Policy Development and Evaluation Service (PDES)

Evaluation of UNHCR's Response to the L3 South Sudan Refugee Crisis In Uganda and Ethiopia

Evaluation Team:
Guido Ambroso
Gita Swamy Meier-Ewert
Julian Parker Independent Consultant
Leah Richardson Independent Consultant

PDES/2016/01

Table of Contents

Acronyms

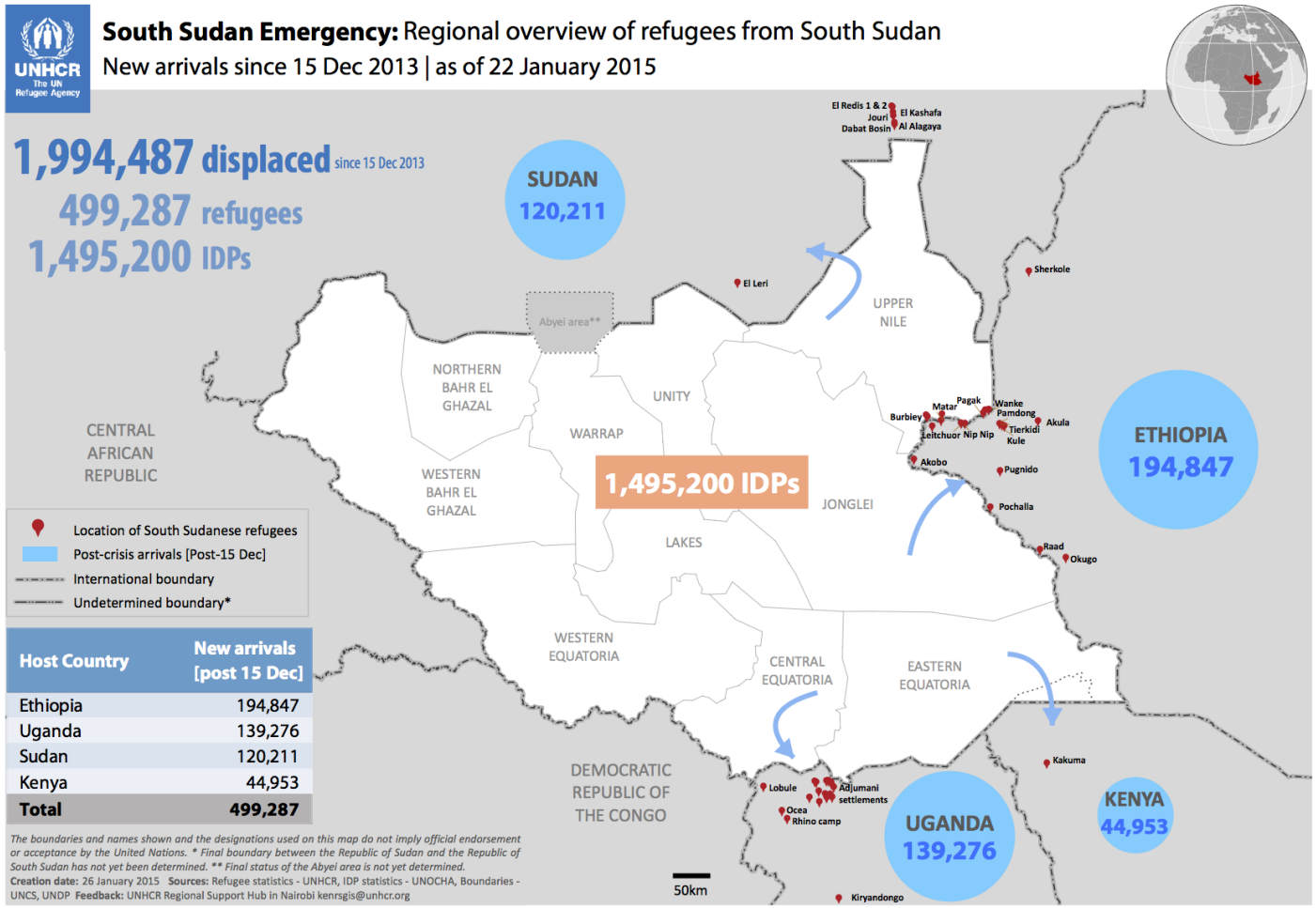
ACF	Action Contre la Faim
ARRA	The Administration for Refugee and Returnee Affairs (Government of Ethiopia)
BID	Best Interest Determination
BIR	Basic Indicators Report
BSFP	Blanket Supplementary Feeding Programme
CBP	Community-Based Protection
CLTS	Community-Led Total Sanitation
COA	Community Outreach Agent
COW	Community Outreach Worker
CP-IMS	Child Protection Information Management System
CSB	Corn-soya blend
DAC	Development Assistance Committee
DEM	Digital Elevation Model
ECD	Early Childhood Development
ECHO	European Commission Humanitarian Aid and Civil Protection department
EPRP	Emergency Preparedness Response Plans (measles, malaria, cholera, meningitis)
ERT	Emergency Response Team
GAM	Global Acute Malnutrition
GIS	Geographic Information System/s
HCOA	Hygiene Community Outreach Agent
HCOW	Hygiene Community Outreach Worker
HEB	High Energy Biscuit
HIS	Health Information System
HIV	Human Immunodeficiency Virus
IASC	Interagency Standing Committee
IDP	Internally Displaced Person
IM	Information Management
IO	International Organisation
IP	Implementing Partner
LoMI	Letter of Mutual Intent
LOU	Letter of Understanding
LWF	Lutheran World Foundation
l/p/d	litres per person per day
KAP	Knowledge, Attitudes and Practices
MCH	Maternal and Child Health
MoH	Ministry of Health
MSF	Medecins Sans Frontiers
MSRP	Managing Systems, Resources and People
MUAC	Mid-Upper Arm Circumference
NGO	Non-Governmental Organisation
OCHA	Office for Coordination of Humanitarian Affairs
OEDC	Organisation for Economic Cooperation and Development
OP	Operational Partner
OPM	Office of the Prime Minister (of the Government of Uganda)
PHAST	Participatory Hygiene and Sanitation Transformation
PSN	Person with Specific Needs

RCM	Refugee Coordination Model
RH	Reproductive Health
RHB	Regional Health Bureau (of Gambella Region, Ethiopia)
RRP	Regional Response Plan
RSH	Regional Support Hub (UNHCR, in Nairobi)
RWB	Regional Water Bureau (of Gambella Region, Ethiopia)
SAM	Severe Acute Malnutrition
SGBV	Sexual and Gender Based Violence
SOP	Standard Operating Procedures
SPLM/A	Sudan People's Liberation Movement/Army
SRP	Strategic Response Plans
TB	Tuberculosis
TSFP	Therapeutic Supplementary Feeding
UASC	Unaccompanied and Separated Children
UAM	Unaccompanied Minor
UASC	Unaccompanied and Separated Children
UGX	Ugandan Shilling
UNDP	United Nations Development Programme
UNDAF	United Nations Development Action Framework
UNEG	United Nations Evaluation Group
UNICEF	United Nations Children's Fund
UNHCR	United Nations High Commissioner for Refugees
VHT	Village Health Team
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme
WHO	World Health Organisation

Acknowledgements

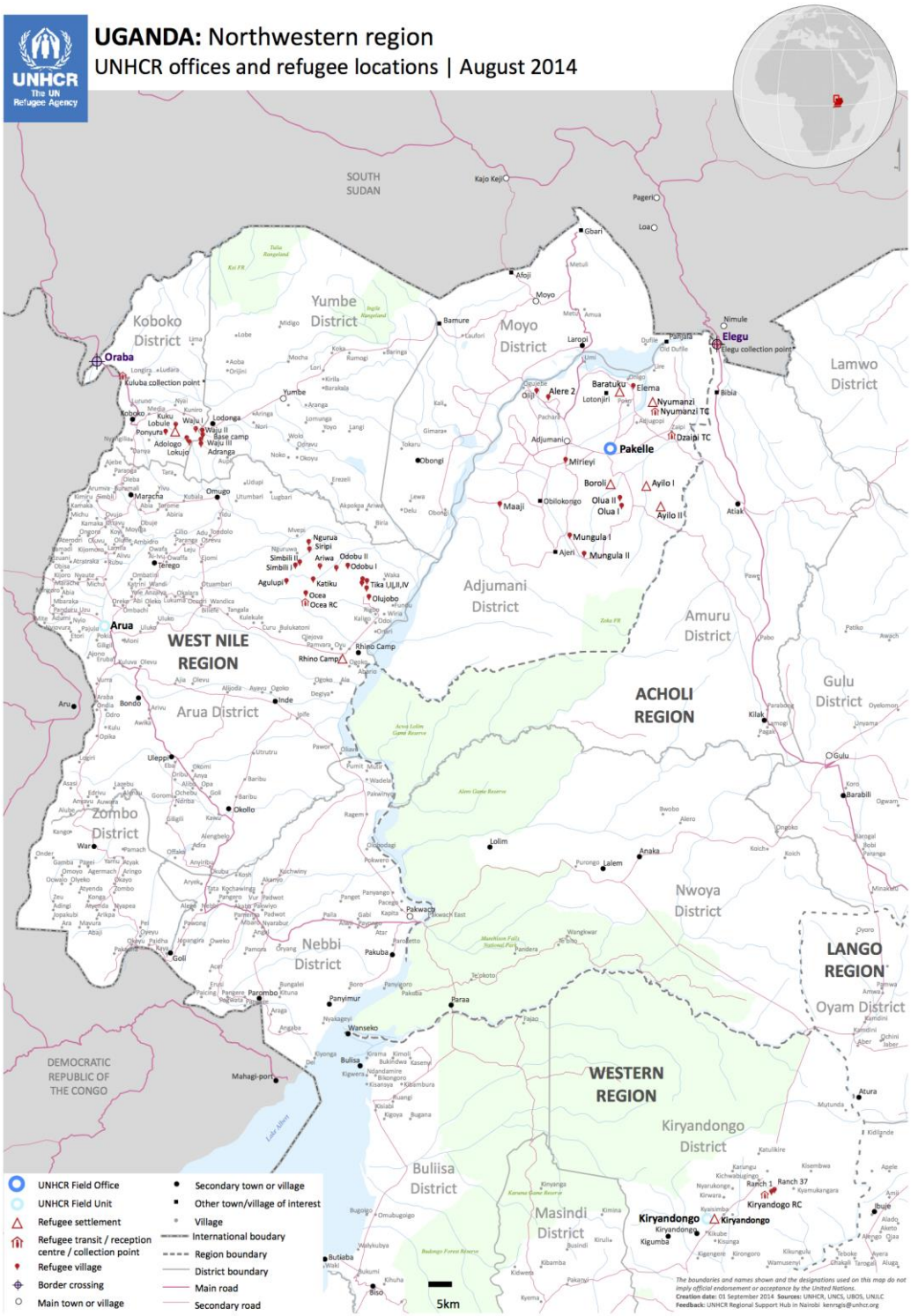
The Evaluation Team would like to acknowledge the support of UNHCR staff at HQs, Kampala, Adjumani and Kiryandongo in Uganda and Addis Ababa and Gambella in Ethiopia to facilitate the mission by providing logistical support and facilitating meetings and interviews. Many thanks also to the many government, UN and NGOs officials as well as to the refugees in both countries who gave their time to meet the evaluation team. The Evaluation Team also acknowledges the hard work of staff belonging to UNHCR and its partners (Government, UN, NGOs and other agencies) to the service of South Sudanese refugees, often in very difficult living and working conditions.

Maps

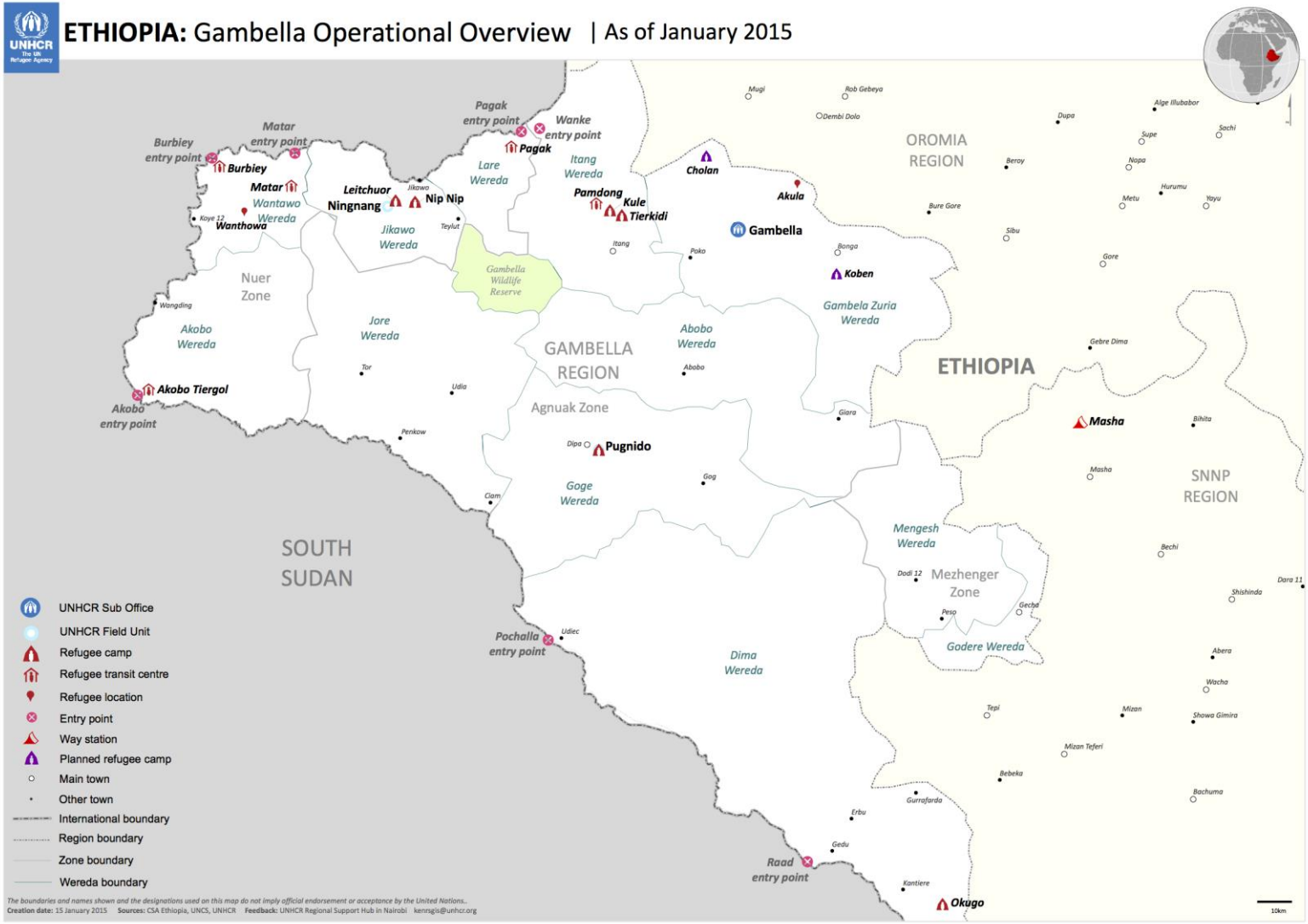

South Sudan Emergency: Regional overview of refugees from South Sudan
New arrivals since 15 Dec 2013 | as of 22 January 2015
1,994,487 displaced since 15 Dec 2013
499,287 refugees
1,495,200 IDPs
SUDAN
120,211
ETHIOPIA
194,847
UGANDA
139,276
KENYA
44,953
1,495,200 IDPs
CENTRAL AFRICAN REPUBLIC
DEMOCRATIC REPUBLIC OF THE CONGO
NORTHERN BAHR EL GHAZAL
WESTERN BAHR EL GHAZAL
WARRAP
UNITY
UPPER NILE
JONGLEI
LAKES
WESTERN EQUATORIA
CENTRAL EQUATORIA
EASTERN EQUATORIA
Abyei area**
El Leri
El Redis 1 & 2
Jouri
Dabat Bosin
El Kashafa
Al Alagaya
Sherkole
Burbiey
Matar
Pagak
Wanke
Pamdong
Akula
Leitchuor
Nip Nip
Tierkidi
Kule
Akobo
Pugnido
Pochalla
Raad
Okugo
Kakuma
Lobule
Adjumani settlements
Ocea
Rhino camp
Kiryandongo
Location of South Sudanese refugees
Post-crisis arrivals [Post-15 Dec]
International boundary
Undetermined boundary*
50km
Host Country
New arrivals [post 15 Dec]
Ethiopia 194,847
Uganda 139,276
Sudan 120,211
Kenya 44,953
Total 499,287
The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations. * Final boundary between the Republic of Sudan and the Republic of South Sudan has not yet been determined. ** Final status of the Abyei area is not yet determined.
Creation date: 26 January 2015 Sources: Refugee statistics - UNHCR, IDP statistics - UNOCHA, Boundaries - UNCS, UNDP Feedback: UNHCR Regional Support Hub in Nairobi kenrsgis@unhcr.org

UGANDA: Northwestern region

UNHCR offices and refugee locations | August 2014



ETHIOPIA: Gambella Operational Overview | As of January 2015



The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations..

Creation date: 15 January 2015 **Sources:** CSA Ethiopia, UNCS, UNHCR **Feedback:** UNHCR Regional Support Hub in Nairobi kenrsgis@unhcr.org

Executive summary

The Evaluation of UNHCR's response to the refugee emergency in Ethiopia and Uganda follows from the declaration of the L3 emergency for South Sudan on 3 February 2014.[1] It was undertaken in line with UNHCR's revised Policy on Emergency Response, Activation, Leadership and Activities approved by the High Commissioner on 21st January 2015.

On 15 December 2013, clashes broke out in Juba between competing factions within the ruling Sudan People's Liberation Movement/Army (SPLM/A) which constituted the backbone of the Government, and the situation quickly degenerated into a full-scaled conflict along ethnic lines. By the beginning of 2015 there were approximately 1.5 million IDPs registered in South Sudan and over 500,000 South Sudanese refugees in the neighbouring countries in addition to the 130,000 who had fled before the December 2013 violence, for a total of over 630,000 refugees. This influx stretched the local absorption capacities considering that these countries were already hosting hundreds of thousands of refugees such as Somalis in Ethiopia and Kenya, Congolese in Uganda and Eritreans in Sudan. The vast majority of refugees were women and children. The speed and magnitude of the influx appears to have taken everyone by surprise.

A Regional (Refugee) Response Plan (RRP) was elaborated in March 2014 incorporating the financial requirements of UNHCR, other UN agencies, IOs and NGOs for a total of USD 370 million and targeting the needs of 340,000 refugees. The RRP was revised in July 2014 with a new total of USD 657 million and targeting the needs of 715,000 refugees. Whilst views on the value of the RRP as a fundraising tool were mixed, many stakeholders interviewed felt that it was a useful tool for top-level coordination and setting out the comprehensive financial requirements of the response. The RRP could not, however, standardise the response across countries, partly due to differing host country policies towards refugees. Moreover, it did not contain a recognisable results framework, instead setting out a list of planned activities.

The Uganda and Ethiopia budgets included in the RRP of $ 224.3 million and $210.9 million were funded at the rate of 48% and 57% respectively out of which the UNHCR portions, 123 million for Uganda and 90 million for Ethiopia were 44% and 59% funded. The funding pipeline was problematic for UNHCR and some of its partners who had to pre-finance their operations or intervene with their own funding for the first quarter. Moreover, partners received money in a piecemeal fashion requiring constant budgetary revisions.

Uganda Findings

In Uganda, UNHCR worked with the over 60 partners including the Department of Refugees within the Office of the Prime Minister (OPM), UN bodies, local and international NGOs. Refugees in Uganda have, in principle, access to public services and facilities at the same level as the nationals. The 129,470 refugees mostly settled in designated settlements where they are allocated a plot of land to cultivate, but they are also permitted to go to urban centres where they need to have the means to support themselves.

UNHCR operations in northern Uganda were scaling down at the time of the influx and there was no specific contingency planning or preparedness for the emergency that ensued. Considering that Uganda was also facing a refugee influx from the D.R. of Congo, the capacity of the Ugandan Government, UNHCR and partners was therefore stretched. Uganda was already hosting 220,555 refugees at the time of the start of influx.

---

[1] UNHCR Emergency Policies and procedures – A summary of the Guidance Notes 1 October 2012,

Interviewees and online survey respondents agreed that UNHCR played a positive coordination that promoted synergies and avoided duplications, although the quality of sectorial coordination varied depending upon individual skills and staff turnover.

The refugee response was underpinned by a strong protection orientation and protection objectives, although the extent to which protection considerations were integrated across sector strategies and interventions varied with some protection gaps visible in shelter, food and site planning interventions. While protection needs and risks were assessed as part of multi-sectoral assessments early on in the response, no protection specific assessment informed the response priorities. Accountability to affected population, a central element for protection outcomes, was partially achieved through participatory assessments and other mechanisms that provided some opportunities for participation and sharing of information. By and large, age and gender diversity dimensions were incorporated into the design and implementation of the response, with some gaps, such as, for example the inadequate support (for a population comprising mostly women and children) for shelter construction. Community-based mechanisms for protection, outreach and sensitisation across sectors remained underperforming in the first year.

