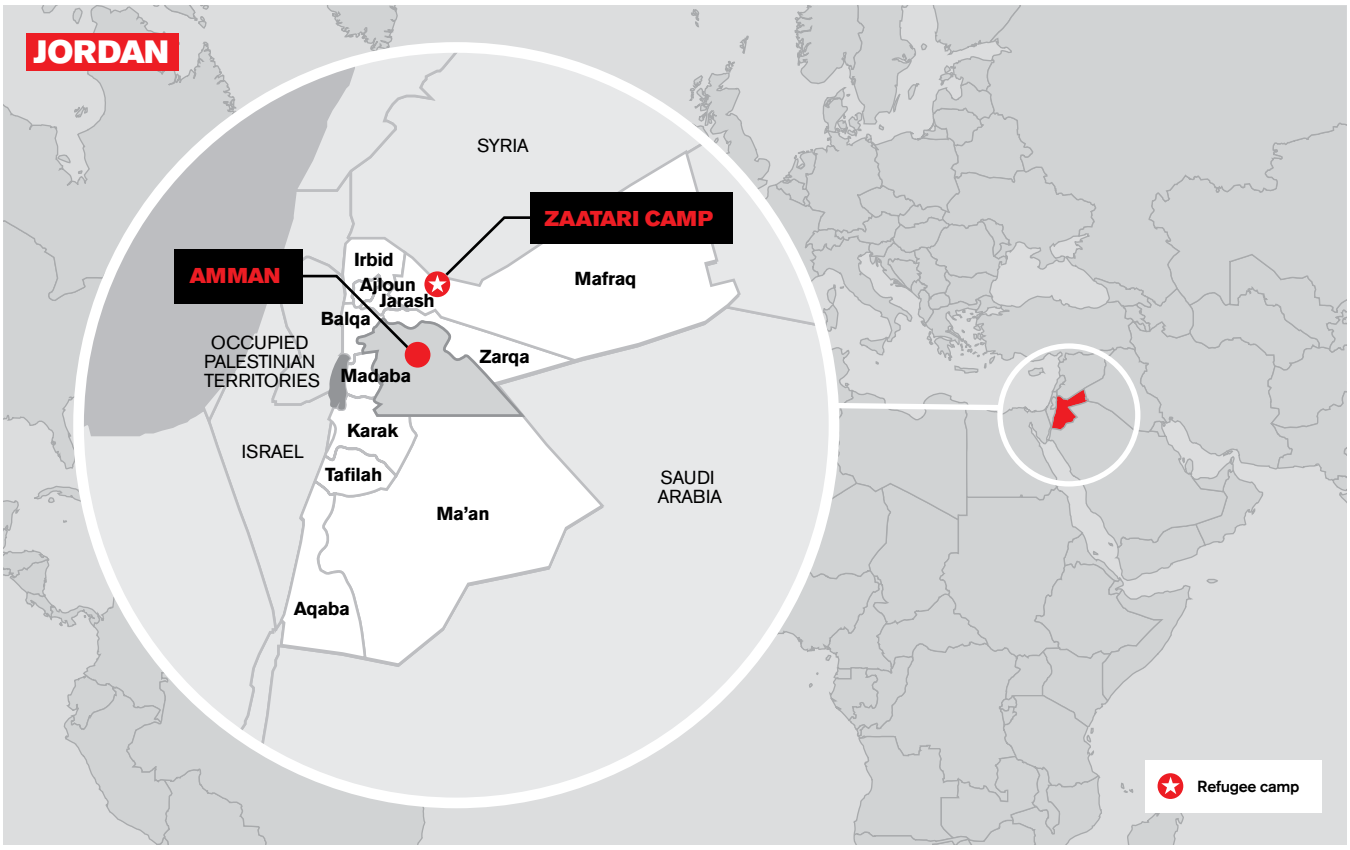
of households interviewed, in the two weeks prior, there had been at least one sick person.

Source: Carrion Martin, AI (2013), Retrospective mortality survey in the MSF catchment area in Walikale, North Kivu, Democratic Republic of Congo. MSF: Goma. Baseline mortality rates in Walikale territory are not known.