Several protection outcomes relating to access to territory and asylum were achieved: South Sudanese asylum seekers were granted *prima facie* refugee status in Uganda and no cases of *refoulement* were reported. Refugees had continuous access to Ugandan territory, asylum and protection. UNHCR set up efficient and timely registration procedures for refugees and registered 100% of refugees with level 2 registration (including biometrics) in 2014. Some challenges with capturing specific needs categories early in the response were rectified within the first few months and a targeting approach based on specific needs codes was established and utilized for sectoral interventions. The civilian character of asylum was maintained.

Critical SGBV response services were set up, but insufficient capacity building of SGBV partners and weak harmonisation resulted in low quality and underutilised services, weak case management and weak prevention mechanisms, even if studies on SGBV incidents among South Sudanese refugees in 2014 indicate a high SGBV prevalence and high underreporting. The identification of Unaccompanied and Separated Children (UASC) was not harmonised across partners, resulting in duplication and weakened case management. As many children (who constituted 66% of the new refugee influx) had been sent to Uganda by parents who remained behind, reunification was often not possible or desired. While identification of UASC was adequate, the identification of children at risk beyond separated and unaccompanied children was an area that could be further strengthened together with the integration of children with disabilities into existing services.

The health sector enjoyed strong leadership, coordination and partnership. The Health Strategic Action Plan for the South Sudanese Refugees that guided the emergency refugee response was developed in a timely and consultative manner and based upon early and continuous assessments, and had appropriate objectives. Good coverage of health services was achieved, but integration of refugee health services in the MoH health system required an initial high investment, especially upgrading of infrastructure. Drug supply was complicated by challenges with population estimates, regular MoH stock-outs and a lengthy international procurement process for UNHCR.

The crude mortality rates remained well below emergency thresholds and a spike in under 5-year mortality rates in the first weeks of the response was brought down by February 2014. Outbreaks were largely prevented. An Emergency Preparedness and Response Plan for outbreaks and cholera contingency plan was in place, although emergency WASH stocks were not in place by late June[2]. There was blanket measles immunization at entry points and a vaccination campaign in response to an outbreak in South Sudan. Disease and epidemic surveillance, however, were poor due to a deficient health outreach system, which also

[2] Hygiene Promotion Task Force minutes, 24 June 2014

hampered malnutrition case finding and preventive programming. Whilst a malaria outbreak in January 2014 was quickly contained, a high disease burden of malaria remained and effective bed-net usage was limited due to a single distribution, limited outreach and diversion to inappropriate uses.

The profile of the refugee population meant that there was a high burden on Reproductive Health (RH) services at all the health centres in Adjumani and Arua, although many pregnant women still delivered at home and antenatal care was poor due to a weak community outreach system that refugee communities were not compelled to participate in. Mental and psychosocial care was considered from the first phase of the emergency response. The management of chronic disease received little focus.

Nutrition interventions were planned as an integrated component in the Ugandan health system that targets both the refugees and the host community, but there was no nutrition programme in the West Nile region prior to the onset of the crisis. Limited attention was given to nutrition until the nutrition survey in March 2014 indicated 20% GAM prevalence (although survey results and nutrition screenings gave incongruous results). Services (targeted supplementary feeding and, later, therapeutic feeding) were scaled up and blanket supplementary feeding of women and under-5s was introduced by WFP. A follow-up nutritional survey released in late 2014 showed remarkable improvement.

The food security situation in the three settlement districts was stable throughout 2014, but dependent on external food aid. WFP provided refugees with high-energy biscuits immediately on arrival in Uganda, cooked meals at transit centres and dry rations in the settlements. Pipeline breaks, and insufficient access to land for agriculture production, and income generating activities remain obstacles to food security in the medium and longer-term.

After a slow initial start, when poor environmental health conditions prevailed in the reception centres, the WASH sector scaled up rapidly, making use of the large number of available WASH partners. Sphere standards with respect to emergency water provision (litres/person/day) and ratios of toilets to people, were achieved across most settlements by June 2014. UNHCR appropriately focused on drilling and hand pump installation, motorising boreholes where yields allowed. The majority of refugees constructed their own household latrines, but difficult environmental conditions led to low coverage in some areas and latrine designs for such conditions were not finalised in 2014. The longer-term sustainability of water and sanitation facilities is, however, hampered by the absence of an operation and maintenance strategy for water supplies. Water and sanitation infrastructure was generally constructed to a high standard, apart from a few significant design mistakes.

Hygiene promotion was not sufficiently focused, with too many messages and some inappropriate approaches for the context. Key indicators for hygiene promotion were not developed in 2014, despite some initial efforts in this direction. Household hand washing stations were rolled out across the settlements, but their use appears to have been inconsistent over time and between locations as per field observations. Key informants and reports[3,4], indicating a need for more hand washing promotion, particularly as the influx reduced and the response operation begin to stabilize.

Site identification was done relatively quickly despite challenges and a need to negotiate for community-owned land, which was in short supply, and limited involvement of the district government in Adjumani and Arua Districts. The grid layout used, whilst making efficient use of the land, is not conducive to the development of community identities and ownership of infrastructure, notably water points. Plot demarcation was initially delayed by a lack of

[3] Murray Burt Mission by the Senior Regional WASH Officer (Nairobi) To Uganda from 3 to 9 August 2014

[4] Knowledge Attitudes and Practices Assessment on Water, Sanitation and Hygiene Nyumanzi, Olua 1 and Olua 2 settlements, Adjumani district, LWF, August 2014

manpower. Site planning did not utilise GIS and detailed topographic analysis based on digital elevation models. A few sites suffered waterlogging during the rainy season, but this was identified during physical site planning surveys. Site plans resulted in reasonably good access to services, given the large population and large plot size, with a few gaps

The size of the influx challenged the capacity of the partners to respond, particularly in Adjumani, resulting in emergency shelters being constructed in a rush, and not providing an adequate level of protection. The majority of refugees constructed their permanent shelters themselves, generally to an acceptable standard, although no surveys were conducted on the type, condition and effectiveness of shelters and obtaining some materials for shelter construction was problematic. More support should therefore have been provided, such as plastic sheeting for temporary roofing, which was by and large effective in Ethiopia. Shelters were constructed for Persons with Specific Needs (PSNs) – those deemed unable to construct for themselves – but the design was not sufficiently informed by consultation with the refugees.

The education response by UNHCR and partners was relatively quickly set up and critical efforts were made to ensure access to national education systems and avoid setting up parallel structures. As per the Ugandan Refugee Act, refugee children have access to national schools, however, the absorption capacity of local schools and the large number of school-aged children amongst the refugees required additional learning sites. To complement local schools UNHCR supported 24 additional schools in northern Uganda, of which 13 were community schools and not yet accredited while the others were government accredited schools. Education programming for refugees focused on pre-primary and primary schooling and investments in physical infrastructure, teacher recruitment and training and provision of learning and training materials expanded access to education. Conflict mechanisms in schools and non-violent teaching methods remained as unresolved protection challenges. Six months after the response, the primary school and early childhood enrolment was around 60% in Adjumani. Very limited support for secondary education was provided. Coordination in the education sector was reported as weak in the first year by some partners who added that UNHCR's education strategy was not well understood.

On whole the response was effective and well-coordinated, but lacked a strategy to ensure sustainability, and faces major challenges including insufficient availability of land to support refugee self-reliance. UNHCR has attempted to address this through the Refugee and Host Population Empowerment (ReHoPE) strategic framework, whose initial draft was produced in October 2014 and has a five-year proposed budget of USD 350 million. This strategy however still lacks operational details, has not yet been approved by the Government of Uganda and its fundability is uncertain.

Uganda Conclusions against OECED-DAC Criteria

Effectiveness: Overall the Uganda response was effective in meeting the needs of refugees in a timely manner, despite the absence of recent contingency planning and low ad hoc preparedness for the emergency. The Ugandan Government and institutions, at a central and local level, played a crucial role in creating a very favourable operational context and protection environment. Cooperation with implementing and operational partners was also key for the effectiveness of the response.

Relevance/appropriateness: the design of the RRP and UNHCR's emergency response, including protection priorities and sectorial interventions, were relevant and appropriate to the needs of refugees also thanks to early, participatory, interagency assessments.

Coverage: The UNHCR-coordinated protection and assistance intervention reached the vast majority of the beneficiaries in need. The geographic coverage was even across locations for registration, however uneven with regards to SGBV, Child Protection and security across the four locations hosting refugees. A policy of integration meant that the local population largely benefited from the services available to refugees and vice versa, although not always to the same extent.

Coordination: UNHCR Uganda played a very positive, inclusive coordination role, according to the vast majority of key informants. Good coordination products and processes happened on a regular basis. The lack of an information management specialist until 2015 however contributed to UNHCR limitations in issuing technical, sector specific and demographic/statistical information products.

Connectedness: The large investment in service infrastructure (reception centres, health and educational facilities) could be challenging to longer-term sustainability and maintenance. The formulation of the ReHoPE strategy focusing on self-reliance and resilience of refugees and host communities, integrated service delivery, suggest that UNHCR and partners have started to address this issue.

Impact: The emergency response provided protection to refugees by enabling unhindered, non-discriminatory access to Ugandan territory and registration and enabling access to protection services. It saved lives and enabled refugees to enjoy essential services and some degree of self-reliance.

Ethiopia Findings

In Ethiopia, UNHCR worked with over 40 partners among governmental entities, UN bodies, local and international NGOs. The main institutional partner is ARRA (Administration for Refugee and Returnee Affairs), the *de facto* responsible body for the protection of refugees, including registration, refugee status determination, camp management, security and protection, but also some other sectorial activities such as health and food distribution. South Sudanese refugees are formally required to reside in designated camps, but informally they are allowed to move outside the camps and to work in the informal sector. The camps do not have enough land for cultivation except for very small-scale vegetable gardening. Issues concerning the very limited availability of land, the delicate ethnic balance in the Gambella region and cross-border Nuer ethnicity (i.e. ethnic Nuers present both in Ethiopia and in South Sudan) were important contextual factors that constrained the effectiveness of the response.

The UNHCR operation in Gambella was in a downscaling mode but a contingency plan was drafted in March 2013, even if it substantially underestimated the scale of the influx. Although preparedness specifically for a South Sudanese refugee crisis was limited, a Letter of Understanding signed in June 2012 between UNHCR and UNICEF formed a crucial component of preparedness. UNHCR Ethiopia was stretched owing to ongoing refugee influxes from Somalia, Eritrea and Sudan, but it was able to immediately redeploy some key staff from the other more “mature emergencies” towards the Gambella theatre of operations. UNHCR Ethiopia made only belated use, however, of the various available human resources emergency deployment schemes.

Limited use was made of assessments in the planning of the design of the response and refugee participation was minimal. One key weakness was that even in July 2014, when the revised RRP was issued, the strategy foresaw the development of semi-permanent (‘transitional’) shelters in Leitchuor, which at this point in time UNHCR knew was at high risk of flooding. Aside from specific isolated examples, such as the water system for Tierkidi and Kule, a true long-term strategic plan, linking host community and refugee service delivery for long-term efficiency and sustainability was lacking as the response struggled to keep up with the various challenges presented by the crisis.

With limited funds and capacity, UNHCR staff felt compelled to accept all offers of help from all partners as they arrived. An increased openness to NGO partners on the part of ARRA facilitated this inclusive approach. The unity and collaboration displayed by UNHCR and UNICEF was widely appreciated by other partners, as providing a strong boost to the response. Partners’ ability to plan and develop strategies, however, was constrained by poorly coordinated and opaque decision-making, particularly around the Accountability Matrixes, that are supposed to determine who does what where, which were a focus of discontent. High staff turnover and poor handover, particularly in some technical sectors, also negatively impacted UNHCR’s ability to effectively coordinate the response.

The refugee influx from South Sudan created large-scale protection needs and risks among women, men, boys and girls and UNHCRs emergency response had formulated protection objectives in the Refugees Response Plan. Although critical protection approaches and interventions were applied and initiated, such as for example on registration and child protection, the evaluation found that the overall response was not sufficiently guided by clear protection priorities and strategies. Protection considerations were partly integrated into the response but some aspects remained weak in sectors such as site planning, shelter, food as well as health, nutrition, shelter and WASH at the transit centers.

Choices in response planning, such as the flood prone Leitchuor site, and the long stays in transit centers had strong impact on the protection situation of refugees. Sectoral approaches and interventions therefore only partially contributed positively to protection outcomes and, in some cases, may have exposed people of concern to unnecessary protection risks (for example at transit centers). The response was not based on protection assessments that would have been necessary to identify particular protection needs and risks, especially in a situation where the majority of refugees are women and children with a very high number of unaccompanied and separated children. Although some safety audits took place and multi-sectoral assessments included general references to protection, no overall protection strategy was put in place for the emergency to guide protection priorities for the entirety of the response across sectors, including protection areas as well as responding to particular protection risks and needs specific to the different groups of refugees, resulting in a segmented protection approach.

The Senior Protection Officer function for Gambella, which could have been catalytic in establishing such as process and ensuring protection wide coordination among partners, was recruited only in mid-July for 2 months, followed by another deployment in the last quarter of 2014. Coordination mechanisms were set up for specific protection areas and only merged into an overall protection working group at Gambella level towards the end of year one. Mechanisms for accountability to persons of concern were established only sporadically at specific locations (only in some camps, not transit centers) for specific sectors or sub-sectors and no overall approach for participation and for “giving, taking and being held to account” was set up. Community-based mechanisms for protection, services and support were fragmented and weak. With regard to access to territory – one important protection area - South Sudanese asylum seekers were granted *prima facie* refugee status in Ethiopia and no cases of *refoulement* were reported.

UNHCR’s approach to managing the civilian character of asylum – to the extent to which UNHCR is involved in this State responsibility - was appropriate and timely. Early on UNHCR established procedures as part of registration to identify combatants and ex-combatants and register these as asylum-seeker instead of refugees.

Refugees were registered on a household basis (biometric level 1 registration) at entry points and received ’fixing token’ for accessing food if and when available before being relocated to camps. Once relocated into camps, detailed registration (biometric registration at level 2) was conducted, and refugees and asylum-seekers were subject to the Government of Ethiopia’s encampment policy. The need for nationality screening (due to the difficulty in determining whether asylum seekers, overwhelmingly belonging to the Nuer ethnic group which is found on both sides of the border, were Ethiopian or South Sudanese), however caused many registration suspensions and, together with the difficulty in finding suitable land, delayed movement to the camps, resulting in long waiting periods at transit centres at border crossings. This caused extreme overcrowding in poor environmental health conditions at the transit centres, which were also partly flooded between June and October. The Government restricted the delivery of services, including food, at transit centres, in order to avoid a pull-factor for more refugees. As a result, standards for reception conditions at entry/transit points remained low. After the flooding in Leitchuor and some delays owing to the difficulty in finding suitable land and security concerns , the relocation of approximately 48,000 refugees from Leitchuor to the newly opened camps was conducted expediently (in less than one month), under time pressure with national elections in Ethiopia and the rainy season approaching.

Partners conducting the preparation at the arrival sites (for which UNHCR did not have sufficient funding) however reported that the process was chaotic.

SGBV response services and prevention interventions were established in the majority of the camps in July 2014, but the quality remained weak due to low partner capacity, a lack of training of health providers on the Clinical Management of Rape and a lack of functioning community based mechanisms relating to SGBV and security in place. Key informants reported that case referrals were taking place and that services were provided to SGBV survivors, but the scope and timeliness is uncertain due to the lack of data collection and documentation by UNHCR Gambella. Children, who constituted 69% of the influx, were registered on an individual basis, and child-headed households received individual ration cards The child protection case management system remained weak due to lack of harmonization, coordination and capacities and only reached a portion of the children in need of specific protection interventions or at risk, including among UASC. The regional Child Protection Framework contributed to strengthening and structuring the child protection response. The education response (please see below) created some protection gains for refugee children between 3 and 10 years of age, but was not able to cover a large proportion of children, including those at entry points.

Based on lessons learn from prior emergencies, UNHCR facilitated timely assessments, good collaboration and timely information sharing for the nutrition sector, and ARRA welcomed nutrition interventions and support from international NGO partners. A pre-agreed set of operational modalities for nutrition and a well-executed strategic partnership with UNICEF afforded some preparedness. With no dedicated nutrition focal point at Addis Ababa level, however, the response management was primarily reactive with limited strategic thinking around longer-term strategies and sustainable programming. The prevalence of malnutrition remained high throughout 2014, although an initial estimate of 37% GAM rates in February 2014 was brought down significantly by June to 13.4% GAM and an even lower rate in early 2015. Coverage rates for nutrition programmes were extremely poor due to weak preventive measures, limited community involvement and a weak outreach system.

Nutrition services were scaled up in a timely manner in the camps and were fairly well integrated with one agency/NGO managing the full package of nutrition services in a camp, except for the stabilization centres that are operated through the health centres. Routine screening for malnutrition, appropriate therapeutic or supplementary feeding, prioritisation of the malnourished for relocation, and blanket supplementary feeding for all children under-five years and pregnant and lactating women (at the entry points and in the camps) was essential in minimizing deterioration of the cases of malnutrition. Given the high numbers of arrivals, lengthy waits and the high burden of malnutrition upon arrival at the Pagak transit centre it would not have been unusual to see high mortality rates. Reliable mortality data was however extremely challenging in the first months of the response, community reporting on mortality was low, and dead were buried on the South Sudan side of the border. Anecdotal reports of high mortality in the first stages of the influx could not be confirmed and to date there continues to be limitations with accurate collection of mortality data.

A substantial portion of the general dry food ration provided in the camps was sold or bartered in order to cover other unmet needs, and the ration did not last the full month for most families[5]. A lack of income to purchase food prevented refugees from diversifying their diet. Vulnerable group identification and prioritisation for food distribution was absent. WFP initially provided only High-Energy Biscuits (HEB) in the transit centres, but later included dry rations when it was recognised that refugees were spending long periods awaiting relocation. On the whole, however, food distribution in the transit centres was ad hoc.

[5] As reported by a key informant and in the official ARRA, UNHCR and WFP Joint Assessment Mission Report of December 2014, (pages 2, 16).

The coordination of the health response was collaborative and effective, with no notable gaps in leadership, and effective information sharing. It was a while before reporting formats were streamlined, however. The Gambella Regional Health Bureau (RHB), with the support of UNICEF, was instrumental in the health response for the refugees at the border points and transit centres, as was a collaborative partnership between UNHCR, MSF and ARRA following an agreement signed in January 2014.

The outpatient utilization rate was within the expected range, but access to secondary health care remained a challenge as the local health facilities were overwhelmed by the refugees. Despite extensive efforts for comprehensive measles vaccinations the coverage still remained below the desired standard, and an outbreak occurred between March and July 2014 with over 500 confirmed cases in Pagak, Leitchuor and Tierkidi. An outbreak of Hepatitis E in Kule and Tierkidi saw over 400 cases. A feared outbreak was avoided in Gambella after a mass oral cholera vaccination campaign was conducted following a cholera outbreak in South Sudan in April 2014. Trends in the high morbidity diseases improved over the course of 2014 but not very dramatically. Mortality rates in the UNHCR Health Information System (HIS) were too low to be credible and were contradicted by a retroactive mortality study.

UNHCR provided consistent coordination and leadership in WASH, using an LoU with UNICEF and humanitarian space opened by ARRA to maximize the engagement of WASH partners. This helped speed up the immediate response but there were inefficiencies later on due fragmentation of services. Conditions in transit centres were appalling for the first few months of the crisis and deteriorated again with each new wave of refugee arrivals or delay in relocation. Water availability appears to have reached acceptable standards in the second quarter of 2014, but Tierkidi and Kule relied on water trucking throughout 2014. A permanent system for these two camps (and Itang town) requires a major investment and will be undertaken by RWB with UNICEF support. Progress on latrine construction was slowed down by environmental and social challenges, variable partner performance and the delayed roll out of agreed latrine designs by the WASH Technical Working Group. The target of less than 50 persons per latrine was only achieved at the end of 2014.

Site planning was reliant on short-term affiliated workforce personnel and suffered high turnover, but site plans were completed in good time and made good use of GIS with integration of digital elevation models to make good use of the topography and analyse flood risk. A partially community-oriented structure was put in place, but some services were poorly located, reducing their accessibility. Obtaining suitable sites was extremely difficult due to strong national and local political, economic and social factors. Despite the high flood risk for Leitchuor, ARRA and the Gambella Regional Government did not approve any alternative sites. Higher than normal flooding occurred, increasing the vulnerability and protection risks of the refugee population, physically blocking access to services and destroying some facilities. Whilst some flood mitigation actions were taken, there was no planning for the worst-case scenario in Leitchuor.

A shelter strategy was developed early on and transitional shelter design informed through consultation with refugees. The installation of emergency shelters described in the strategy might have reduced the financial impact of flooding in Leitchuor, but was not implemented. Instead UNHCR invested in semi-permanent ‘tukul’ shelters in Leitchuor, which were later damaged or destroyed by flooding. At the entry points, the limited availability of hangars provided for shelter meant that transit centres were overcrowded and some refugees went without shelter. The rate of the refugee influx, poor communication by UNHCR to partners on the timing or relocations, delays in plot demarcation and short-term shortages of some construction materials challenged the ability of the response effort to provide adequate emergency shelter on a timely basis. The progress of transitional shelter construction did not keep up with the rate of the refugee influx and UNHCR didn’t engage additional partners until the end of 2014, when 87% of the refugee population was still living in emergency shelter. The availability of local materials, notably thatching grass, contributed to delays in permanent shelter construction. However, quality control of transitional shelters was inadequate and refugee participation in transitional shelter construction was low and variable.

While the mandate of formal primary education for refugees in Ethiopia lies with ARRA, there was a need to provide education opportunities before refugees could access education opportunities in the national system. UNHCR lacked emergency staff for education but a Letter of Understanding between UNHCR and UNICEF enabled UNICEF to second education expertise to UNHCR several months into the emergency. The education response was based on several education specific inter-agency assessments but an education strategy remained in draft format and had limited impact on inter-agency programming for education. The education response slowly began at the end of March 2014 and was initially disorganised, scaling up and becoming more structured from August once coordination mechanisms had been agreed upon. The large numbers of school-aged children, poor infrastructure, high pupil/teacher and pupil/classroom ratios, limited partners, and a lack of interventions to increase access of children with disabilities were significant challenges and education was rated as the most problematic sector in an online survey that formed part of the evaluation.

Ethiopia Conclusions against OECED-DAC Criteria

Effectiveness: In spite of the limited usefulness of the contingency plans and the limited preparedness, the UNHCR-coordinated response on a whole was timely and effective in saving lives and met the RRP's broad objectives. This was partly thanks to support received through the crucial UNICEF partnership and from other partners who intervened with their own funds, in addition to ARRA's openness to early international interventions. There were, however, significant shortcomings. In particular, the timeliness and effectiveness of the protection response was primarily limited by external constraints on which UNHCR had limited control, such as the opening of new camps mainly owing to the scarcity of suitable land and several suspensions of the registration which meant lengthy periods in which the refugees were held in sub-standard transit centres.

Relevance/appropriateness: The design of the RRP and UNHCR's emergency response were largely relevant and appropriate and the protection response was guided by relevant priorities in most areas, although implementation was challenging. With the exception of nutrition and education, however, there is no evidence of early, participatory, interagency assessments.

Coverage: On a whole the UNHCR-coordinated emergency response ensured a good coverage of the refugee population, although there were some significant gaps, such as in shelter and latrines.

Coordination: Compared with previous emergency responses, the coordination of the emergency response was much more collaborative and inclusive. The strategic partnership with UNICEF, and ARRA's openness to early NGO intervention opened up the humanitarian space, and played a crucial role in providing effective protection and assistance. The selection and retention of IPs and OPs however, was not transparent and not based on clear criteria.

Connectedness: Within the timeframe under evaluation there was limited strategic thinking to longer-term sustainable programming and very few resources devoted to livelihoods and self-reliance.

Impact: The UNHCR-coordinated response and the Ethiopian Government's strict adherence to the principle of *non-refoulement* enabled life-saving activities to be implemented, rapidly decreasing the high levels of malnutrition and along with it the associated mortality however the collection of mortality data needs to be strengthened. Scarcity of suitable land for refugee settlements and nationality screening had a negative impact on the well-being of refugees who were held for lengthy period of time at border transit centres.

Uganda Summary Recommendations[6]

1. **Documentation, including birth registration, should be made a protection priority given existing national laws that facilitate documentation to all.**
2. **Develop an integrated community-based protection** and **community mobilization strategy across sectors.**
3. **Strengthen case management for Child Protection and SGBV.**
4. **Harmonise policies and procedures for the identification, referrals and follow up on persons with specific needs across partners**.
5. **Strengthen and systematize accountability to affected populations as a cornerstone of the centrality of protection.**
6. **Operationalize and develop a fund raising plan for the ReHope strategy in order to ensure a solution orientation of the response as well as sustainability.**
7. **Fully operationalize the community health and nutrition outreach system**
8. **Strengthen the prevention, early diagnosis and treatment of malaria**.
9. **Conduct an analysis of the drug procurement process** to identify the key points of delay in the lines of procurement.
10. **Immediately begin regular water quality monitoring and develop an appropriate water safety plan for each** settlement.
11. **Develop a formal operation and maintenance strategy for water supply.**
12. **Revise the hygiene promotion strategy to focus on reinforcing priority public health messages through a more appropriate mix of communication channels**.
13. **Finalise key indicators for hygiene promotion.**
14. **Conduct a survey of the type and condition of shelters.**
15. **Develop a Shelter Strategy.**
16. **Develop an action plan for strengthening access to post-primary education.**
17. **Streamline education data management across locations.**
18. **Strengthen coordination on education programming.**

Ethiopia Summary Recommendations

1. **Conduct a performance review of the current IPs per sector and camp, taking into account the views of technical / sector specialists.**
2. **Define protection priorities for the ongoing response and align protection and sectorial interventions under an overall protection chapeau.**
3. **Invest in strengthening SGBV service provision and improve data collection and analysis through the roll-out of GBV-IMS**.
4. **Advocate strongly for the rapid processing of nationality screening procedures in order to quickly decongest transit centres.**
5. **Streamline child protection case management and facilitate child protection standards and coordination among partners.**

[6] The full text of the recommendations can be found at the end of each country chapter.

6. **Implement a response wide community mobilisation strategy that builds on community structures and is effective in supporting protection and sectorial programming.**
7. **Establish an accountability mechanism to persons of concern through the development of systematic feedback and complaints mechanisms.**
8. **Improve the infrastructure and services at transit centres at border entry points (in consultation with the concerned authorities).**
9. **Advocate for, coordinate and provide support to the regional Gambella hospital.**
10. **Facilitate the development of strategic linkages between the national Ministry of Health and ARRA**.
11. **Strengthen hygiene promotion activities, with a particular emphasis on exclusive latrine use and hand-washing at critical times.**
12. **Undertake a detailed capacity assessment of the RWB for the management of the Tierkidi/Kule water**
13. **Speed up the upgrading of refugee shelter conditions by putting in place milestones for the development of semi-permanent tukuls or suitable upgraded emergency shelters.**
14. **Standardise shelter support, including refugee participation, and ensure that protection principles are fully incorporated.**
15. **Ensure that there is high quality supervision and coordination in the shelter sector with the necessary continuity**.
16. **Explore opportunities for strategically steering UNHCRs educating programming towards integrating refugee children into national education systems.**
17. **Utilize UNHCR's existing education strategy in Ethiopia to its full potential so that it can** be applicable in emergency situations as early as possible by further expanding education opportunities beyond the first four years in primary school.
18. **Strengthen education programming as part of UNHCRs comprehensive protection strategy and delivery to increase an integrated programming response**.

Systemic Summary Recommendations

1. **In an L3 emergency, consider appointing a dedicated Regional Refugee Coordinator to be co-located in the region with peers from other UN agencies**
2. **Explore how to further simplify Budget Committee submissions and processes** in line with a recently instituted Working Group.
3. **Embed the centrality of protection** further in UNHCR's emergency response and ensure that UNHCR's mandate in adequately reflected in staffing, resources, accountability mechanisms and assistance programmes.
4. **In collaboration with other relevant actors, and as a part of on-going research where possible, conduct operational research on the measurement of malnutrition** and calculation of prevalence in anthropometrically unique populations such as the Dinka and Nuer from South Sudan.
5. **Develop a latrine strategy for environments with high water tables and rocky soils**, which are commonly encountered in refugee settlements.
6. **Set in place organisational standards, mechanisms and procedures on education programming in emergencies** to ensure that education is an essential and timely intervention with adequate staffing and resourcing.
7. After the first phase of the emergency (3-6 months) **ensure that there is high quality supervision with the necessary technical and coordination skills and continuity (at**

least one year) for "technical" sectors, particularly if they have high budgets. Co-coordination by an experienced partner, should also be institutionalised, in light of recent guidance.

8. **Carry-out an assessment on the utilization of the Affiliate Workforce.**

9. **Ensure that updated contingency plans are in place with a realistic assessment of sites of an adequate size to receive the forecasted refugee influx.**

Introduction

The Evaluation of UNHCR's response to the refugee emergency in Ethiopia and Uganda follows from the declaration of the L3 emergency for South Sudan on 3 February 2014.[7] It was undertaken in line with UNHCR's revised Policy on Emergency Response, Activation, Leadership and Activities approved by the High Commissioner on 21st January 2015.[8]

South Sudan is the 193rd and youngest member of the United Nations, having gained its independence from Sudan on 9 July 2011 after protracted conflicts and negotiations, following the results of a self-determination referendum held in January 2011 in which the overwhelming majority of its citizens voted for independence following the signature of a Comprehensive Peace Agreement in January 2005. A few months later South Sudan started receiving tens of thousands of refugees from the southern areas of Sudan proper who numbered almost 170,000 by the end of 2012.

In spite of the hopes that the newly gained independence brought about, on 15 December 2013, clashes broke out in Juba between competing factions within the Sudan People's Liberation Movement/Army (SPLM/A) which constituted the backbone of the Government, and the situation quickly degenerated into a full-scaled conflict along ethnic lines. The spark that ignited the crisis was when in July 2013 President Salva Kiir sacked Vice-President Riek Machar and other cabinet ministers. As argued by the International Crisis Group "although the dispute within the SPLM that led to the conflict was primarily political, ethnic targeting, communal mobilization and spiralling violence quickly led to appalling levels of brutality against civilians, including deliberate killings inside churches and hospitals".[9] President Kiir belongs to the Dinka ethnic group, the largest in South Sudan, while vice-President Machar belongs to the Nuer, the second largest.

Although they are quite closely related culturally, socially and linguistically, the Dinka and Nuer have a long history of animosity rooted in cattle rustling and territorial expansion[10]. In more recent times, during the struggle against the Arab-speaking and overwhelmingly Muslim northern part of Sudan, both Dinka and Nuer (overwhelmingly Christian or animist) joined the SPLM/A, the liberation movement founded in 1983 and led by John Garang (an ethnic Dinka). The conflict between the SPLA and the Governmental authorities in Khartoum sent hundreds of thousands of refugees from the southern parts of Sudan to neighbouring Ethiopia, Kenya and Uganda in the 1980s.

In more recent times tribal conflict related to cattle disputes broke out at the end of 2011 in the Jonglei state of South Sudan, mainly between Nuer and Murle tribes, resulting in the first, albeit limited, exodus of "South Sudanese" to neighbouring countries. The latest conflict which started in December 2013 caused, according to some estimates, a death toll including both civilians and armed elements exceeded 50,000 by November 2014[11] more than the number of deaths in decades of liberation war against the Muslim "north". At the same time hundreds of thousands of Southern Sudanese were displaced internally, often in the bases belonging to UNMISS (the UN Peacekeeping Mission in South Sudan) or externally as refugees mainly in Ethiopia, Uganda, Sudan and Kenya.

---

[7] UNHCR Emergency Policies and procedures – A summary of the Guidance Notes 1 October 2012,

[8] Policy on Emergency response, activation, leadership and accountabilities (UNHCRHCP/2015/1) Section 10, Accountabilities, Paragraph 10.5

[9] International Crisis Group "South Sudan, a Civil War by Any Other Name", Africa Report No. 217, 10 April 2014

[10] E. Evans-Pritchard: *The Nuer: A Description of the Modes of Livelihood and Political Institutions of a Nilotic People*. Oxford: Clarendon Press

[11] http://reliefweb.int/report/south-sudan/50000-and-not-counting-south-sudans-war-dead

As a result of these events UNHCR declared its internal Level 3 (L3) corporate emergency on 3 February 2014 while on 11 February the IASC Principals declared an L3 system-wide emergency in accordance with the criteria of the Transformative Agenda to ensure a coordinated response to the internal and external dimensions of the displacement. By the beginning of 2015 there were approximately 1.5 million IDPs registered in South Sudan and over 500,000 South Sudanese refugees in the neighbouring countries in addition to the 130,000 who had fled before the December 2013 violence, for a total of over 630,000 refugees.

Table 1: South Sudanese refugees in neighbouring countries as of 1 February 2015

Country	Refugees pre-December 2013	Refugees post-December 2013	Total
Ethiopia	63,341	195,453	258,794
Uganda	22,264	140,462	162,726
Kenya	45,239	44,953	90,192
Sudan	-	120,401	120,401
Grand Total	**130,844**	**501,269**	**632,113**

Source: UNHCR Operational data portal, South Sudan Situation

This influx stretched the local absorption capacities considering that these countries were already hosting hundreds of thousands of refugees such as Somalis in Ethiopia and Kenya, Congolese in Uganda and Eritreans in Sudan. Moreover the new refugees included a "disproportionate number of women and children" requiring not only immediate assistance in life-saving sectors such as health, water, sanitation and emergency shelter, but also attention and assistance in key protection areas such as sexual and gender-based violence and support to unaccompanied and separated children.[12].

The Regional Response Plan

The concept of a Regional (Refugee) Response Plan (RRP) was first introduced by UNHCR in March 2012 for the Syrian emergency. The "philosophy" was to initiate a consultation process bringing together numerous humanitarian partners including those who, while working with the aim of protecting and assisting refugees, did not intend to be funded by or through UNHCR, i.e. "operational" instead of "implementing" partners. It is closely related to the "Refugee Coordination Model" (RCM), though the latter was introduced later, in December 2013. The RCM "builds on principles developed by the Inter-Agency Standing Committee (IASC), the primary mechanism for inter-agency coordination of humanitarian assistance, on leadership, coordination and accountability while taking into account the specific situation of refugees and the needs of their host communities"[13]. The main elements are[14]: Leadership, strategic planning, resource mobilization, operational coordination, delivery of protection and services, and advocacy.

Refugee Response Plans are defined as "comprehensive inter-agency plans for responding to refugee emergencies".

[12] UNHCR, South Sudan Refugee Emergency Revised Regional Response Plan, January – December 2014

[13] http://www.unhcr.org/pages/538dd3da6.html

[14] "Presentation on Refugee Response Coordination"

"They are a key feature of the Refugee Coordination Model, and provide the vehicle through which leadership and coordination of a refugee response may be exercised. An RRP articulates the protection and solution priorities and describes the needs of refugees, host communities, and other persons of concern, states how and by whom these needs will be addressed, and defines the financial requirements of all the humanitarian actors involved… The planning process should be inclusive and should involve all key actors… In addition to deciding who is responsible for what, and financial requirements, the RRP is also a fundraising tool for agencies involved in the response. Where refugees from a country flee to more than one country of asylum, a Regional RRP is prepared. This sets out a regional strategy that incorporates the country-level inter-agency response plans of all refugee-receiving countries affected by the situation"[15].

RRPs do not cover UNHCR's involvement in IDP and natural disaster response situations, which are covered by the Strategic Response Plans (SRPs) that in turn are formulated under a planning process led by the Humanitarian Coordinator and supported by OCHA. If applicable, however, a chapter on refugees might be included in SRPs in mixed refugees-IDPs situations.

The first RRP for the South Sudan situation (confusingly called "Inter-Agency Appeal for the South Sudanese Refugees Emergency") was issued in March 2014, incorporating also the financial requirements of twenty-four other agencies and NGOs for a total of USD 370 million targeting 340,000 refugees for the period January-December 2014. In July 2014 this Appeal (now called "South Sudan Refugee Emergency Revised Regional Response Plan") was revised upwards to USD 657 million (including 210 million for Ethiopia, out of which 90 million for UNHCR and 224 million for Uganda, out of which 123 million for UNHCR), targeting 715,000 refugees. The number of partners covered by this appeal rose to thirty-three. Eventually the USD 657 million appeal for the whole sub-region was 54% funded and the total UNHCR requirement (USD 329 million) was 56% funded[16].

In line with the Refugee Coordination Model, on the 13 March 2014 the High Commissioner appointed a Regional Refugee Coordinator "to support in a coherent and consistent manner the protection and assistance of refugees inside and outside camps, while also bearing in mind the situation of the host communities. The regional coordination functions will also include addressing in a predictable way any regional and global challenges affecting the responses".

Evaluation methodology and limitations

The evaluation team was composed of four members, namely an independent consultant focusing on nutrition and public health, an independent consultant focusing on water, sanitation, hygiene, shelter and site planning, a monitoring and evaluation specialist within the UNHCR Division of International Protection and a staff member from the UNHCR Policy Development and Evaluation Service who was the evaluation manager.

The evaluation was carried out in conformity with best practices and the UNEG code of conduct for evaluators.[17] Terms of Reference with evaluation questions grouped around the main OECD/DAC evaluation criteria and inception reports provided and orientation for conducting this evaluation. The July 2014 Revised RRP was one of the main benchmarks for the evaluation.

---

[15] UNHCR Emergency Handbook 2014, https://emergency.unhcr.org/entry/61168/refugee-response-plans-rrps-interagency

[16] See Annex I for more information

[17] http://www.uneval.org/document/detail/100 UNEG Code of Conduct for Evaluation in the UN system

The evaluation employed a mixed-method approach consisting of both qualitative and quantitative methods including the following activities, the results of which were then triangulated during the compilation of the report:

- Exhaustive document review including strategies, plans, assessments, budgets, site plans, technical designs, minutes of sectorial working groups;
- Interviews with key UNHCR staff in Geneva (25), Uganda (25), Ethiopia (28) and telephone interviews with staff in Nairobi Regional Support Hub and former staff (3).
- Interviews with partners and stakeholders such as governmental counterparts at the national and local level, NGOs, UN agencies, donors in Uganda (58) and in Ethiopia (49) both in the capital cities and in the field.
- Site visits of camps, settlements, reception and transit centres, schools, health facilities, markets, child friendly spaces, walk-over surveys and direct observation of services and assistance were undertaken in selected settlements (Nyumanzi, Ayilo 1, and Kiryandongo in Uganda, and Tierkidi, Kule and Leitchuor[18] camps in Ethiopia).
- Focus group discussions were held with a range of refugee groups, including age- and gender-segregated groups. They included refugee leaders, different committees and groups, persons with specific needs, women and youth in the settlements and in Kampala in Uganda (13) and the camps in Ethiopia (7).
- Brief interviews with refugees in their compounds and at water points.
- An anonymous online survey with 18 questions grouped according to the OECD/DAC criteria, distributed to the mailing list recipients of UNHCR Uganda and Ethiopia emergency updates on the refugee influx from South Sudan (Governmental counterparts, UN and other International Agencies, international and local NOGs and UNHCR staff).
- The evaluation team visited Uganda from 2 to 15 June and Ethiopia from 16 to 27 June, and in both cases with roughly the same amount of time was devoted to interviews in the respective capitals and to interviews and field visits in the theatre of operations, namely Adjumani and Kiryandongo in Uganda and Gambella in Ethiopia.

The methodology faced the following limitations:

- The Evaluation team was not able to visit all refugee settlements; in Uganda the team visited selected settlements in Adjumani and Kiryandongo, but did not visit Rhino camp due to time constraints; in Ethiopia, the team was only able to visit one of the border entry points (Pagak) due to the poor accessibility of the others.
- The online survey was answered by 16 respondents in Uganda and 11 in Ethiopia, representing roughly 20% of the addressees (UN, Government, NGOs, donors) to whom it was sent and is not a representative sample of the views of all the key stakeholders involved in the emergency operation. It however constitutes an independent source of information that can contribute to the triangulation of evidence.
- High staff turnover within UNHCR, combined with weak or absent handover and document storage practices meant that institutional memory was poor for some sectors.

[18] The last refugees from the Leitchuor camp had just been evacuated a few days before the visit.

General Findings

The RRP and the Regional Refugee Coordinator

Interviews suggest that there was an inclusive consultation process and the document provided a good snapshot of "who does what, where" hence helping coordination. In terms of fund-raising, views were mixed, with the most positive comments coming from some NGOs who wanted to operate independently from but in coordination with UNHCR for whom the RRP provided visibility and "a place on the map". It was less important as fund-raising tool for UN Agencies who used other tools, although one UN agency commented that it is "a common reference tool to refer to for the fundraising purposes - and there were no questions asked [concerning] where the planning figures come from and what are the constraints that the humanitarian community is facing".

The RRP could not, however, standardise the response across the region, given different host countries policies on hosting refugees. As can be seen in the following table, there were large differences in budgeted cost per refugee, some of which could be justified by differences in the approach to hosting and supporting refugees which can only partially be explained by the systematic inclusion of a component for host communities in Uganda). Furthermore, refugee planning figures in Uganda were quite close to the actual refugee population by the end of 2014, but in Ethiopia the planning figure was 63% higher than the actual population.

810 **Table 2: Uganda and Ethiopia funding requirements (USD) and actual funding in the Revised 2014 RRP[19]**

Uganda	RRP Planning population: 150,000					
	Actual refugee population at end 2014: 136,000					
	RRP Budget	Budget per refugee (RRP planning figure)	Budget per refugee (actual refugee population)	Funding received (income)	Income per refugee (RRP planning figure)	Income per refugee (actual refugee population)
UNHCR	123,167,156	821	906	53,917,241	359	396
All Agencies	224,303,989	1,495	1,649	106,961,550	713	786

Ethiopia	RRP Planning population: 300,000					
	Actual population at end 2014: 191,000					
	RRP Budget	Budget per refugee (RRP planning figure)	Budget per refugee (actual refugee population)	Funding received (income)	Income per refugee (RRP planning figure)	Income per refugee (actual refugee population)
UNHCR	90,707,304	302	475	53,515,064	178	280
All Agencies	210,975,801	703	1,105	120,544,064	402	631

It is rather weak as an operational document since it does not contain a recognizable results framework, either from UNHCR (objectives/impact indicators, outputs/performance indicators) or from other UN bodies (activities, outputs, outcomes). The RRP instead talks about "Planned Response" under which it lists a number of planned activities. It is also weak as a strategic document as it has a one year time frame, does not look at the longer term strategic objectives and does not take into account issues such as sustainability.