CASE STUDY 3

THE HUMANITARIAN RESPONSE TO THE SYRIAN REFUGEE CRISIS IN JORDAN, 2012-13

3



The conflict in Syria broke out in March 2011 and has since had massive humanitarian consequences both inside and outside the country. In neighbouring Jordan, by June 2013 some 600,000 people had sought refuge. This prompted a large-scale response to meet the needs of those refugees by the Government of Jordan and by the international humanitarian community. The overall response has been largely effective, and has managed to prevent excess mortality, although refugees did have relatively good background health status. However, in assessing this response, several gaps and problems emerged:

- The Jordanian government and people have been largely welcoming of the refugee influx, and the GoJ has also sought to contain the wider effects of the influx on political stability and living standards. **However, government services have come under increasing strain**. This has led to growing concerns and even hostility, and therefore growing restrictions, especially on the border. The principal international support to the Jordanian government has been through the humanitarian community. Bilateral development assistance has been generally rather limited.

- The single largest refugee camp is at Zaatari, which in May 2013 held approximately 150,000 refugees. **Humanitarian agencies have overwhelmingly focused their efforts in Jordan on Zaatari camp**, due to its size, visibility and difficult security situation. While there were initial difficulties in establishing it (up until winter), the levels of assistance are now appropriate. There is no health crisis in the camp, watsan, shelter and food likewise. This is despite the unhappiness of many refugees with the conditions. The exception is in protection, where initial failings to set up a proper police system have been compounded by lack of consultation with residents by humanitarian agencies and by refugee unhappiness to create a rather tense situation. This is only now starting to be addressed. Efforts to redirect donor and agency resources away from Zaatari have not been successful.

- Despite Zaatari's purpose as a pressure release, the numbers of Syrian refugees in the cities have grown tremendously, to more than 400,000 in June 2013. Most refugees (85%) are registered with UNHCR and so are eligible to receive assistance from both the humanitarian community (cash, vouchers) and from the government (free access to most services). However, **the assistance that urban refugees receive is not sufficient**, either in breadth (numbers who receive it) or in depth (amount that they each receive). As a result, many are finding themselves in situations of destitution: one needs assessment found that 62% of urban refugees were living in situations considered less than acceptable for livelihoods and income, education, health, shelter and non-food items. The most vulnerable are those who are not registered – or whose registration has expired (after six months).