820 Interviews suggest that overall the Regional Refugee Coordinator played a positive and supportive role, however constrained by the "dual hatting" (Deputy Director for the Horn and eastern Africa) and by the fact that the position is based in Geneva, rather than Nairobi, where most agencies have their Regional Coordinators and where the support team of the regional refugee coordination was based. Considering that the role of Deputy Director is a very demanding one involving almost every aspect of an operation (operational strategy, budgets, staff, administration) the dual hatting has posed a lot of strains on the incumbent who was required to go constantly on mission without being able to develop informal ties with peer Regional Directors that co-location would have facilitated.

830 Various divisions and services at HQs supported the emergency operation by providing strategic direction, guidance and support through a dedicated Emergency Task Force that was set-up at the beginning of the emergency and met regularly. A South Sudan Situation Regional inter-Agency Contingency Plan covering the period from May to December 2014 was also developed. It should also be noted that when this emergency unfolded, both

[19] More details can be found in Annex 1

Ethiopia and Uganda were already affected by multiple refugee influxes, such as from Somalia, Sudan and Eritrea in Ethiopia and from the D.R. of Congo in Uganda, stretching UNHCR's human, financial and material resources.

Uganda Operational Context

According to the Human Development Index [20] included in the UNDP 2014 Human Development Report, Uganda ranked 164th (out of 187 countries), with a life expectancy of 59.2 years, a Gross National Income of USD 1,335 per capita per year, 5.36 Mean Years of Schooling[21], a total population of 37.5 million and a population density of 194 inhabitants per square km. From an ethno-linguistic point of view, Uganda is a very diverse country and some groups straddle across the border with South Sudan. However the main tribes that constitute the vast majority of South Sudanese refugees from the current conflict, the Nuer and the Dinka, are not found in Uganda and hence are easily identifiable as Southern Sudanese.

Regarding the total number of refugees, in 2013, before the new influx from South Sudan, Uganda hosted 220,555 refugees and ranked 7th in terms of number of refugees per 1 USD GDP per capita, i.e.152. The refugees were mainly from the D.R. of Congo, South Sudan, Rwanda, Somalia and Burundi. By the end of 2014 Uganda ranked 9th in the world with a total of 385,513 refugees and 4th in the world in terms of number of refugees per 1 USD GDP per capita, i.e.195[22].

Uganda has a long history of hosting refugees dating back to the 1960s first with Rwandese and then with refugees from the southern part of Sudan. In 2013 it was already dealing with an influx from D.R. Congo. There was a total of 180 UNHCR staff (international and national). The available funds for refugee programmes were USD 45.8 million out of a needed total of USD 102.6 million [23]. The UNHCR presence included, besides the Representation in Kampala, one Sub-Office, two Field Offices and several Field Units. Crucially one Field Office was Adjumani in northern Uganda, which historically was the base for protection and assistance programmes for Sudanese and for the first South Sudanese influx after independence. However the Adjumani operation, including the Sub-Office, were in a down-scaling mode on the assumption that South Sudan's independence would encourage all the remaining refugees to repatriate, as evidenced by the projection in the 2013 Global Appeal that by the end of the year the South Sudanese refugee population would have dropped from 18,460 to 17,380.

In terms of partnerships, UNHCR worked with over 60 partners among governmental entities, UN bodies, local and international NGOs, including both implementing as well as operational partners. The main institutional partner is the Department of Refugees within the Office of the Prime Minister (OPM) that has the mandate "to protect and coordinate the refugees programs in the country". According to Article 189 Schedule 6 of the 1995 Constitution of Uganda refugees protection functions are a prerogative of the central government. Refugee issues are regulated by the 2006 Refugee Act in 2006 which stipulate *inter alia* that refugees have the following rights to:

- Education (elementary) on the same level as nationals.
- Own and dispose of property.
- Engage in agriculture, industry, handicraft and commerce

[20] http://hdr.undp.org/en/countries

[21] "Average number of years of education received by people ages 25 and older, converted from education attainment levels using official durations of each level". By comparison the UK has 12.3 Mean Years of Schooling

[22] UNHCR Global Trends/ Forced Displacement 2014 http://www.unhcr.org/556725e69.html

[23] UNHCR Global Report 2013

- Practice a profession.
- Association and freedom of movement subject to certain restrictions.
- Have access to employment opportunities and engage in gainful employment.

Refugees in Uganda, in principle, have free access to public services and facilities such as health, education, water and sanitation at the same level as the nationals. Most refugees are hosted in designated settlements (rather than camps) where they are allocated a plot of land to cultivate, thereby enjoying livelihood opportunities and reducing dependency. At the same time they have access to life-sustaining assistance from UNHCR and the international community. Most settlements are established on community-owned land, rather than on gazetted land.

Refugees have also the choice to settle in urban centres, where they can only get minimal assistance (mainly counselling), as long as they can support themselves. Moreover the 2010 Refugee Regulations issued by the Ugandan Government adds that refugees should be integrated into the communities where they are settled.

Overall Uganda provides a very favourable operational and protection environment for refugees.

UGANDA Findings

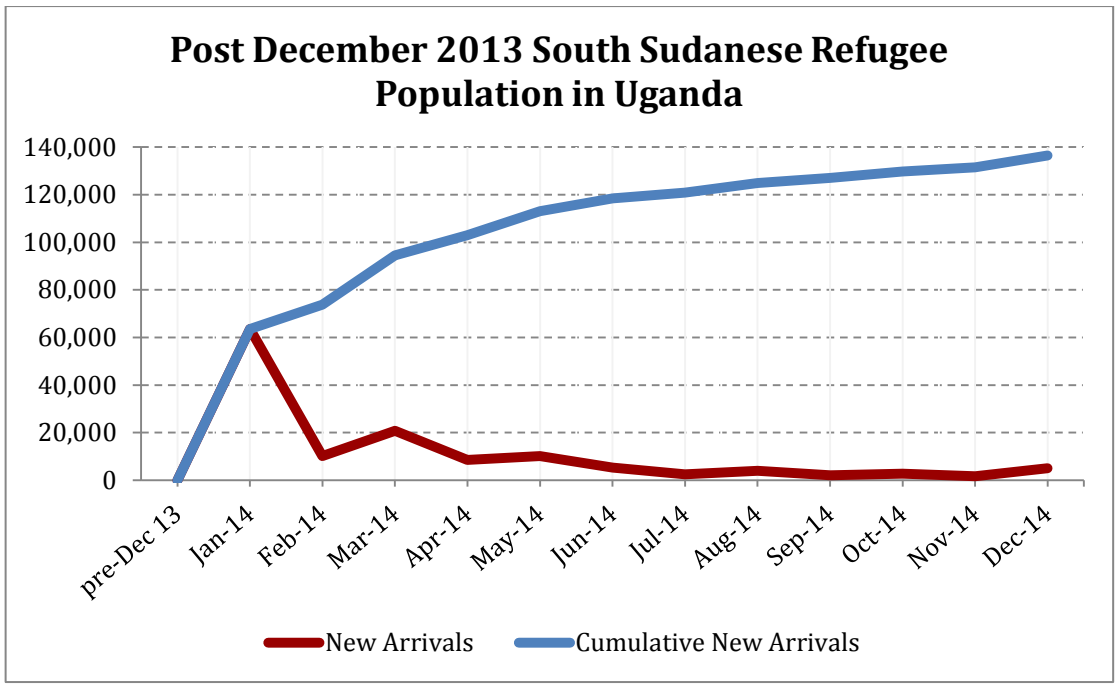
Strategic Planning

Contingency Planning and Preparedness

There was a **contingency plan** for a possible influx of refugees from South Sudan drafted in May 2012[24]. The plan was mainly prompted by the conflict in the Jonglei state of South Sudan that erupted towards the end of 2011. The rather sketchy plan (without indicators, not broken-down by sector and without an indication of which Implementing Partner would take up which activity) envisaged two scenarios, one with an influx of 10,000 refugees, and one with 30,000 refugees. By the end of January 2014 the new arrivals from South Sudan were already more than twice of the highest planning figures (see Figure 1 below). The Evaluation found no evidence of any update of the plan from mid-2012 and the plan was therefore only of marginal use when the December 2013 influx started. Another contingency plan was prepared in April 2014 (four months after the beginning of the emergency) with planning figures of new arrivals ranging from 100,000 to 300,000, but with precious little operational detail except for the identification of entry and transit points.

[24] UNHCR and OPM: "Draft Preparedness and Response Plan 30,000 Refugee Influx from South Sudan to North Uganda"

Figure 1: New Arrivals in Uganda from South Sudan 2014



Source: UNHCR Kampala

Given the downscaling mode of the UNHCR operations in northern Uganda and the underestimation of the refugee influx, there was **limited specific preparedness** for the emergency situation. As several key informants pointed out, contingency planning is also of limited usefulness when population scenarios greatly exceed the population that can be served with available resources. The most significant consequence of the lack of contingency planning was a limited preparedness, including a lack of contingency stocks and a lack of planning with partners as to how responsibilities might be divided up. Nevertheless, there were some mitigating factors such as the availability of settlements that had been previously used by Sudanese refugees[25], and the fact that UNHCR was fully operational with an emergency response for a refugee influx from the D.R. of Congo. This meant that even if UNHCR Uganda was stretched, it could immediately redeploy some key staff, such as an Associate WASH Officer, from the D.R. Congo more "mature emergency" towards the northern Uganda theatre of operations. UNHCR had, additionally, shared a delegation plan for the Christmas holidays indicating who was in charge during this period which enable fast inter-agency response.

But since the fall-out between President Kiir and Vice-President Machar took place in July 2013, the question of whether the influx that started in December could have been foreseen may be posed. In this respect all interviewees from UN agencies, NGOs and donors unanimously said that political problems and conflicts happened before and did not lead to substantial external displacement and since nothing happened for five months in this case, they all assumed that it was going to be again "business as usual" and hence the magnitude of the influx caught everyone by surprise.

[25] Using GIS, UNHCR Uganda found that, in Adjumani, the new settlements were mostly adjacent previous refugee settlements, with little overlap i.e. the host community moved into areas that had been cleared and provided with water etc. after the previous refugees left, and then adjacent areas were used for new refugees.

Response Strategy and Design

The main overarching document[26] outlining UNHCR Uganda's response strategy was the Regional Response Plan (RRP). Under "Planned Response" the Uganda section of the RRP lists approximately 70 activities under the different sectors, but with no quantified targets, except for an overall planning figure of 150,000 refugees. One of the most noteworthy features is however that it identifies the crucial role of hosting districts as the first port of call to take on the burden of a refugee influx and points out that all priority programmes should incorporate a host community component from the outset" to ensure a protective environment and peaceful coexistence. All respondents to the on-line survey agreed that 'the design and delivery of the RRP have been based on sound assessments of the context and needs' with one third strongly agreeing. The overwhelming majority of respondents on the online survey agreed that 'given the operational and contextual constraints satisfactory humanitarian conditions have been met' which reinforces the findings that both the strategy and implementation of related activities was carried out effectively.

The RRP was produced in March 2014. The development process in Uganda was an inclusive one in which all prospective partners were invited to participate in assessments and meetings to develop the document. A draft of the document was circulated to partners for review prior to finalisation. The document was therefore useful for enhancing collaboration and coordination, although its usefulness as a fundraising tool was doubted by some actors (particularly from other UN agencies) interviewed during the evaluation.

A true long-term strategic plan, linking host community and refugee service delivery for long-term efficiency and sustainability was not visible in 2014, until the formulation of the ReHope strategy (see below)[27]. The promotion of refugee self-reliance faced certain challenges and was not fully realised. Whilst the government of Uganda provided refugees with access to land, the large size of the influx in Adjumani meant that the size of plot allocated to each family had to be reduced to 30 by 30 metres (in some settlements 20 by 30) compared to the 50 by 100 meter plots previously allocated. Many refugee families struggled to construct permanent shelter, having no adult males to do the construction and/or struggling to access key materials such as thatching grass. Houses and family latrines were constructed for persons with special needs (PSNs) but this categorisation did not capture all families in need of assistance with construction. The new influx of South Sudanese refugees was considered unwilling and unable to pay user fees for water points, whereas host communities and refugees from previous influxes were paying for water. At the end of 2014 strategy for introducing user fees for the new refugees was still under discussion.

This weakness however was noted by UNHCR Uganda and steps were taken to address it through developing the *Refugee and Host Population Empowerment (ReHoPE)*, **a strategic framework to strengthen the self-reliance and resilience of refugees and host communities in Uganda,** through support for sustainable livelihoods and enhanced service delivery integrated with local government systems. The ReHoPE Strategy, whose first working draft was produced in October 2014, constitutes an important step towards integrating the refugee operation into a host community development plan. The perception of a limited availability of funding, a rapid tail off of funding after the initial emergency period and the need for high early investment to support the government's policy of promoting refugee self-reliance, leads many actors to want to see at greater focus and investment on self-reliance and integration in development plans. The ReHoPE strategy contains a five-year proposed budget of USD 350 million to be channelled through the Government, UNDAF and the private sector towards sustainable livelihoods, governmental service delivery and peaceful

[26] There were, however, several sectorial strategy documents.

[27] It was mentioned as one element of the RRP's Response "Strategy", but without any detail.

coexistence. However at the time of the Evaluation it had not yet been approved by the Government and still needed operational details and its fundability remains an open question.

Response Management

Coordination and Partnerships

On the whole UNHCR Uganda played a very **positive coordination role**, as agreed by the vast majority of the external (non-UNHCR, including the OPM) interviewees. This positive assessment is confirmed by the online survey in which 100% of the respondents agreed or strongly agreed that "UNHCR has effectively coordinated the emergency response, involving all actors which ensured filling of gaps and avoiding duplication, thus making best use of the limited resources." In addition to the Government entities (OPM, Line Ministries and District authorities, UNHCR collaborated with 7 UN agencies and as many as 40 NGOs. In terms of coordination processes UNHCR, together with OPM, held regular interagency coordination meetings, Protection Working Group Meetings and sectorial meetings in Kampala as well as in the field. It also issued numerous good quality coordination products such as an early Interagency Emergency Assessment [28] , a comprehensive emergency contact list, comprehensive updates presented at interagency meetings, and regular 3Ws (Who What Where) updates not only broken down by settlement and sector, but also showing on-going activities, their status/progress as well as the remaining gaps (which may be considered as a best practice). This 3W (in Uganda actually called 4W, including "When") therefore constituted also a useful monitoring tool. The quality of sectorial coordination varied depending on individual skills and staff turnover.

Decisions over **who would do what where**, and Implementing Partner (IP)[29] selection, were delayed and were not sufficiently transparent particularly in the early stages of the emergency which caused "unhealthy competition among NGOs for UNHCR funding". Although an internal UNHCR IP Selection Committee was eventually established (and these decisions were contingent on OPM's approval) UNHCR could have done a better job of communicating the main reasons behind decisions. Conversely, Partners did not always inform UNHCR or OPM on the amount of funds they received from non-UNHCR sources and implementation details which also hampered coordination.

A Public Health 3W matrix was first issued on 27 January 2014 and the first multi-sector 3W matrix for Adjumani on 5 February. Moreover many key IP and OP informants complained that UNHCR Uganda did not give enough credit and visibility to their achievements obtained with their bilateral funds. Furthermore with specific sectors there were specific IP issues. For example, due to big problems in the water sector an International NGO was taken on as a new IP despite not having been previously selected by the IP selection and retention committee. This decision was only made after analysis and input from WASH technical staff. A tension existed between the need for partners with strong emergency WASH experience and the need for partners to run affordable services in the long run. In the area of protection, some partners with very limited protection experience were taken on board.

[28] "South Sudanese Refugee Inter Agency Emergency Assessment Report for West Nile Region and Acholi Sub-Region" (6-8 January 2014)

[29] UNHCR distinguishes between Implementing Partners, who get most or all the funds through UNHCR, and Operational Partners (OPs), who coordinate and collaborate with UNHCR to provide protection and assistance for Persons of Concern, but who do not get funding through UNHCR.

Information Management

A weakness of the Uganda operation was the lack of an **Information Management** (IM) officer until April 2015 in spite of the provision in the Emergency Preparedness Guidance Note that "IM specialists will be deployed at the onset of an emergency operation to support the response"[30]. Although, as mentioned above, UNHCR Uganda produced regular and high quality general information products such as updates, factsheets and 3Ws matrixes, little or no sector-technical and indicator information was regularly produced and put in the public portal such as demographic and statistical information, and sectorial indicators analysis. Finally there was limited use of GIS, which could have greatly enhanced planning and coordination of the response, considering that the refugee population was relatively dispersed compared to a typical refugee camp. UNHCR Uganda were aware of the usefulness of GIS but were unable to recruit someone with this skill set.

Information was shared via the coordination meetings at both the Adjumani and Kampala level with an overview included current status, indicators and priority areas. At the capital level some key informants interviewed however stated that UNHCR did not share information very willingly or timely. This could be partially attributed to the fact that UNHCR did not have a dedicated information management officer for this emergency response and therefore sharing of information outside of UNHCR was not a systematic as it could have been. For example the UNHCR web portal that was set up for the regional South Sudan response remained essentially unpopulated even though relevant information was being produced.

Human Resource Management

In the initial weeks of the response the capacity of existing UNHCR staff and partners to respond was overwhelmed and there were almost no partners on the ground in the West Nile region. At the request of the UNHCR Uganda Representative Deputy Representative, the **UNHCR Regional Support Hub (RSH)** undertook a multi-sectorial mission to Uganda from the 12-24 January 2014.[31] During the mission RSH staff was able to effectively support the UNHCR emergency response, taking leadership in coordination of activities, and providing overall strategic planning and leadership for development of the Transit Centres and Settlement sites. The evaluation team noted from a wide range of key informants that this strategic use of support mechanisms was crucial in the provision of a timely and coordinated response and laid a solid foundation for continued response.

Human resource requirements were quickly scaled up through the use of different staffing tools for emergencies, such as short-term mission, redeployments, emergency deployments and fast track recruitment for relevant and appropriate areas. The very first line of response in terms of staffing was a temporary redeployment of UNHCR staff involved in the "maturing" D.R. Congo emergency, such as an Associate WASH Officer. UNHCR Uganda was initially overwhelmed, but the senior management reacted quickly making an optimal use of the various available emergency staff deployment schemes, including emergency team, deployees from stand-by arrangements with partners and technical specialists from the Nairobi RSH. By the end of January 2014, a total of 20 staff members were deployed, including an Emergency Coordinator, and various Protection, Programme, Registration, Administration, WASH, Public Health and Site Planning officers.

---

[30] "The Guidance Note on Information Management in Emergencies", IOM-FOM 34/35/2012.

[31] UNHCR Joint Mission by the RSH to Uganda 12-24 January 2014, WASH: Murray Burt, Protection: Irina Conovelli, Public Health Khamis Khamis, Registration Allison and Justin.

UNHCR Uganda then applied for 13 Fast Track positions with a closing date of March 2014, and 5 by end-July, including an Administration and Finance Officer post[32]. It did also apply for a P2 Associate Information Management Officer but one was only approved in December[33] and eventually arrived only in April 2015. No Senior Protection Officer post was included in the Fast Track. In 2014, UNHCRs protection portfolio for all operations in Uganda was managed by an Assistant Representative for Protection but no dedicated Senior Protection Officer was leading the South Sudan response. On a whole there was high staff turn-over and a great reliance on affiliate workforce for protection and sectorial response (education, nutrition, etc.).

The UNHCR staffing of the health response was of good quality but suffered from high turnover at the field level. Key informants indicated however that this did not significantly affect the overall coordination of the health response perhaps due to the fact that the quality of UNHCR health staff was perceived to be high and there was a competent nutritionist who covered the health gaps when needed. The support from the UNHCR RSH and the ERT covered human resources for the nutrition response. A deployee from affiliate partner, Danish Refugee Committee (DRC), joined the nutrition response in Adjumani within the first quarter. This high quality support was maintained throughout 2014 and there were no nutrition human resource gaps for UNHCR during the response. Protection staff members were rapidly deployed to Adjumani and Kiryandongo as emergency deployments, including staff evacuated from South Sudan, but no senior protection officer was included in the Fast Track to lead the overall protection response. Sub-areas for protection were largely delivered by affiliated workforce who were also doing sectorial coordination in their respective sub-areas. While education capacities were available in the first few months of the response, the education response was marked by **limited UNHCR education capacities**. UNHCR had a dedicated national education officer in the first few months of the emergency but no education staffing was requested for deployment or as part of the fast track staffing requests.