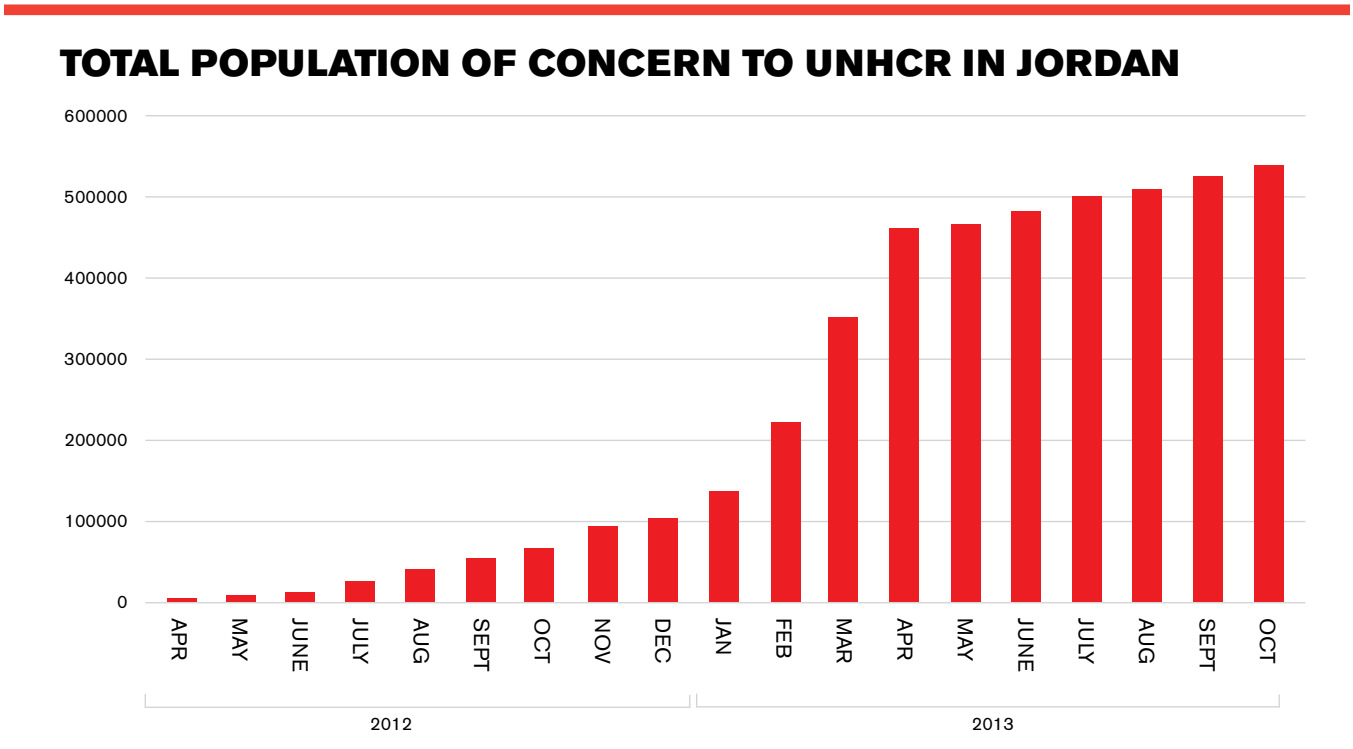


Figure 4: The total population of concern to UNHCR in Jordan.[17]

- There has been a **large mobilisation of "emerging" actors in Jordan**, especially from the Muslim and Arab worlds. This includes significant assistance from Arab donor countries, both through UN funds and directly to the Jordanian government. Arab NGOs and Red Crescent societies have also mobilised to respond to this crisis, with varying degrees of connection to the existing humanitarian system. In health, there is a particularly important representation of these organisations, and they have played a cornerstone role in Zaatari camp. There are questions about how well these actors adapt to the political and technical (public health) realities of emergencies like this. However, the consensus view is that these actors have filled very important needs: they can be more flexible (especially as they often provide unearmarked cash), they can be better adapted to the middle-income setting, and they are certainly culturally acceptable to the refugee population.

- **MSF** started looking more closely at the Jordanian situation from late 2012, and its response has **largely tracked the evolution of health needs**. A long-running surgical programme in Amman, responding to those who need reconstructive surgery, has been expanded: Syrians now account for 50% of the patient load. MSF responded to a request from the Ministry of Health to intervene at Zaatari by establishing a paediatric inpatient/outpatient department there, which is ongoing and stable. Exploratory missions have pointed to larger needs in cities, and MSF is responding now with a surgical programme on the border at Ramtha and a mother and child healthcare programme in the northern city of Irbid.

- Humanitarian agencies have attached a high level of visibility to the refugee crisis in Jordan, but this has not always resulted in a clear picture emerging of that crisis (rather, the picture in the international media appears considerably worse than it is). **Humanitarian agencies have been largely silent on the increasing restrictions on border access for Syrian refugees**. If restrictions continue to mount, humanitarians will have some uncomfortable decisions to make.

- **UNHCR can be praised for its implementation** of a large-scale and largely effective response. There has been greater criticism of its coordination role, although this should be tempered by the scale of the coordination challenge. The more significant criticism is of its ability to lead or strategise. On various crucial points, its advice has either been ignored or not been incorporated, and it does not seem to have been very successful in influencing the course of events.

A very large humanitarian machine has been built, and relatively quickly, but it has largely focused on more manageable targets, finding it significantly harder to do more complex tasks, such as the urban response. Further, this appears to have occurred even though many people warned against it. It was not from lack of understanding or knowledge of the needs and challenges; rather it seems that, once in motion, the humanitarian response has been very difficult to direct.

Table 1: Numbers of recipients, and coverage rates for select forms of international humanitarian assistance for Syrian refugees in Jordan, May 2013

SECTOR	INDICATOR	NUMBERS		COVERAGE	
		Camp	**Urban**	**Camp**	**Urban**
	Estimated total registered refugee population	111,000	360,000		
	Estimated total registered school-age children	36,000	94,434		
Protection	Children reached through child protection/ SGBV activities	31,056	6,808	86%	7%
Education	School-age children enrolled in school	10,000	23,000	28%	24%
Food	Recipients of food assistance	103,766	121,581	93%	34%
Health	Medical consultations per person per year	3.6	1.5	N/A	N/A
Health	Recipients of mental health services	1947	450	1.8%	0.1%
NFIs	Blankets distributed	220,000	21,300	198%	6%
Watsan	Recipients of improved water provision	100,000	74,000	90%	21%
Watsan	Recipients of improved sanitation	100,000	46,000	90%	13%

Source: UNHCR (2013), *Regional Response Plan 5*. UNHCR: Geneva.

Zaatari camp, Jordan

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ENDNOTES

[1] The authors are humanitarian advisers for Médecins Sans Frontières/ Doctors Without Borders (MSF) United Kingdom.

[2] By "humanitarian system", we refer to the international institutions which respond to appeals for international assistance during emergencies, comprising the three pillars of UN humanitarian agencies, Red Cross Red Crescent movement, and international NGOs, along with the principal government donor agencies which fund this "system".