Programme Management

Out of the total requirement (for all agencies) of USD 224.3 million in the Revised 2014 RRP for Uganda, of which USD 123.1 million for UNHCR, USD 107 million was funded in total (48%), out of which USD 53.9 million for UNHCR (44%). As hinted above, the budgeted cost per refugee in Uganda was almost twice as high than the one in Ethiopia and the funding actually received between 20% and 30% more in Uganda than Ethiopia. This higher cost is normally justified by the need to systematically incorporate 30% of local host community beneficiaries in view of the generous Ugandan Government out of camp policy and free access to services, but in the documentation we could only find this provision in the WASH budget[34].

While most Implementing Partners (IPs) received their first instalments in January, the funds were not sufficient and therefore many had to complement using other funding. UNHCR Uganda tried to accelerate funding where possible, for example by allowing a partner to use funding for another population group for the new influx of South Sudanese. A number of partners had huge construction budgets that they struggled to spend within 2014. A no cost extensions until March 2015 was agreed by HQs Geneva, but only in January 2015, which caused a lot of stress among UNHCR and IPs Sites and construction designs and budgets had to be approved by the District Government, which also added to the time required.

We should also note that the funding did not come in one go, but in as many as 11 subsequent instalments, the first of which was actually transferred to the Uganda operation on 8 January 2014 (by USD 2.7 million) and the last on 17 October 2014 (by USD 9.4 million).

---

[32] But in practice acting as Human Resources Officer, a low-visibility, but crucial and often forgotten post in emergencies in which dozens or more staff on short-term secondments, deployees, etc., have to be managed.

[33] According to interviews there were differences between Geneva and Kampala about the suitability of candidates.

[34] WASH Strategy and Standards, UNHCR Kampala of 6/3/2014

Each instalment represented additional donor funding and required the submission of a budget increase request from the Africa Bureau to the Budget Committee. The time interval between the submission for budget increases by the Africa Bureau (with the knowledge of the arrival of fresh funds) and the decisions by the Budget Committee was relatively short - less than one week on average - but many key actors (including senior managers) stated that the process is cumbersome and requires many documents. By the end of the year, and after the 11 budget increases, the total UNHCR budget (authorized expenditure level) amounted to USD 48.5 million for the response to the South Sudanese emergency to cover some 136,000 South Sudanese refugees which results in and average of USD 355 per refugee. But the amount is twice as much if we take into account the funds of other agencies not channelled through UNHCR. The expenditure rate was 92%.

This piecemeal incremental approach, dictated by intermittent funding, had two consequences. First, in many cases, International NGOs said that Implementing Partners (IPs) had to pre-finance their first emergency interventions at least until April 2014, when funds from UNHCR started trickling in, and Operational Partners (OPs) who do not receive UNHCR funds, such as MSF, were crucial for life-saving activities at the very beginning of the emergencies. Second, the 11 budget increases implied constant revisions of Project Partnership Agreement at times involving hundreds of budget lines and dozens of objectives. This process is therefore very time-consuming both for UNHCR and IP programme staff, to the detriment of other activities such as visiting the field, interacting with refugees and coordination.

In terms of sector budgets, the lion's share (57%) understandably went to "basic needs and essential services" and in particular to shelter, education, public health, WASH and domestic items. The second was "logistics and operational support" (20%), followed by "security from violence and exploitation" (11.5%, particularly SGBV mitigation and crime prevention), and only 4.8% to "favourable protection environment" and "fair protection processes and documentation" combined and 6.2% to "community empowerment and self-reliance" (including natural resources and peaceful coexistence)[35].

The following table gives an overview of UNHCR Uganda's authorized budget and expenditure for South Sudanese refugees in 2014 by "Rights Groups", while more detail at the level of "objectives" [36] can be found in Annex 2.

[35] Source: MSRP, accessed on 01/09/2015

[36] In UNHCR's Results Framework (RF), Rights Groups are groups of sectoral objectives framed in human rights language. Objectives are one step below in the RF and one step higher than "outputs".

Table 3: Authorized expenditure level and actual expenditure for South Sudanese refugees in Uganda in 2014 by Rights Groups

RIGHTS GROUPS	2014 Authorized Expenditure Level	% Against Total A.E.L.	2014 Actual Expenditures	% Against Total Actual Exp.
Favourable Protection Environment	658,437	1.28	357,071	0.75
Fair Protection Processes and Documentation	1,790,610	3.49	2,131,339	4.49
Security from Violence and Exploitation	5,930,054	11.55	4,275,693	9.01
Basic Needs and Essential Services	28,999,022	56.49	28,568,148	60.20
Community Empowerment and Self-Reliance	3,464,236	6.75	2,985,409	6.29
Durable Solutions	23,287	0.05	18,221	0.04
Leadership, Coordination and Partnerships	220,194	0.43	171,213	0.36
Logistics and Operations Support	10,246,191	19.96	8,950,999	18.86
GRAND TOTAL UGANDA	**51,332,031**	**100.00**	**47,458,093**	**100.00**

Source: MSRP accessed on 01/09/2015

1. Protection

The response was based on a number of multi-sectorial assessments, **but no protection specific needs assessments had taken place.** Protection considerations were integrated in the multi-sectoral assessment but did not specifically assess protection risks and needs specific to different age, gender and diversity groups. Protection priorities were based on interventions outlined in the refugee response plans. A **protection strategy matrix** was developed for Adjumani early on outlining priority interventions for protection but did not include a protection framework for the emergency response including across sectors. The matrix was not widely known or used by partners in Adjumani, partly also because of high staff turnover among partner and UNHCR staff, but served as a roadmap for protection interventions for the UNHCR office. It was found that the **geographic location** of the settlement sites led to some degree of uneven coverage by protection partners: while Adjumani had received the largest number of refugees, it was also more accessible than Arua, resulting in more partners and services being present in Adjumani. Kiryandongo was facing an overall lack of partners in the first few months and partner capacities on protection was low. Protection services for refugees in urban areas were very minimal in Kampala, reflecting an uneven coverage between settlements and urban settings. In Adjumani and Arua UNHCR opted to contract partners for a range of sectors for a specific geographic area, but some of these partner organisations lacked protection expertise and experience. UNHCRs **financial resources** for protection remained at 16.3% of UNHCRs South Sudan emergency budget at the end of 2014, with SGBV prevention and response being allocated 2.8 million USD.

Overall protection coordination has largely created synergies and avoided some gaps especially at Kampala, Kiryandongo and Adjumani level while coordination on case management for child protection and SGBV remained weak at the field level.
There were protection working group meetings at field level which took place regularly, were well attended and documented and protection task forces at village/settlement level in some

locations. At Kampala level, protection coordination was integrated into the overall response coordination meetings. No 3W matrix that could have supported coordination was established for protection. Some partners expressed that stronger coordination on gap areas would have been necessary, especially in a context where partners came with their own resources. Key informants found coordination between field and Kampala level mechanisms insufficient due to different levels of delegated authority to the field level by different partner agencies: agreements reached at the Adjumani level were not always in line with policies issued by respective agencies in Kampala, resulting in reversal of decisions and delays**.** According to key informants, coordination on child protection between UNHCR and UNICEF was functional but marked by policy differences and lack of a partnership spirit.

Collaboration with the Government of Uganda (OPM, District Government) was effective and facilitated synergies, especially with policies and processes relating to inclusion of local population and peaceful co-existence. Minutes of coordination meetings noted that there was fragmented service delivery partially due to partners coming in with their own money at the district level with predefined areas of intervention and with little interest to cooperation and coordinate, including with OPM and the district level.

Information management remained a gap area in 2014 and limited systematic data and information on protection is therefore available. Even though the operation did not have a senior registration officer and registration was supported from the regional hub in Nairobi, the operation regularly shared population statistics on refugees. Data on key indicators for protection and sub-sectors for protection was not collected sufficiently and shared. At the level of sub-sectors of protection, the lack of information management impacted on the quality of coordination.

Protection mainstreaming, accountability and community mobilization

The response did not establish a response wide framework for protection across sectors. **Protection considerations were generally integrated into the response but weaker in some sectors such as site planning, shelter and food.** The design and implementation of sectoral interventions partly integrated protection considerations, but also led to some gaps and protection risks. Site planning included key protection infrastructure (although child friendly spaces were included late which compromised quality and standards), while the overall grid lay out of the settlement did not favour community building. Locations of primary schools remained largely within acceptable walking distance (5 km). Gender considerations were reflected in water and sanitation planning (for example separate latrines in schools and reception centres) and provisions were made for people with specific needs. For shelter, the programming approach foresaw self-collection of most material and self- construction of all shelter, including household latrines, aiming at refugee participation with the exception of persons registered with specific needs. However, this approach had not fully taken into account that the majority of refugees were women and children that partly required additional support such as child care during material collection and construction. Self-collection of material was also reported to expose refugees to protection risks and as a potential for conflict with local communities in an increasingly fragile situation of environmental degradation. During the general food distribution women, children and the elderly had to walk long distances carrying a heavy load as there was only one food distribution point in the settlement. No household energy was provided which required refugees to search for firewood and thereby exposing themselves to protection risk and conflicts with the local communities. Child-and youth friendly adaptation of processes and procedures was a gap specifically identified in the Child Protection Framework Review.

Accountability to affected populations. By and large, different groups within the refugee community participated in, and had access to, protection and assistance programmes. Respondents to the evaluation survey respondents stated that diversity aspects did not receive sufficient attention during the response and that the concerns of older people were not specifically considered.

Registration data was used to identify specific needs of individuals and a large scale participatory assessment was undertaken at the end of 2014. No information was available on how partner staff implemented an **age and gender diversity (AGD) approach**. Selected

examples – such as the decision to use self-constructed shelters when the majority of refugees were women and children – suggest that AGD dimensions were not always incorporated.

UNHCR together with partners conducted a large-scale participatory assessment within the first year of the response, which identified priorities of different groups within the refugee population (women, men, youth), **a commendable exercise early on in the response.** UNHCR also undertook a PSN inter-agency assessment exercise during the first six months which resulted in the profiling of specific needs. In addition, UNHCR and partners interacted regularly with a wide range of refugees, including through participatory assessments, and 70% of survey respondents who were engaged in implementing the response found that 'participation of people of concern was systematically ensured during planning, implementation and monitoring'. At the same time, the evaluation could not find evidence that **systematic formal feedback and complaints mechanisms** were set up. Refugee communities did not sufficiently and systematically receive reports back after assessments or discussions with UNHCR, partners or visitors coordinated by UNHCR. Data collected for this evaluation indicated that refugees were not systematically asked to provide feedback on UNHCR and partner activities. Focus group discussions with refugees indicated that they did not know where to lodge complaints. In Arua, no viable feedback mechanisms were set up to enable the host population to complain or provide feedback – something that might have positively contributed to mediation efforts in the ongoing tensions between refugees and host communities. The evaluation concluded that while UNHCR facilitated participation of people in planning, refugees were not sufficiently included in monitoring and evaluation of the response.

The response was underpinned by a myriad of community-based protection mechanisms that were established early on in the response. While no response-wide **community mobilization or community based protection** strategy was explicitly developed, community mobilisation was part of UNHCRs protection and assistance response: a range of community structures and mechanisms for outreach, support and services (committees, outreach workers, volunteers etc.) were set up in almost all sectors across the response with little coordination among these structures. In the area of protection, several community groups were formed including child protection committees, community support groups, community watch groups, and youth groups. These groups worked alongside community volunteers and outreach workers who mostly received some form of remuneration. Evidence suggests that the community structures set up for protection were only partly functioning for several reasons, including because their set up was not based on ananalysis and mapping of existing community structures, power dynamics and because a diverging remuneration schemes was adopted by organisations: different partners paid different incentives for the same or similar functions, which not only created tensions but also undermined the community structures. While the community support group functioned well as a mutual support mechanism where refugees with psycho-social issues could turn to, the child protection committees and community watch groups lacked motivation and were found to be only partially effective in fulfilling their function.

Access to asylum, registration and documentation

Uganda's **protection environment** was very favourable for receiving refugees from South Sudan: refugees arrived from South Sudan were given unhindered access to Ugandan territory and granted prima facie refugee status. No cases of *refoulement* were reported and borders between Uganda and South Sudan remained continuously open, allowing all refugees to access Ugandan territory, asylum and protection. The South Sudanese refugees entering Uganda were mainly members of the ethnic group Dinka who are associated with the south Sudanese government and military[37].

[37] Not all Dinka are politically aligned with the government of South Sudan, but the majority are.

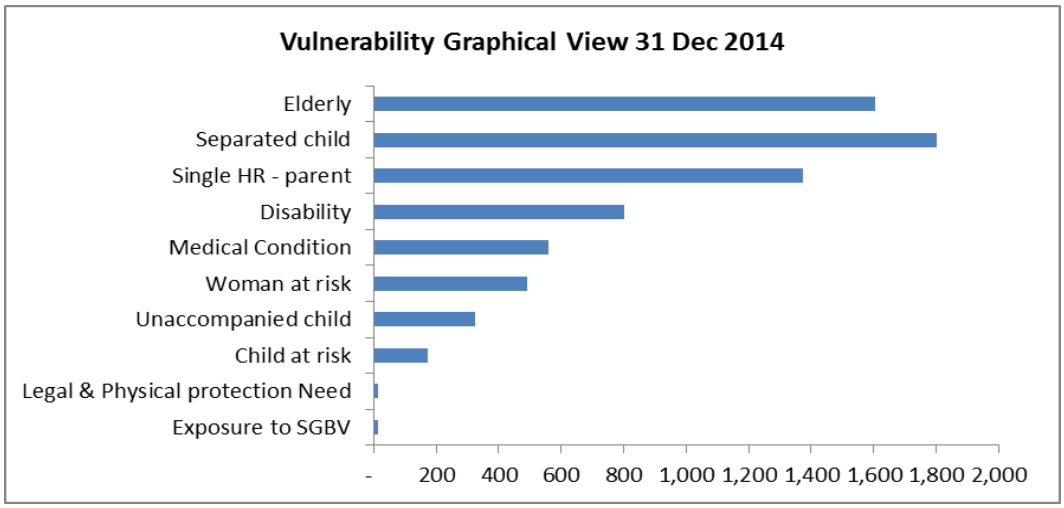
Uganda's refugee policy favours a non-camp setting and the national legal frameworks grant refugees the right to work, access to national services such as health, education and freedom of movement. The freedom of movement policy enabled refugees to decide whether to reside in one of the three settlements in the North of Uganda or to move to urban areas such as Kampala. The 129,470 refugees settled in four main locations: Adjumani, Arua, Kiryandongo (northern part of Uganda) and urban centres, mainly Kampala.

UNHCRs registration response was based on a population flow analysis and clear objectives defined in a registration strategy. South Sudanese crossed Uganda through two main entry points (Elegu in the North and Oraba in the North-West) with the majority of refugees relocated to the transit center in Dzaipi and, later on,to the transit center in Nyumanzi before being relocated to land plots at the settlement site. Arrival numbers peaked in January and March 2014 (see Figure 1 in previous section) leading to overcrowded and overstretched reception and transit centres. UNHCRs registration priority in the first three months was to decongest reception and transit centres by enabling rapid registration, relocation and settlement. Upon arrival in Uganda, the Government of Uganda registered refugees at household level (level 1) with UNHCRsupport at entrypoints, where people with specific needs were also identified and referred. Unaccompanied and separated children were received by a specific protection desk at reception and transit points. After relocation to a settlement, the Government and UNHCR registered refugees individually through biometrics (level 2 registration) in ProGres and verification was conducted weekly. In 2015, UNHCR has handed over registration to the Government of Uganda. The evaluation found that **efficient and timely registration procedures were set up** for refugees at appropriate locations in reception points and transit centres and registered 100% of refugees with level 2 registration in 2014.

While reception centres were overcrowded in the first few months, the UNHCR led response achieved high standard **reception conditions** both at the border points as well as the transit centres in the settlements, in part due to the timely and quality cooperation with different parts of the Government of Uganda. At the beginning of 2015, entry points and transit centres corresponded largely to standards in reception conditions.

In the initial response UNHCR encountered challenges in adequately capturing **specific needs** categories of refugees and in consistently providing ration cards to all refugees. UNHCR rectified the collection of specific needs data and the ration card distribution within the first few months. The registration process subsequently functioned as an effective step in setting up a protection pathway through identifying persons with specific needs and initiating case referrals. 26 vulnerabilities were used to categorize persons with short-term or long-term vulnerabilities based on a UNHCRs specific needs code list. While the response was later on effective in identifying diverse vulnerabilities, it was not clear how partners further assessed vulnerabilities, prioritized and decided on the type of assistance per category. The evaluation team also found that refugees frequently used the "PSN" to describe a special status among the refugee community rather than in line with UNHCRs intention to ensure targeted assistance.

Figure 2: Vulnerability characterization of South Sudanese refugees in 2014



Source: UNHCR Uganda

The **civilian character** of asylum was maintained during the refugee response. The Government of Uganda screened refugees entering the country and did not permit people in uniforms or any military equipment (arms, uniforms) being brought into the country, in an effort to ensure the civilian character of refugee status. Although no detailed information on how the Exclusion Clauses of Article 1F of the 1951 Convention[38] were applied and ensured, the registration data from 2014 indicates that UNHCR captured information on former soldiers and combatants at registration and registered these as asylum-seekers (about 400 in 2014). Their refugee status will need to be determined by an individual refugee status determination process. Refugees with specific protection needs relating to political or military affiliations were relocated in one camp with special security precautions. Key informants, including refugees, highlighted that male family members regularly crossed the border into Uganda as civilians to take rest and recuperation with their families in the settlements before returning to South Sudan to continue fighting. Since these soldiers did not seek refugee status in Uganda and since they crossed the border as civilians, this practice did not strictly speaking compromise the civilian character of asylum. At the same time and at a philosophical level, the fact that the refugee settlements functioned as safe havens for the families of soldiers and as areas for rest and recuperation of soldiers did raise the abstract question on whether the refugee settlements played some role in enabling the continuous fighting in South Sudan. UNHCR was conducting regular border monitoring but no reports were available.

Even though Uganda's refugee act foresees individual documentation for all refugees, **individual documentation** for refugees from South Sudan, including birth, marriage, divorce and death certificates remained a gap area in 2014[39]. Key informants highlighted that this gap did not seem to have affected the access to services in the short term, especially in the settlements. However, experience demonstrates that the lack of ID cards and other documentation can negatively affect the protection status of refugees in the medium and long term. In lieu of individual documents, refugees received a household attestation of registration, which enables refugees to access education, health and other services. Officially, refugees have to obtain travel authorization for travel inside Adjumani District, however, that does not seem to be strictly enforced[40].

Security from Violence, abuse and neglect

The refugees settled in four main locations: Adjumani, Arua, Kiryandongo and urban areas (mainly Kampala). Ensuring the **security** of the refugees is the responsibility of the Government of Uganda. To increase security, police (male and female) were stationed in and around the settlements and received some training on protection issues. UNHCR has promoted community-based watch groups in the settlements consisting both of men and women; the evaluation found that these structures were weak and members not motivated to work without additional equipment or remuneration. While no large-scale security problems were reported, several refugees mentioned security incidents in one settlement and their perception that the police were not effective in acting quickly or following up on security incidents.

The security situation of refugees was also affected by the ethnic identities of refugees and to some extent the political/military affiliations of refugees. Approximately half of the refugees arriving in 2014 were Dinka while about one-fifth were Nuer. While the Government of

[38] UNHCR Guidelines on the Application in Mass Influx Situations of the Exclusion Clauses of Article 1F of the 1951 Convention relating to the Status of Refugees, 2006

[39] Refugees need to pay for obtaining marriage and divorce certificates. While no birth certificates are provided, children can receive birth notifications.

[40] UNHCR in Uganda is waiting with the issuance of ID cards until after the verification of South Sudanese refugees in order to ensure that ID cards are issued for the right number of people. However, the verification is likely to be delayed due to the handing over of registration to the Government of Uganda.

Uganda promoted settlements to be ethnically heterogeneous, many refugees preferred to reside in ethnically homogenous settlements or urban settings. In the case of the refugees from the Nuer ethnic group, this preference was based on their perceived fear and lack of security in some settlements[41]. Overall, focus group discussions with refugees in the different locations have highlighted a much higher feeling of insecurity of ethnically Nuer refugees both in Kiryandongo and Kampala. Anecdotal reports of burglaries, attacks, refugees being taken away by night and attempted killings have led to a feeling of insecurity, especially among women in Kiryandongo, while the perception of insecurity among Nuer refugees in Kampala is mainly based on fear of being followed and taken away by South Sudan military. The Evaluation could not find concrete evidence to back up these reports. Refugees politically not associated with the South Sudan government questioned the neutrality of the Ugandan Government in providing asylum.

Peaceful co-existence among refugee communities in settlements as well as between refugees and host communities remained problematic throughout 2014 despite efforts and mechanisms set up to strengthen dialogue and alternative conflict resolution methods. Conflicts and problems between refugees and local communities on land allocation, use of environmental resources for construction of shelter and firewood and competition over resources were continuously reported in 2014.

UNHCR established **SGBV prevention and response** as part of its emergency response based on multi-sectoral assessments that were undertaken early in the response and identified specific SGBV risks and possible actions. In line with UNHCR's approach on SGBV prevention and response, SGBV programming focused on SGBV response services covering the four key response services (medical, legal, psycho-social and safety and security) as well as referral mechanisms, awareness raising and sensitization campaigns. Response services were established after a few months of the emergency and accompanied by large-scale information campaigns on referral pathways and awareness-raising on SGBV (billboards, radio messaging, hotlines). The **response services** were found to be comprehensive as they covered the full range of services early on. In the case of safe houses for SGBV survivors, this was identified as a gap and interim measures were taken (use of Dzaipi reception centre) while a safe house was being built.

Studies and research on SGBV incidents among South Sudanese refugees in 2014 indicate a **high SGBV prevalence and high underreporting**. A 2014 LWF prevalence study indicated a 47% prevalence rate among South Sudan refugees in Uganda and the draft report of a population-based child protection research conducted by the Columbia Group[42] highlights that two third of the adolescents that had been physically forced to have sex, did not tell anyone about it, indicating that reported SGBV numbers in the GBV-IMS are far from showing prevalence. Key informants repeatedly highlighted the South Sudanese cultural context which contributing to the underreporting of SGBV incidents. While large scale sensitisation and information campaigns on were carried out, changes in behaviour, including on reporting, take time. As a result of this as well as insufficient community based mechanisms and coordination among partners (please see below) SGBV response **services remained underutilized** except for psycho-social services, for which demands were higher than available services. For example, in the area of medical treatment of rape, health facilities have been equipped but are less frequented than expected. In the area of legal services, there remained a lack of clarity on legal representation and processes for testifying in court demand a medical report by a qualified doctor which local doctors or nurses were often unwilling to provide.

[41] At the end of 2014, only 0.4% of the 20.8 percent of Nuer refugees arriving in Uganda resided in a settlement. Dinka refugees who constitute 90% of refugees in Adjumani, were much less represented in Arua and Kiryandongo (43.9 and 56% respectively). Source: UNHCR registration data

[42] Meyer, Steinhaus, Stark: Draft report: Measuring impact through a child protection index. Report of Uganda baseline study. Kiryandongo and Adjumani refugee settlements. Research undertaken in December 2014/January 2015.

Early in the response UNHCR set up a **Gender-Based Violence Information Management System (GBV-IMS)** which was a strategic measure to collect data and trends on reported SGBV incidents for programming and advocacy. Based on the GBV-IMS, 311 SGBV incidents were reported among South Sudanese, with 12% male and 88% female survivors (see Table 5 for a breakdown by type of incident per location).

Table 4: SGBV incidents in Adjumani, Kiryandongo (March-Dec 2014 and Arua Jan-Oct 2014)

SGBV Incidents	*Kiryandongo*	*Adjumani*	*Arua*	*Total*
Rape	11	7	6	24
Sexual Assault	3	10	2	19
Physical Assault	21	73	7	96
Forced Marriage	0	15		15
Denial of resources	5	31		36
Emotional Abuse	3	118		121
Total	**43**	**258**	**15**	**312**

Source: compiled from GBV-IMS Annual Statistics Report, UNHCR Uganda

The evaluation found that the response did not sufficiently built **capacities on SGBV** among partners, leading to weak case management and slow GBV-IMS data availability. Most partners did not bring strong SGBV expertise and only a small number of partner staff were reportedly trained on SGBV issues. High turnover among partner staff also led to a capacity loss and required constant retraining. SGBV training was also provided to police, teachers and health workers, but no data is available on their capacities. SGBV referral pathways were put in place early on and in consultation with partners and Standard Operating Procedures were drafted in all locations with partners. At the same time, these referral pathways were not necessarily known to the community and new partner staff, and coordination and information sharing among partners on individual cases remained a challenge. No information sharing protocol was agreed upon. As a result**, individual case management** remained less efficient than expected given the efforts made in coordination, referral systems and services.

Specific **SGBV prevention mechanisms** remained minimal despite the fact that some sectorial planning incorporated general safety and security concerns into their designs. Solar lamps established in settlements to light public places during the nights were perceived as having increased security; however, the management of these lamps did not seem adequate and processes following stolen lamps in Kiryandongo appeared lengthy. Although the pattern of reporting suggests a strong role of the community in SGBV (163 out of 180 SGBV cases were reported through community structures and leaders), key informants found that the community based mechanisms established relating to SGBV (community watch groups, child protection committees) have remained weak due to low motivation and inconsistent incentive policies by different organizations in the response. Community engagement in community watch groups was limited and the majority of members were not active in Adjumani (engagement in Kiryandongo and Arua was reported as slightly higher). In 2015, the SGBV response has been strengthened through a senior SGBV deployment under the US funded "Safe from the Start' project.

Coordination on SGBV was done through a specific working group in Kiryandongo and as part of other protection related mechanisms in Arua and Adjumani. A SGBV specific coordination mechanism was established in August 2014 in Adjumani. SGBV response services were established within the first four months of the response and were a critical and timely part of UNHCRs emergency response. UNHCRs implementation approach for some protection areas including SGBV – one partner for one geographic zone covering a range of different protection areas – required additional coordination among partners and contributed to a weak harmonization of SGBV approaches and low quality of SGBV services due to the lack of specific SGBV expertise of partners.

With children constituting 66% of refugees from South Sudan, UNHCR prioritized **child protection** through the development of a regional child protection framework based on data

and information available from multi-sectorial assessments that included protection. The regional child protection framework defined five regional objectives (registration, child friendly procedures, protection from violence, children with specific needs, and education). The child protection response covered the individual registration of all children, identification of children with specific needs, particularly unaccompanied and separated children at registration in the reception and transit centres, referral and follow up, case management, training of staff and partners, family tracing and reunification and the set-up of community based child protection systems, child friendly procedures as well as child friendly spaces across the settlements.

The child protection response included more than 13 partners and **coordination mechanisms** under the leadership of UNHCR and the Government of Uganda were established in all locations with regular meetings taking place. The majority of the partners valued the coordination mechanisms but highlighted duplication and gaps in child protection programming. Overlapping plans and project, lack of information sharing and a lack of standardized tools and processes were mentioned in particular.

The response achieved to **register all children** on an individual basis. Documentation of children was provided as part of proof of registration at household level. *Birth registration* for all refugee children born in Uganda was a challenge, although the review of the regional Child Protection Framework states that progress has been made especially in Adjumani, with 1,578 children receiving birth notifications (not certificates). No reports were available on whether the lack of identity cards affected children's ability in accessing national services such as health and education, especially in urban settings.

Unaccompanied and separated children constituted the larger part of children with specific needs and at risk. At the end of 2014, the total number of south Sudanese refugee children in Uganda was 106 000 with unaccompanied and separated children constituting 3% (3180) [43].

Table 5: Children at risk/with vulnerabilities

Vulnerability category	Adjumani	Arua	Kiryandongo	Total per category
Child at risk	80	71	11	162
Unaccompanied Child	270	130	28	428
Separated Child (SC)	866	800	1507	3173
Total	**1216**	**1001**	**1546**	**3763**

Source: UNHCR October 2014, utilized by ECHO mission report[44]

As part of registration, UASC were identified at entry points, transit centres and in settlements and referred to services and follow up. Child protection desks at registration were staffed by different child protection partners who were responsible for referral mechanisms. The evaluation found that the overall **identification of unaccompanied and separated children** (UASC) at the point of registration worked well in 2014 after some initial coordination challenges in the first few months of the emergency. Key informants agreed that the child protection referral mechanisms were not clear for partners and SOPs for child protection took a long time to be developed. The 3 different partners involved in registration of UASC (LWF/UNHCR, UNICEF/Save the Children and ICRC/Ugandan Red Cross) used different lists, templates, tools[45] and definitions of UASC and UAM and only shared data on a very limited scale. The Regional Child Protection Framework review for Uganda concluded that "*in some locations, child protection actors in the field had overlapping projects and plans and*

[43] Review of Regional South Sudan Child Protection Framework

[44] Note: the numbers need to be cross-checked, as there are discrepancies. Registration info from Kampala requested.

[45] UNICEF used the Mobile FTR to track separated children while ICRC/UGR only captured data required for restoring family links but not for any other child protection service.

sometimes confusion around roles and responsibilities"[46]. As a result, the **child protection case management system** was not fully harmonized among actors and no data sharing protocol was established, leading to gaps and duplication in handling child cases.

The best interest procedure, which should be the cornerstone of case management systems for child protection in refugee settings, was seen as a UNHCR only process rather than integrated into the processes of other agencies working on case management. UNHCR would not necessarily know who had what data on children during the response and in handling child cases partner agencies interviewed the same children several times because of a lack of coordination. The total number of social workers remained low (1 social worker for 2159 children). Best interest assessment and determinations were conducted by partners with varying quality and methodologies and a backlog of Best Interest Determination (BID) cases still exists.

The full identification of **children at risk,** especially identification of vulnerable children other than UASC such as children with disabilities, married children and survivors of SGBV remained challenging together with the regular updating of information on specific needs[47]. At the same time, services and integration of children with disabilities into existing services (schools, child friendly spaces) remained insufficient and UNHCRs education approach to bring children with disabilities into boarding schools outside the settlements was not widely supported.

In finding solutions for UASC, UNHCR and partners established **foster care arrangements,** which were successful. 98% of registered UASC were in \interim or long-term alternative care (compared to 37% in Ethiopia[48]) but did not necessarily receive appropriate support, monitoring and follow up. Child protection committees and peer-to-peer support groups were set up to strengthen the community-based approach to child protection. While the evaluation found that the child protection committees were not fully functional due to lack of motivation, the regional child protection framework reviews rates the peer-to-peer support groups as a best practice.[49]

Family tracing and reunification was a controversial and time consuming issue among child protection partners in 2014 because of different roles, interests and understanding of what should or should not be done. Even though the number of unaccompanied and separated children among the refugees was high, the overall tracing and reunification needs of UASC remained limited because the large majority of UASC had been sent to Uganda by their parents for reasons of education and safety. Reunification was therefore often not possible or desired, even though family tracing had been successful.

The **child friendly spaces** set up by UNHCR's operational partners were a critical component in offering children a safe place to play and receive some psycho-social support. Child friendly spaces were set up in both transit centres and settlements. Many of them served as locations for early childhood education centres in the morning (children aged 3-5) and as places to play or undertake organised social activities in the afternoon. The child friendly spaces visited in Adjumani were large places with both indoor and outdoor facilities and a range of material for children at different age groups. 16 % of children were reportedly accessing child-friendly spaces, making this a low coverage.

---

[46] Review of the Regional Framework for the Protection of South Sudanese and Sudanese Refugee Children in Uganda, 2015, page 2

[47] "Review of regional child protection framework for Uganda". Nevertheless 17 children with special education needs were supported in Gulu.

[48] Regional Child Protection Framework review, August 2015

[49] In Kiryandongo these groups of very active and well-trained children impressed reviewers with their knowledge of child protection issues and referral mechanisms. They identify children who need support, listen to their concerns, and refer them if necessary. Source: Child protection regional framework review for Uganda.

To support community based protection for children, the response set up child protection committees with a large coverage. The evaluation found that these **community-based structures** set up in the last quarter of 2014 were not fully functional and child protection committees lacked motivation[50]. As an example, one responsibility of child protection committees was sensitisation and awareness-raising on how to report abuse and violations. A recent study came to the conclusion that at the end of 2014, 88.5% of caregivers in Adjumani who did not report abuse or violence didn't know where or to whom to report.

Although some initial contacts were made, linkages with the national child protection are an area where more integrated thinking could have benefit the wider strategy if integrating refugees into national services.

Summary Protection

Considering Uganda's extraordinarily favourable protection environment, the protection response enabled refugees to access territory and protection while principally maintaining the civilian character of asylum. Although no overall protection framework was established for the response, sectoral responses partly integrated protection considerations. Accountability to affected population was initiated but not fully established yet. Community based mechanisms were not fully effective at the end of the year. Registration was effectively conducted for 100% of refugees on an individual basis under continuously improving reception conditions and provided a pathway for identifying people with specific needs. Perceptions of security varied among different groups of refugees and linked back to their political affiliations in South Sudan. Co-habitation between refugees and Ugandan local population was marked by tensions that reduced over time through Government, UNHCR and other inputs but did not fully disappear within the first year. Timely sexual and gender based violence response services were set up but remained underutilized and case management systems, including information sharing protocols insufficient. The set-up of a GBV-IMS was a strategic step that is expected to improve SGBV programming in the medium term. The prioritisation of child protection resulted in full registration of all children, identification of unaccompanied and separated children, strengthened child protection services and structure but also in some duplication and overlaps in case management systems due to lack of harmonised systems and tools.

Table 6: Overview of key protection indicators, January – December 2014

Key protection indicators	January	March	June	December	Standard
Access to Asylum					
# of known cases of *refoulement*	0	0	0	0	0
% of persons of concern registered				100%	100%
Civilian character of asylum maintained	Yes	Yes	Yes	Yes	Yes
Extent reception conditions meet minimum standards	Low	Medium	Medium	High	High (100%)
Security from violence, abuse and neglect					
# of police in camps	n/a	n/a	76	91	n/a
# of UASC	n/a	n/a	n/a	3,180	n/a
% of UASC for whom a best interest process has been initiated or completed	n/a	n/a	n/a	98%	100%
Ratio Child/social worker	n.a	n/a	n/a	2159:1	n/a
# of BIAs conducted	n/a	n/a	n.a	2761	n/a

[50] This finding was confirmed in the recent CP index study, CPC network.

# of children attending child friendly spaces	0	n/a	n/a	16%	n/a
% of children with specific needs receiving appropriate services	n/a	n/a	n.a	87%	100%
# of PoC trained on SGBV prevention and response	n/a	n/a	34	468	n/a
# of community-based committees/ groups working on SGBV prevention and response	n/a	n/a	23	42	n/a
# of awareness raising campaigns on SGBV prevention and response conducted	n/a	n/a	n/a	133	n/a

Source: UNHCR Monitoring data, UNHCR Uganda, review of child protection framework

2. Health

The **objectives of the health response were relevant and appropriate** and were informed by the out-of-camp policies of the Uganda government with the focus integrating health services for refugees and the host population. There were both early[51] and continuous interagency health assessments to inform the development of the **Health Strategic Action Plan for the South Sudanese Refugees** that guided the emergency refugee response. Along with consideration of the needs of the population as identified via assessments, this action plan was developed based on UNHCR's Global Strategy for Public Health 2014-2018 as well as the UNHCR Uganda Public Health Strategic Plan 2013-2017. Key informants overwhelmingly indicated that the strategy was developed in a timely and consultative manner taking into account evidence from the needs assessments. The plan took into consideration immediate and mid-term recommended actions. The specific objectives were to:

1) Improve access to quality Primary health care services,
2) Decrease morbidity from communicable diseases,
3) Improve Access to non-communicable diseases Services
4) Improve Maternal and Child Health services
5) EPR, surveillance and HIS are in place and functional.

In addition various **Standard Operating Procedures (SOPs)**, clinical guidelines and TORs were developed to meet the needs to the response, for example for community ambulance referrals from the household to the nearest health centre.

Consistent feedback from key informants confirms that there was **good leadership of health sector and excellent coordination and partnership** with Ugandan Office of the Prime Minister (OPM), District health officers, UN sister agencies and partners. Coordination mechanisms were put into place rapidly and by January 2014 health coordination meetings were taking place in Adjumani, likewise at the national level. A detailed **3W public health response matrix** was utilized both at district and national level detailing thematic areas of intervention, specific areas of intervention and a gap analysis.

With specific reference to predictability of the UNHCR health response, it should be noted that during at least the first quarter of the emergency there was a **high reliance on partners who had their own funding**. This was further confounded by a reported confusion amongst partners on designation of who was to do what where. According to a wide number of key informants, this was linked to the fact that UNHCR was not forthcoming with implementing partner designation so agencies were vying for operational space and UNHCR funding.

[51] For example: Emergency preliminary assessment of Public Health situation of Koboko Refugee Programme 18 December 2013

The health facility utilization rate was low although within the standard. However for a refugee population under stress one would expect the utilization rate to be towards the upper range of the standard. Compared to the baseline value of 2 new visits per refugee per year in 2012[52] the rates for the emergency response were low. **The crude mortality rates remained well below emergency thresholds** and a spike in under 5-year mortality rates in the first weeks of the response was brought down by February 2014 and remained well below emergency thresholds. Coverage of complete antenatal care increased early in the response but remained a challenge, as did postnatal care. This can be partially attributed to the weak community health outreach system (see health provision section). Malaria, respiratory diseases and diarrhoeal diseases were the top causes of morbidity. The majority of respondents on the on-line survey agreed that 'The health intervention outcomes have been adequate and proportional to the response'.

Table 7: Selected health indicators* for the Uganda South Sudanese refugee response, 2014

Indicators	January 2014	June/July 2014	November/ December 2014	Emergency Standard
Outpatient Utilization Rate (new visits/ refugee/year)	2.6	1.3	0.98	1.0 - 4.0
Coverage of complete antenatal care	35%	56%	52%	100%
% Births Attended by Skilled Health Worker	89%	88%	97%	Greater or equal to 90%
Anaemia Prevalence Women 15-49yrs	36.3%**	n/a	38-59%***	n/a
Measles Vaccination Coverage	89%**	89-93%	85-95%***	Greater or equal to 95%
CMR (deaths/1,000/month)	0.25	0.21	0.13	Less than 0.75/1,000/month
U5MR (deaths/1,000/month)	1.8	0.21	0.13	Less than 1.5/1,000/month
Measles Morbidity Cases/1,000/month	111	49	54	n/a
ARI Morbidity (LRTI) Cases/1,000/month	7	2	2	n/a
Diarrheal Disease Cases/1,000/month	18	2	2	n/a

*Data is from HIS unless otherwise specified.
** Food Security and Nutrition Assessment among South Sudanese Refugees; New Caseload. Makere University, UNICEF and UNHCR. March 2014.
*** Food and Nutrition Security Assessment among Refugee Settlements in Uganda, Makere University, UNICEF and UNHCR. January 2015

UNHCR established a **Health Information System** (HIS) and was tracking a wide set of indicators already weeks into the response. There were some constraints faced in terms of collating health information from partners including harmonization of tools and timely reporting. For example MSF-F was not using the HIS format and only shared data fortnightly. Often the data would come late and UNHCR staff had to actively request information. The district health office shared monthly reports and information collected from the district health centres via SMS reporting was difficult to obtain. These issues all contributed to difficulties in presenting comprehensive weekly updates. Additionally at the capital level a number of key

[52] UNHCR Uganda Public Health Strategic Plan 2013-2017

informants interviewed, primarily international NGO partners and UN agencies, expressed that UNHCR did not share information very willingly or timely.

Control of Communicable Diseases

A success of the public health response was the **prevention of disease outbreaks** for example in cholera, measles, meningitis and hepatitis E. An overall **Emergency Preparedness and Response Plan (EPRP)** for disease outbreaks in Adjumani was developed as a multi-partner/multi-sectorial effort between all health partners, District Health Office and WASH partners. It identified an outbreak control team, responsibilities and actions. In addition a specific **cholera contingency plan** was developed in advance of the rainy season when heightened risk was foreseen. A cholera preparedness and response plan was developed in April 2014, in the run-up to the rainy season. This was important condidering that cholera is endemic in Uganda and neighbouring countries. The plan included comprehensive list of activities but had several weaknesses. Firstly, stocks of key materials such as chlorine powder were not in stock at the time the plan was developed and procurement plans were vague. Secondly, detailed planning of activities, such as labour requirements, was not elaborated. Ideally a detailed plan should have been put in place and updated on a regular basis according to the partners and resources available. Finally, coordination between the WASH and health sectors appears to have been weak, with the WASH sector noting, for example, its lack of awareness of the planned location for cholera treatment centres [53]. It can be seen as a success that despite cholera outbreaks in surrounding settlements in West Nile in May 2014 there were never any cases within the new refugee population.

There was systematic **blanket immunization against measles** for children 6 months to 15 years at entry points. Furthermore there was an outbreak of measles in South Sudan and identified cases presented at the transit centre in Arua district. A response plan was immediately activated with **mass measles vaccination campaign** carried out by UNHCR, MSF and the MoH. A serious outbreak was prevented. However disease and epidemic surveillance remained poor throughout 2014 primarily linked back to the deficient community health outreach system. The Expanded Programme on Immunization (EPI) was provided in the health centres and also through outreach activities from the health centres.

In January 2014 there was an outbreak of malaria within the refugee populations coming in to Arua. Considering the emergency situation, limited response capacity at ground level, epidemic supportive factors such as congestion of population in reception centre, not having proper shelters, walk in cases, high mosquito density, UNHCR acted on the outbreak with increased screening and number of health care workers, community awareness and distribution of mosquito nets to vulnerable groups.[54] By February the outbreak was contained however there remained a continued **high disease burden of malaria** in the refugee population, straining the health systems, and is one of the main causes of mortality. The evaluation team found that there was only one initial distribution of mosquito nets upon relocation and no replacement distributions. Furthermore, focus group discussions and interviews revealed that mosquito nets were being used for construction, windows and other purposes (see also under the shelter section). Bednet usage increased from 15% in February to 57% in November[55] but despite that positive trend it still meant that around 50% of the population was without. 'Hang it up' campaigns were limited and the weak community outreach system meant that early community level diagnosis was compromised.