[3] Roberts S and Hofmann CA (2004), "Assessing the impact of humanitarian assistance in the health sector". *Emerging Themes in Epidemiology* 1:3.

[4] The careful conditioning of this point should not hide the negative judgment involved: with 20 years' presence in an area, we still do not really know whether humanitarian assistance has a positive impact on the mortality rates of the population there, so we have to assume it.

[5] UNHCR, Flooding across the border: A real-time evaluation of UNHCR's response to the Sudanese refugee emergency in South Sudan, July 2013 http://www.unhcr.org/51e94e689.html.

[6] This point is substantiated by a recent study by the Consortium of British Humanitarian Agencies: "The average time it takes for civil society organisations to receive pass-through funding from the Central Emergency Revolving Fund (CERF) via a UN agency is 13 weeks for 'rapid response' and 19 weeks for underfunded emergencies. There are similar delays with the Common Humanitarian Funds (CHFs) and Emergency Response Funds (ERFs) in the countries where they are deployed (5 CHFs and 13 ERFs). The 2012 Global ERF evaluation found that the time between formal receipt of an application to the issuance of the first payment averaged between 45 and 70 days, indicating that the ERF is not a first responder. Nevertheless, the global evaluation considered the ERF still a significantly faster mechanism than bilateral donors like the European Community Humanitarian Office (ECHO) and Office of U.S. Foreign Disaster Assistance (OFDA)." Consortium of British Humanitarian Agencies (CBHA), Written evidence submission to International Development Select Committee, 23 August 2013 http://www.publications.parliament.uk/pa/cm201314/cmselect/cmintdev/writev/334/m11.pdf

[7] For instance: Derderian K and Stockaert L (2010), "Can Aid Switch Gears to Respond to Sudden Forced Displacement? The Case of Haut-Uélé, DRC", *Refuge* 27:1.

[8] This finding is backed by a recent CAFOD study which estimates that only 14% of UNHCR's funds have gone to national NGOs. Poole L (2013), *Funding at the sharp end, Investing in National NGO response capacity*, CAFOD: London. July.

[9] HRW (2013) Under siege: indiscriminate bombing and abuses in Sudan's Southern Kordofan and Blue Nile States. HRW: New York

[10] The findings of our review are broadly consistent with those of evaluations conducted by UNHCR and Oxfam. See: Ambroso G et al. (2013), Flooding across the border: A review of UNHCR's response to the Sudanese refugee emergency in South Sudan. UNHCR PDES: Geneva. Begum S (2013), Upper Nile refugee crisis: Avoiding past mistakes in the coming year. [Briefing Paper.] Oxfam GB: Oxford.

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

[12] MSF (2012), Exhaustive retrospective mortality survey in transit refugee camp (T3), Maban county, South Sudan. Preliminary report, 30 June 2012

[13] MSF and Epicentre (2012), Retrospective mortality, non-food items and nutrition survey, Batil Refugee Camp, Maban county, Unity state, South Sudan. August 2012.

[14] OCHA (2012), *Eastern Africa: Displaced Populations Report*. Issue 12, 31 March 2012 to 30 September 2012.

[15] OCHA (2012), *Eastern Africa: Displaced Populations Report*. Issue 12, 31 March 2012 to 30 September 2012.

[16] OCHA (2013), *Eastern Africa: Displaced Populations Report*. Issue 14, 30 September 2012 to 31 March 2013.

[17] UNHCR (2013) Syria regional refugee response: Jordan [online] Available from:http://data.unhcr.org/syrianrefugees/country.php?id=107 [access verified 21st November 2013]

ACKNOWLEDGEMENTS

The authors would like to recognise the invaluable assistance and contributions of many people, who made this work significantly better than would otherwise have been possible, including:

UN, NGO, Red Cross/Red Crescent staff, researchers and academics who shared their insights with us. All of those in MSF who reviewed various chapters of this work, including those working for the desks and missions managing operations in South Sudan, DRC and Jordan; members of MSF's Humanitarian Advocacy and Representation Team (in particular Emmanuel Tronc and Fabien Dubuet); and researchers and advisers in the several MSF research and analysis units.

This work would also not have been possible without the interest, support, feedback and work of MSF's Executive Committee, including in particular Arjan Hehenkamp, Kris Torgeson and Jerome Oberreit who steered the process throughout, and without the guidance provided by our editorial committee of Marc DuBois, Hernan Del Valle, Jeroen Jansen and Andre Heller Perache. Natasha Lewer and James Smith at MSF-UK provided invaluable assistance in preparing and editing our work.

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