Management of HIV/AIDS and TB was handled well. There was a focus on identifying and continuing treatments for those refugees that had been receiving treatment in South Sudan,

[53] Rainy season preparedness and response action plan for the South Sudanese refugees in Uganda, UNHCR, April 2014.

[54] Detection of Increased Number of Malaria Cases in Ocea Transit Centre, Larukwan Dassanayake, UNHCR. 16 Jan 2014.

[55] Food Security and Nutrition Assessments among the South Sudanese Refugees, March 2014 and January 2015.

as well as screening and identification of new cases. HIV/AIDS tests were available and it was reported that there was regular free access to drugs through the Uganda district health services. Case management and protocols were in line with national protocols and national health services were used to managing this disease profile. However in November 2014 it was noted by an ECHO mission that confidentiality and consent of patients with testing of HIV/AIDS is not guaranteed. All children with malnutrition are automatically tested for HIV/AIDS and the result is recorded next to the name without codification. This is against the WHO-standards of HCT-services. [56]

Control of Non-Communicable Diseases

The profile of the refugee population meant that there was a high burden on **Reproductive Health (RH)** services that all the health centres in Adjumani and Arua provided. Dignity kits helped to attract women to deliver at facilities, however, many pregnant women still delivered at home due to cultural beliefs, low education and lack of awareness about services available. Antenatal care was poor, partially related to the weak community outreach system and cultural beliefs. There was an improvement in skilled deliveries but women who did not deliver at facilities also missed out on postnatal care and valuable counselling on infant and young child feeding. Guidelines **for clinical management of rape** survivors were developed and there were SOPs for Response to Sexual and Gender Based Violence[57].

Commendably, **mental health and psychosocial care** were considered within the first phase of the emergency response. A dedicated mental health working group coordinated partners focusing both on case management and community programming. Support was given to Adjumani Hospital to set up an inpatient mental health unit to enable admission of patients who need medication and more in-depth care. A main challenge was the availability of drugs for the implementing partner to manage some of the patients, especially anti-depressants.[58]

Given the extremely large influx of refugees and the focus on setting up basic primary and secondary health care services, **management of chronic diseases** such a cardiac diseases and cancers were understandably not given a large focus. However improved access to non-communicable disease services was part of the overall Health Strategy, recognizing that it was an intervention area. There was a lack of availability of specialised drugs for some chronic diseases.

Provision/Utilization/Coverage

The provision of health services in Uganda is decentralised with districts and health sub-districts playing a key role in the delivery and management of health services at those levels. Prior to the refugee influx, health services had been handed over to the District Government and all the health facilities were run by the District Government Health Office. This required a massive scale up to meet the rapid influx. UNHCR Uganda works through both implementing partners and the national health system to deliver health services to the refugee population of concern. Notable in Uganda is **the integration of services for refugees into the national system** meaning in practice that refugees and the host population have access to the same services in facilities serving both populations. The strategy of integration of refugee health services in the MoH health system required an initial high investment, especially upgrading of infrastructure.[59] The emergency health response focused considerably on expanding and improving the quantity and quality of both physical health structures and the encompassed services through substantial construction of permanent health structures, extensive rehabilitation and renovation of existing structures. Some health facilities were handed over to the NGOs (especially those next to refugee clusters) while others remained under the

[56] ECHO Comprehensive multi sector mission for the response to arrivals of refugees from South Sudan in Uganda. 10-14 November 2014

[57] For more details on the SGBV response please refer to the 'Protection' findings.

[58] End of Mission Report, UNHCR Dr. Susheela R Balasundaram, July 2014

[59] ECHO Comprehensive multi sector mission for the response to arrivals of refugees from South Sudan in Uganda 10-14 November 2014

management of the District Government hence there were issues with non-standardized service delivery because of the differences in partner capacities.[60] The evaluation team noted that staffing levels, drug supplies, medical equipment, and specific skill sets of health care workers were especially challenging[61].

The community outreach system was supposed to expand on the existing Ugandan system of village health teams (VHT) for community based health care promotion and provision including, amongst others, malaria prevention, disease surveillance, information and education on reproductive health services, and nutritional screening and follow-up. Community outreach systems were established early in the response however different partners had different staff, different messages/responsibilities, different coverage and different compensation systems. The variable reimbursement levels created an overwhelming challenge to the recruitment and retention of community volunteers. Efforts were made to standardize and agreed rate (from interagency meetings and as set by the OPM) was set at UGX 5000 per day and UGX 7000 per day for supervisors. There were some partners providing double or more of these rates to their community workers and even more for one-off campaigns.[62] Refugee communities were not compelled to participate and to date the community outreach system is dysfunctional. The ratio for population to community health worker at the end 2014 was more than double the standard.

A **referral system** was established by early March 2014 with governing SOPs for medical referral[63] as well as ambulance provision. There was a struggle to scale up the number of ambulances available however there was considerable interagency collaboration to solve the problem with a wide range of partners either contributing ambulances or directly donating them to UNHCR. Consequently the situation improved greatly. In focus group discussions with refugees, however, there was considerable frustration expressed over the lack of ambulance services or support from the community level to health centre. This centred on a lack of supplies such as bicycle/stretcher/cart, blanket, and torches.

The **coverage of health services** was decent. The population per peripheral health facility was 1:10,000 on average for the whole district, including nationals and this is better than the current situation in the rest of the country. The population per central health facility (Adjumani Hospital) is 240,000, which is better than the standard.[64] Outpatient utilization rates based on new visit per refugee per year were rather low but within the standard. A lack of food support to in-patients or their caregivers was identified by the evaluation team as a barrier to utilization of health and nutrition services. The Integration Policy provided a challenge in terms of **planning figures for health services**. Even with inclusion of the 30% host population the numbers receiving health services at the UNHCR supported health centres were much higher than expected with direct impact on drug supplies, number of consultations per staff, etc. This is partially attributed to the fact that the 30% inclusion figure is based on a national average and in the West Nile region the percentage of the host population utilizing services is estimated to be larger than 30% due to the weak national health services provided.

The **drug supply** was twofold: MoH supplies based on the local population figure and UNHCR complements for the refugees. Drug management was quite complex and in this response it presented an obstacle to effective health care. Population figures present additional challenges as the MoH procures supplies based on official national population figures but with the integration of services there are significantly more people accessing

[60] Comments to ECHO Public Health Report (PH, RH/HIV, Nutrition) _17th December 2015

[61] Triangulated through numerous key informant interviews and the End of Mission Report, UNHCR Dr. Susheela R Balasundaram, July 2014

[62] End of Mission Report, UNHCR Dr. Susheela R Balasundaram, July 2014

[63] Health and Nutrition 7th Coordination Meeting, Adjumani 11 March 2014

[64] Data obtained from the UNHCR health information system

services at each health centre. Furthermore, UNHCR procurement is likewise challenged by fluctuating refugee population figures (with new arrivals coming regularly) and with the inclusion of the 30% host population-planning figure, which is understood to be an under-estimate for the West Nile. There are also issues with regular stock-outs of supplies within the national health service and for UNHCR, lengthy international procurement processes means that drugs are often seriously delayed or based on out-dated population figures. In the early phase of the emergency the UNHCR Uganda country office did not request an Inter-agency Medical Health Kit and this may have affected access to medicines in the first 2-3 months. However, after the emergency phase, it is expected that lines of procurement should be up and running smoothly but there continues to be multiples challenges and constraints throughout the response.

Adequate **national staffing of the health response** was a challenge. The national health system in the region was understaffed and the MoH has challenges recruiting health staff to the remote health centres, keeping staff motivated to provide quality health care, and has ceilings on the numbers (regardless of the drastic population increase due to the refugee influx) even if they were able to achieve 100% staffing levels. UNHCR/partners complement district health efforts with partners operating complementary health centres or services, and in some instances working side by side with MoH staff in national health structures. UNHCR has also provided direct funding to the national health system in West Nile to improve staffing constraints.

3. Nutrition

The response strategy to improve the nutritional well-being of the refugee population was built on the UNHCR Uganda Public Health Strategic Plan 2013-2017, which was developed for a more stable refugee population, and the UNHCR Global Strategy for Public Health 2014-2018. Nutrition interventions were planned as an **integrated component in the health system** that targets both the refugees and the host community in line with the Uganda government's policy of integration. The nutrition response followed the national guidelines for the management of malnutrition, which was consistent with international guidelines and standards.

Initially limited attention was given to nutrition until March 2014. There was some integration of nutrition into health assessments or inter-agency multi-sectorial assessments – the findings were generally that there was not a high burden of malnutrition but that services should be initiated or systematised.[65] In this area of Uganda there were not national services for the treatment of severe acute malnutrition so rapidly scaling up in the event of a deterioriation of the nutritional status was not possible. Through interviews with key informants the evaluation team learned that the nutritional screening of new arrivals indicated that the burden of malnutrition was very low (see Table 8) and at the reception/transit points nutritional screening indicated that the population was in fairly good shape. When the nutrition survey results in March indicated that there was a prevalence of 20% GAM, there was concerns that the results were not indicative of the situation. After the release of the nutrition survey results, then there was significant attention given to increasing the number of nutrition partners and increasing services. Even when the services were scaled up, the expected caseload was not reached. This could partially be attributed to the poor community outreach system for identification of the malnourished, but might also be a reflection of the contradicting prevalence figures (refer to nutrition outcomes section).

[65] South Sudanese Refugee Inter-Agency Emergency Assessment Report For West Nile Region and Acholi Sub Region. 8 January 2014.

Table 8: MUAC Screening Results in Adjumani, Arua, Kiryandongo combined, January to August 2014

Month	Total GAM (MUAC)	Total screened
March	51 (1.5%)	3467
April	34 (0.6%)	5718
May	82 (5.4%)	1534
June	103 (2.8%)	3730
July	201 (5.3%)	3768
August	273 (7.2%)	3738
September	106 (7.2%)	1496
October	488 (8.9%)	5497

Source: Uganda: South Sudanese Refugees Review on the refugee nutritional status as food ration reduces - 9th November 2014

Very good partnership and collaboration was consistently reported to the evaluation team to characterise UNHCR's coordination of the nutrition response. A Nutrition **Coordination Working Group at the Adjumani level** was established and likewise at the capital level Kampala information about the response was shared in a weekly interagency coordination meeting. Since services had to scale up significantly there were some challenges noted with fragmented service delivery due to partners coming in with their own money at the district level with predefined areas of intervention without strategic consultation of needs on the ground. The evaluation team was made to understand that without a direct funding/reporting line to partners, UNHCR lacked some in its convening power and struggled to coordinate a coherent response. There was more than one nutrition partner in each settlement and for example in Adjumani hospital the nutrition services relied on government nurses, Concern who ran the OTP, ACF who managed the stabilization centre, and once graduated out of therapeutic care, supplementary feeding was provided offsite by MTI with limited tracing and follow-up. It was felt that some international partners came in without consultation of the needs on the ground with own funds to work in specific aspect/area and this created both gaps and duplications. A detailed **3W public health response matrix** was utilized both at district and national level and it included nutrition screening and nutrition treatment mapped per settlement or reception/transit centre.

In Adjumani, refugees indicate that most of the new arrivals would not walk for long hours and days, instead would use vehicles to travel to Elegu, the border point with Uganda. Most of new arrivals did not stay overnight at Elegu transit centre; they will receive transport to the reception centres in Nyumanzi. At the reception centres, health and nutrition screening, they receive free basic health services those found with various ailments. Basic and health preventive services provided includes; immunizations, consultation services with triage, SAM children are enrolled into respective feeding programmes, vitamin A supplementation, deworming, water services, shelter, and cooked hot meals. These services are likely to start restoring the health status of the refugees hence preventing expected high mortality rates.[66] Since the beginning of the refugee influxes new arrivals have been screened for malnutrition upon arrival at the reception centre and immediately transferred into the relevant programme if found to be moderately or severely malnourished.

Global and acute malnutrition rates were calculated using weight-for-height measurements through a nutrition survey in March 2014 and showed that the situation was critical with GAM 19.6% and SAM 4%. However when calculating for the prevalence of malnutrition using MUAC, the burden of malnutrition was found to be very low. When the nutrition survey results were presented to the humanitarian community it was noted that the reported rates of malnutrition for West Nile was in contradiction with the regular data generated by the daily

[66] Uganda: South Sudanese Refugees Review on the refugee nutritional status as food ration reduces - 9th November 2014

screening activities done at health centres level and community (MSF-F surveillance team).[67] This created technical discussion about which tool is suitable for measuring malnutrition in the specific South Sudanese population groups which have a notably tall and lean physic.[68] However the critical nutritional results using the standard measurements of W/H could not be discarded and nutritional programming was scaled up.

A follow-up nutritional survey released in January 2015 showed remarkable improvement (see Table 9). The great improvement in the North/West Nile Refugee settlements was attributed to intensive implementation in 2014 of supplementary and therapeutic feeding programs by partners and humanitarian agencies.[69] Since the inception of the influxes of new refugees in Adjumani, Arua, Kiryandongo medical and nutrition teams have continuously performed nutrition screening among refugee children aged 6 to 59 months old (see table 8) and the results indicate a higher burden of malnutrition in the population than captured by the late 2014 nutrition survey (released in 2015). This all contributes to some confusion over the real burden of malnutrition in the refugee population that was expressed by numerous key informants to the evaluation team.

Table 9: Nutrition indicators* for the Uganda South Sudanese refugee response, 2014

Indicators	January 2014	June 2014	December 2014	Standard
GAM	19.6%**	Not available	5.2% - 8.8%***	Less than 10%
	2.5%** MUAC	2.8% (Combined)**** MUAC	3.3% (Combined)*** MUAC	
SAM	4.1% **	Not available	1.5-1.9%***	Less than 2%
	1%** MUAC		0.7% (Combined)*** MUAC	
Recovery Rates for SAM	58-71%	84%	83-86%	Greater than 75%
Death Rates for SAM	0%	0%	0%	Less than 10%
Vitamin A supplementation	79%**	92-94%	83-91%***	Greater or equal or 95%

*Data is from HIS unless otherwise specified.
**Food Security and Nutrition Assessment among South Sudanese Refugees; New Caseload. Makere University, UNICEF and UNHCR. March 2014.
*** Food and Nutrition Security Assessment among Refugee Settlements in Uganda, Makere University, UNICEF and UNHCR. January 2015
****Nutrition screening data see table 8

General Nutritional Support

The food security situation in the three settlements (Arua, Adjumani and Kiryadongo) is stable, but so far heavily dependent on external WFP **food aid**. The food assistance response has been sufficient with uninterrupted food pipeline maintained in 2014. WFP provided refugees with high energy biscuits immediately on arrival in Uganda, cooked meals at transit centres and dry rations in the settlements (Cereals 12kgs; Pulses 2.4kgs; Veg oil

[67] 7th Health and Nutrition Coordination Meeting, Adjumani, 11 March 2014
[68] Comments to ECHO Public Health Report (PH, RH/HIV, Nutrition) _17th December 2015
[69] Food and Nutrition Security Assessment among Refugee Settlements in Uganda, Makere University, UNICEF and UNHCR. January 2015

0.9kgs; CSB+ 1.5kgs; Salt 0.15kg commodity per person per day).[70] 99% of households in the settlements had a ration card[71]. The biggest obstacles to food security are pipeline breaks, and a lack of access to land for agriculture production, and income generating activities.[72]

Based on the high rates of malnutrition found in the nutrition survey released in March 2014, and in consideration of the vulnerability of a population primarily made up of women and children, WFP in consultation with partners decided to implement a **blanket supplementary feeding programme** (bSFP) for women and children under 5 years. Funding challenges within WFP meant that the bSFP did not begin until the last quarter of 2014.

Correction of Malnutrition

The **nutrition services and activities in the settlements were appropriate** and included MUAC screening, targeted supplementary feeding programmes (TSFP) for moderately malnourished children and pregnant and lactating women and outpatient/inpatient therapeutic feeding programmes for the severely malnourished. Nutrition programming was primarily integrated into governmental health structures with international partners strengthening and expanding the services in these health structures to support the additional populations. Additionally, nutritional services were available in reception/transit centres with routine screening to identify the malnourished. These individuals were then immediately referred to the relevant nutritional program for treatment within the transit centre and continued treatment upon relocation.

In Adjumani, the **targeted supplementary feeding** programme started in August 2014 while in Arua it started on the last week of September and in Kiryandongo, it started around May 2014. In Adjumani and Arua, children receive a supplementary 2-week ration of super-cereals plus while in Kiryandongo receive a premix of CSB, vegetable cooking oil and sugar.[73] These programs targeted children under 5 years and pregnant or lactating women who were identified through nutritional screening as having moderate acute malnutrition. A weak community outreach system which results in limited active case finding means that the **coverage of MAM programmes** remain a challenge.

Nutrition activities are currently being implemented as an **integrated component in the health system** that targets both the refugees and the host community. It is important to highlight the fact that there was no nutrition programme in West Nile region until the onset of South Sudan crisis and subsequent influx of refugees. Therefore, although primed as integrated services within the health system, the current nutrition activities are mainly focused on providing emergency nutrition assistance to the South Sudan refugees, through direct intervention by humanitarian partners.[74] Programmes are running smoothly although the large number of nutrition actors covering different components of care may hamper the continuum of treatment, making tracing and follow-up complicated.

The **community outreach strategy** was never fully realized. The existing village health team (VHT) community outreach system in Uganda utilises volunteers from the community for community based interventions with no incentive scheme. However in the early weeks of the emergency response different partners recruited their own health workers and paid them differently and this created a disharmony in the implementation process. Refugees became

[70] ECHO Comprehensive multi sector mission for the response to arrivals of refugees from South Sudan in Uganda. 10-14 November 2014

[71] Food Security and Nutrition Assessment among South Sudanese Refugees in Adjumani, Arua and Kiryandongo districts, New Caseload. Makere University, UNICEF and UNHCR. March 2014.

[72] Uganda Joint Assessment Mission (JAM), OPM, UNHCR, WFP. October 2104

[73] Uganda: South Sudanese Refugees Review on the refugee nutritional status as food ration reduces - 9th November 2014

[74] ECHO Comprehensive multi sector mission for the response to arrivals of refugees from South Sudan in Uganda. 10-14 November 2014

used to being paid an incentive for their time and were reluctant to engage in community activities for free or for the finally standardized and agreed rate (from interagency meetings and as set by the OPM) of UGX 5000 per day. Since malnutrition was being tackled through community management of malnutrition programming, a dysfunctional outreach system had significant effects on areas such as active case finding and nutrition sensitive programming areas. This was acknowledged in the nutrition survey released in January 2015 which called for agencies implementing nutrition program to scale up promotion of preventive programs and essential nutrition actions.[75] Infant and young child nutrition (IYCF) which includes awareness creation of community members on IYCF, and counselling mothers/caregivers about optimal breastfeeding and appropriate complementary feeding of children under 2 is an area that has had limited scope[76] and there was generally poor knowledge of complementary feeding, which should be addressed through nutrition promotion programs.[77]

4. WASH

A clear set of targets guided the WASH response. These were presented to WASH partners in March 2014[78]. **The water supply strategy focused on a prioritised set of targets**, beginning with provision of at least 7 litres per person per day, increasing to 15 within two weeks, and 20 in the long-term. Water would be provided within 1 km of every settlement, per Uganda national standards, and the number of persons per usable water point would be 500 initially, reduced to 200 as soon as practicable. Ensuring the long-term sustainability of water points, including a strategy for financing operation and maintenance costs was a neglected part of the strategy. The **excreta disposal strategy**, on the other hand, **focused on the efficient use of resources, self-reliance and long-term sustainability,** whilst not focusing adequately on the need to rapidly provide sufficient communal latrines to minimise open defecation as a public health measure to prevent outbreaks of disease. A focus on household latrines from the outset meant that communal latrine construction was delayed.

After a slow initial start the WASH sector scaled up rapidly, making use of the large number of available WASH partners. Outbreaks of WASH-related diseases were largely avoided[79]. Just over 85% of respondents to the online survey agreed that the WASH response met the needs of the refugees in a timely manner. For the first few weeks of the crisis, environmental health conditions were poor in the reception centres[80], and decongesting them by relocating refugees was a priority. The initial response by implementing partners appears to have been slow, with only one partner having capacity and significant activities for the first 6 weeks. As a result UNHCR decided to engage directly in implementation itself, notably with water trucking. By the start of June 2014, the quantity of water available per person per day and the ratio of persons per latrine were approaching **Sphere standards** across most settlements (see Table 3 and 4) and the achievements they show reflect a huge effort to construct and rehabilitate water points and construct latrines, which facilitated relatively expedient relocation of refugees from reception and transit centres to refugee settlements.

Key indicators for hygiene promotion were not finalised and key indicators for sanitation required verification; a household WASH survey across sites could have helped resolve these

[75] Food and Nutrition Security Assessment among Refugee Settlements in Uganda, Makere University, UNICEF and UNHCR. January 2015

[76] ECHO Comprehensive multi sector mission for the response to arrivals of refugees from South Sudan in Uganda. 10-14 November 2014

[77] Food and Nutrition Security Assessment among Refugee Settlements in Uganda, Makere University, UNICEF and UNHCR. January 2015

[78] Plenary presentation of SS Emergency Response at Interagency meeting on 6 March 2014

[79] e.g. only one of the 96 cases of cholera in Arua was refugee, as noted in the UNHCR/UNICEF response letter to ECHO's WASH monitoring mission dated 18 June 2014.

[80] South Sudanese Refugee Inter-Agency Emergency Assessment Report for West Nile Region and Acholi Sub-Region (6-8 January 2014)

issues. The hygiene promotion working group in Adjumani set out in July to develop key indicators for hygiene promotion[81], but the process was delayed and there were no key indicators being reported for hygiene promotion at the end of 2014. The persons-per-latrine indicator treats communal and household latrines equally, which leads to overestimation of access to latrines where coverage is low. In this situation *all* latrines are *assumed* to serve many people, whereas in reality family latrines would likely just be shared amongst a few neighbouring households. An accurate depiction of the situation would require measurement at a lower level of detail, such as a block. Household latrine coverage should be estimated first – including an allowance for sharing based on survey data - and then the ratio of people without a family latrine to the available local communal latrine stances could be calculated for the remainder. Data on communal and household latrine numbers was provided in weekly reports from Adjumani. The water supply indicator for Adjumani in figure 3 (litres per person per day), despite relying upon the accuracy of population data, and assumptions regarding the hours of operation and pumping rates, tallies well with data from a KAP survey in Adjumani[82].

UNHCR provided the **strong coordination** that was required given a fluid situation and a large number of WASH partners. UNHCR-led coordination mobilised partners for joint planning, identifying and addressing gaps and preventing duplication of efforts. Focal points (partners) were assigned for each settlement to coordinate borehole siting. Partner's plans and achievements, and gaps in their combined efforts, were tracked by location and updated matrices were provided to WASH partners on a regular basis. UNHCR organised joint assessment missions for new sites, outbreak preparedness meetings as required, and made sure that exit strategies were in place when partners were planning to close operations in a particular settlement or district. Over 85% of respondents to the online survey agreed that the intervention outcomes in WASH were adequate and proportional to the response.

The District Government was involved in coordination meetings, and was engaged to provide information and review and approve designs and costing for infrastructure. Engagement with the district on **long-term planning**, notably around water supply management, was limited, although this owed partly to their limited manpower being overstretched. Mapping capacity (GIS) would have improved coverage and gap analysis. The absence of a WASH Coordinator in Kampala (the WASH Coordinator was based in Mbarara and had a full-time workload with another population group) was also a constraint on UNHCR's ability to develop and transition to a longer-term strategy (which would involve more engagement with UNICEF at Kampala level).

Whilst partners were generally kept informed as to the status of their **funding proposals**, the process of developing budgets for 2015 could have benefitted from greater participation of UNHCR's and the partners' technical teams. UNHCR unilaterally made changes to the budgets in some partners' proposals without properly consulting them and without engagement of the WASH Officers in the field. As a result changes were made that were sometimes not internally consistent. For example infrastructure construction was removed from two partners WASH proposals whilst leaving in place budgets for training and caretaking relating to the infrastructure that would not now be built. This could have been avoided by organising discussions over proposals between UNHCR's and partners' technical teams.

The most significant weakness of the coordination was the management and oversight of certain thematic issues. **Water quality monitoring** was identified as an important issue early on in the response, and yet at the end of 2014 regular microbiological testing of water points and household storage containers had not been undertaken to any significant degree. Similarly, by the end of the year a **standard design for household latrines** for flood prone areas had not been agreed, despite on-going work on this issue over several months.

---

[81] Hygiene Promotion Technical Working Group Meeting - minutes, 1st July 2014.

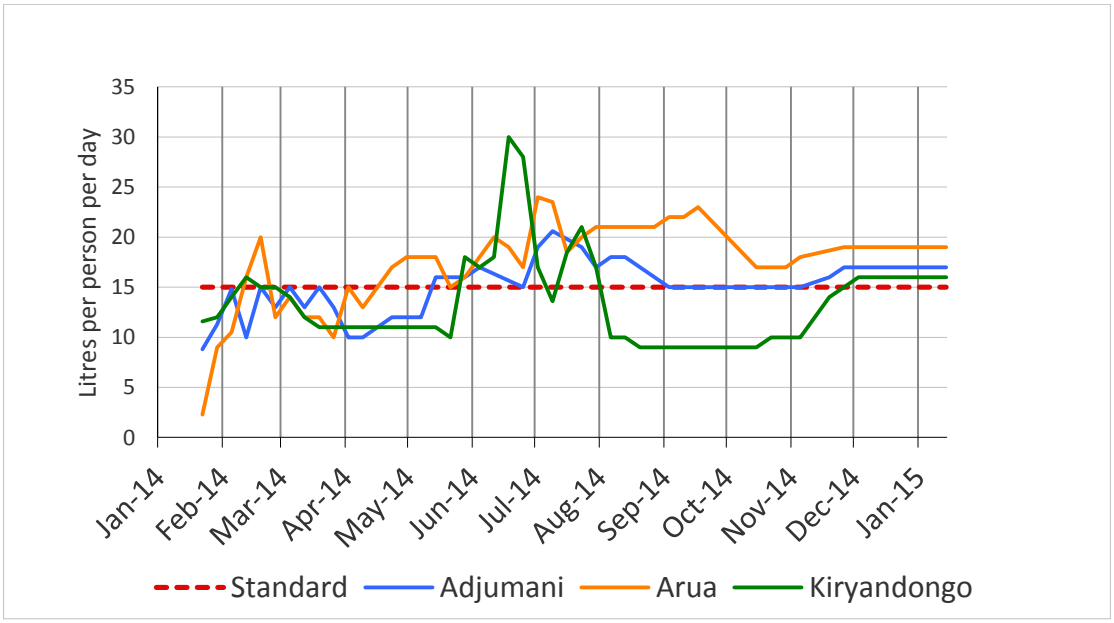
[82] Knowledge, Attitude and Practices Assessment on Water, Sanitation and Hygiene (WASH), Nyumanzi, Olua 1 and Olua 2 settlements, Adjumani District. LWF. August 2014

Water

Initially **water trucking** was unable to keep up with the large influx and UNHCR conducted some water trucking by direct implementation due to a lack of partners on the ground, but by March 2014 access to water had improved. UNHCR also focused on rehabilitating **hand pumps** and re-activating those that had been taken out of operation following the return of previous influxes of refugees to South Sudan. Most of the boreholes currently in use in Arua were previously decommissioned by removing parts for storage and capping the wells, protecting them and maintaining them as a contingency for future need. These were uncapped, flushed and equipped as the current influx arrived[83].

An extensive borehole drilling and hand pump operation, motorising where feasible, was the right approach for dealing with generally low groundwater potential across the intervention areas. The majority of the refugee population got their water from hand pumps[84,85]. Partners drilled boreholes around the settlement areas on the assumption that low yields would only permit hand pumps, but motorising where higher yields worth were encountered. Drilling contracts included hydrogeological and geophysical studies to locate borehole sites, incentivising contractors to pay careful attention to site identification. UNHCR also engaged an experienced International hydrogeologist to conduct a detailed study in Adjumani District. This study recommended regular groundwater monitoring at boreholes but this was not undertaken during 2014. Additional hydrogeological studies are required for other areas and were planned for 2015.

Figure 3: Refugee Access to Water by District in Uganda 2014



Data Source: Regional Support Hub water and sanitation access tracking spreadsheet

Water quality was not adequately addressed. Water being trucked from a river to Baratuku settlement was found to be inadequately treated. Some boreholes were initially found to be contaminated[86], but repeat tests only found contamination in 1 borehole. Partners also recognised that contamination of stored water at household level was widespread. Despite

[83] UNICEF and UNHCR Comments on ECHO WASH Mission (June 2014)

[84] West Nile Emergency Situation Update, 24th October 2014

[85] Uganda Joint Assessment Mission 2014, p23

[86] Ellen Milnes Hydrogeological field mission in the Adjumani refugee settlements (Northern Uganda) 12th to 22nd May 2014 MISSION REPORT - DRAFT

exhortations by UNHCR from early 2014 for partners to conduct regular water quality monitoring[87], by the end of 2014 only ad hoc water quality testing had been conducted, and no standardised system was in place. A need for training of partners was a major constraint. At the same time hygiene promotion did not focus sufficiently on the safe water chain. At the beginning of 2015 WASH partners agreed to distribute 'OXFAM' buckets with built in taps for drawing water, based on some field evidence that this resulted in better water quality.

An **operation and maintenance strategy for water supplies** was yet to be developed at the end of 2014. UNHCR engaged partners, including the District Water Offices, in discussions on operation and maintenance in the latter part of 2014, but a strategy was still pending at the end of the year. Water User Committees and new hand pump mechanics were trained and with District Water Office assistance. User fees for refugee water points is a difficult issue. Refugees remaining from the 'old caseload' and host communities pay user fees, but the refugees from the new caseload do not. The willingness and ability to pay for services is low in general amongst the new South Sudanese influx of refugees, as is willingness to provide voluntarily service to water committees.

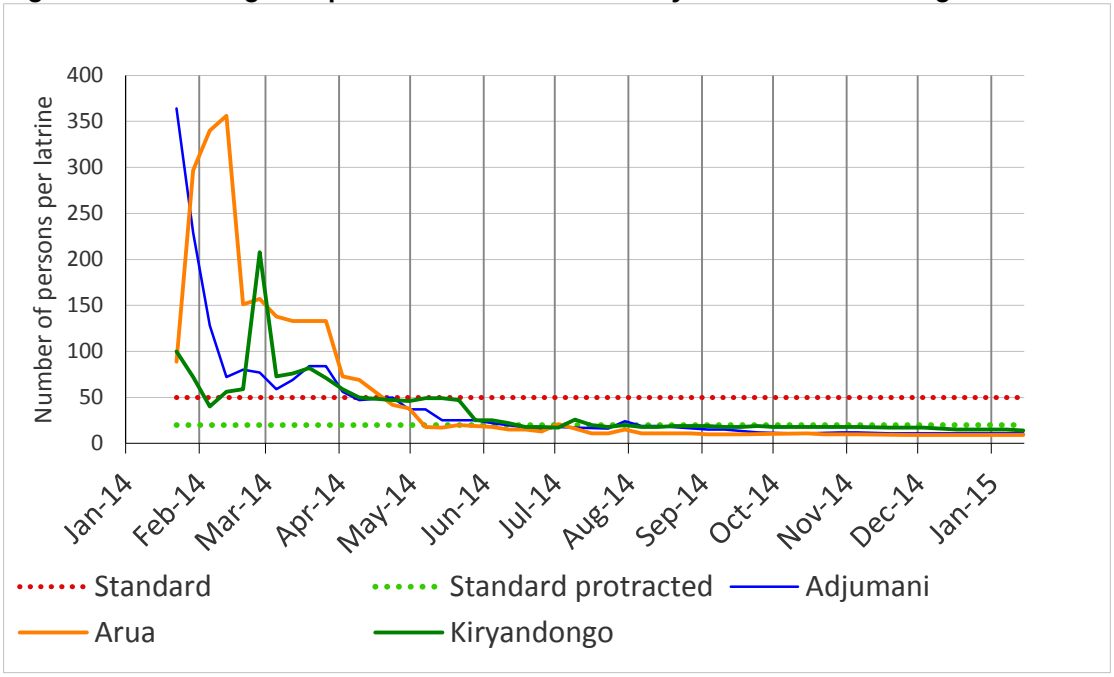
Sanitation

The latrine strategy focused on household latrines and achieved high coverage relatively quickly. The majority of households constructed the latrines themselves being provided only with logs, plastic or concrete slab and a eucalyptus pole for the superstructure. PSN households had latrines constructed for them. By focusing early on household latrine construction WASH partners helped facilitate rapid mobilisation of the population. This approach, however, resulted in low latrine coverage initially and more attention to communal latrines would have been appropriate early on. In Nyumanzi, the first settlement that was developed for the new influx in Adjumani District, communal latrines were only introduced several weeks after the settlement opened when it was realised that household latrine construction was taking time and open defecation was common. The communal latrines were reported to be of poor build quality[88]. From this point on, communal and household latrine construction were implemented concurrently and by different partner in new settlements. Construction progress was tracked separately for communal and household latrines.

[87] WaSH Coordination Meeting Adjumani - MINUTES, 28th March 2014.

[88] WaSH Coordination Meeting Adjumani - MINUTES, 4th April 2014.

Figure 4: Refugee per Latrine Ration by District in Uganda 2014



Data Source: Regional Support Hub water and sanitation access tracking spreadsheet

The **design and quality of household latrines** varied and some did not hold up to environmental challenges. Some were damaged or collapsed due to flooding and waterlogged soils[89]. Some household latrines are too shallow, and fill up quickly, for example in Baratuku where the ground is rocky. A shallow, wide diameter latrine design was used in Baratuku from April 2014, yet in coordination meetings in September 2014[90], a standard latrine design for flood-prone areas was still being discussed and developed. The selected design facilitates disabled access, which was a key reason for its selection over an alternative elevated design. Latrines also filled quickly for households that were sharing a latrine.

Household pits for solid waste and regular burning of the contents was the main strategy employed for solid waste management. A collection and disposal mechanism was not in place. **Solid waste** was not a significant problem or priority during the first year of the response, but is a concern for the longer-term. **Medical waste facilities** were being stretched due to the overburdening of health facilities, and will need to be upgraded in the long-term.

Hygiene

Hygiene promotion was **not sufficiently focused.** The array of messages being communicated went beyond key priority public health messages and messages were not based upon assessments of hygiene behaviour in the target population and its relationship to the context. Different partners were using different implementing strategies. Efforts should have been focused predominantly on the safe water chain, and importance and proper / consistent use of the latrines and hand washing facilities that many households had constructed or were constructing.

Key hygiene indicators for hygiene promotion were not developed, even though this was on the agenda of the hygiene promotion working group in Adjumani when it reconstituted in July. The ratio of hygiene promoters per population was tracked, however, and agencies were

[89] WaSH Coordination Meeting Adjumani - MINUTES, 26th August 2014.
[90] WaSH Coordination Meeting Adjumani - MINUTES, 4th September 2014.

encouraged to reach the Sphere target of no more than 500 people per promoter. This did not happen.

Hygiene promotion activities included inappropriate activities and lacked some activities to raise the visibility and emphasise the importance of personal hygiene. House to house visits by hygiene promoters appears to have been the most common activity. Other activities, such as discussion groups, health clubs, drama and so on, would help to provide a stronger entry point for household discussions/promotion, and an opportunity to introduce the hygiene promoters and their work. Mass media, such as posters, were largely neglected. The appropriateness of PHAST, used by various partners, is uncertain as it relies upon community cohesion and disposition to collective planning and action. Similarly, the CLTS triggering process was introduced by some partners, but its appropriateness is questionable given that it does not address the main barrier to latrine construction – the physical ability of the refugees, most of whom were women and children – and assumes that communities are sufficiently tight knit for peer pressure to be a powerful motivating force.

The presence of latrines with **hand washing facilities** at many household latrines provides a solid foundation for promoting hand washing, but hand-washing promotion needs to be strengthened. During a visit to Ayilo I many tippy tap containers were dry and it was commented that some families don't use them but just fill them with water when they see hygiene promoters nearby. During a KAP survey conducted in August 2014 in Adjumani only a third of tippy taps had water and only a tenth had soap.[91] The presence of hand washing equipment and materials is a key enabler of good hand washing behaviour. The opportunity to link desired behaviours to new products was not fully exploited.

Infrastructure

Water and sanitation infrastructure was generally constructed to a high standard, but **a few design mistakes were not caught.** School toilets were constructed to a high standard with a privacy wall and appropriate disabled-access facilities. In Nyumanzi settlement, however, girls' toilets were equipped with urinals, and the school toilets lacked drainage. Two water points in the same settlement were dry due to a mistake in the hydraulic design of the water distribution system. Inadequate road drainage in Boroli resulted in flooding of a Child-Friendly Space. Adjumani District line departments approved designs, but did not have sufficient manpower to thoroughly review them. Therefore, UNHCR and the District Water Office were relying on the partners' engineers to ensure proper engineering procedures and standards were met.

5. Site-planning

Site identification was done relatively quickly despite challenges and a need to negotiate for land with communities in Adjumani and Arua Districts. Allocation of **community-owned land** in Adjumani and Arua required extensive negotiations with communities, which was carried out by OPM. Despite disappointment with unfulfilled expectations of rewards for previous hosting of refugees, and perceptions of mistreatment of Ugandans in South Sudan after the signing of the Comprehensive Peace Agreement, land was made available relatively expediently. The conflict sensitivity of OPM and UNHCR contributed greatly to this outcome.

The **involvement of the district government** in site identification and planning was limited in Adjumani and Arua Districts. The district authorities approved selected sites but did not attend site identification meetings. The targeting of support to host communities is largely being decided by UNHCR and OPM and is focused on the immediate vicinity of the refugee camps. The wider impact of the hosting operation, such as the wear and tear on access and feeder roads and the environmental impact, require joint assessment with the district authorities and

[91] Knowledge Attitudes and Practices Assessment on Water, Sanitation and Hygiene Nyumanzi, Olua 1 and Olua 2 settlements, Adjumani district, LWF, August 2014

need to be addressed in a participatory manner. This should be done as soon as possible before potential funding sources dry up.

Land is in short supply but UNHCR and partners continue to seek ways to overcome this challenge in pursuit of refugee self-reliance. A shortage of land meant that plot sizes had to be reduced from 5,000m^2 to 900m^2 in Adjumani and Arua. Plot sizes were 250m^2 in Kiryandongo, but later new refugees were settled in 25m by 25m plots cut out of previously allocated plots. Negotiations to secure separate land for farming by the refugees were therefore initiated, as these plot sizes are sufficient for a small kitchen garden but not for agriculture[92]. The host community rented land to refugees for farming, but in some cases claimed it back after one season, in order to benefit from the bush clearing done by the refugees of fertile land. Indeed, all but one of the large refugee settlements in Adjumani were new ones, and many were located adjacent to settlements of the previous South Sudanese refugee influx, now being used by the local community[93]. The refugee community is also oriented toward a pastoral lifestyle. Partners are pursuing other strategies, such as modern (sedentary) cattle-rearing.

A top-down approach was used to plan **community layouts**, with blocks laid out in a grid structure. A bottom-up approach is preferred, whereby communities are developed in such a way as to maximise access to communal facilities[94]. As refugees are provided sizeable plots of land and had on site latrines and showers, and given the need to maximise use of the available land, this approach is understandable, but the lack of a community-oriented approach to the physical planning will likely make it more difficult to promote ownership over water points.

A few sites suffered **waterlogging** during the rainy season. Although permanent wetlands were identified and avoided in the siting of plots, parts of Nyumanzi, Baratuku, Olua 1 and 2 were waterlogged during the rainy season. Refugees in waterlogged areas preferred to relocate within the same site, which required further negotiations with the host community. This also resulted in some water points being abandoned in vacated areas. Some issues with plot demarcation were noted by partners in Boroli (not well demarcated) and Baratuku (map different from reality on ground). The use of a standardised open-source GIS platform with integration of digital elevation models (DEMs) would have allowed more detailed spatial analysis in the planning and promoted better use of topography.

Site plans resulted in **reasonably good access to services**, given the large population and large plot size, **with a few gaps**. Due to the time required to identify appropriate borehole locations, sites were planned before water points were in place. Community services, notably Early Childhood Development Centres and Child Friendly Spaces, were sometimes not given adequate consideration in the site plans and many are concentrated in one area. Although they tend to be centrally located, many refugees are still living far from community services due to the large plot sizes. Some families were also relocated prior to the opening of water points or communal latrines in Adjumani District. In Arua District OPM was leading the site planning and developed a villagisation concept – small, dispersed refugee settlements. Services to refugees were dispersed, but this was inefficient and expensive. UNHCR therefore promoted the development of larger settlements. Site planning for settlements with large plot sizes needs to ensure a balance between good distribution of community services and cost-efficiency, through participatory planning.

Plot demarcation was initially delayed by a lack of manpower and became a bottleneck. Decongesting the transit and reception centres became a priority from the early days of the response, placing emphasis on rapid site planning, demarcation and allocation. Initially,

[92] UNHCR (2014) South Sudan Regional Refugee Emergency Response Plan January - December 2015

[93] Informal GIS analysis conducted by UNHCR Uganda with RSH support.

[94] UNHCR (2007) Emergency Handbook

UNHCR left site-demarcation to OPM. OPM had limited manpower and lacked site planners, however, and surveyors were not widely available in the local market in refugee-hosting areas. As a result refugees were held up at reception and transit centres (around 30,000 were residing in Dzaipi Transit Centre in February). When UNHCR took a more active role, working closely with OPM, demarcation proceeded more quickly.

6. Shelter

Emergency shelters were necessarily constructed in a rush, and did not afford an adequate level of protection. The size of the influx challenged the capacity of the partners to respond, particularly in Adjumani, where a huge effort was made to decongest the reception/transit camps once plots were demarcated in the settlement sites. Emergency shelters were constructed for PSNs by casual labourers. The remaining refugees, the vast majority of whom were women and children, were not given sufficient support on shelter construction, and many struggled to construct a shelter. Refugees were not given a standard plan, but constructed their shelters as best they could from the materials they were able to gather or purchase from local vendors. Typically they constructed walls from poles, sticks and/or grass and suspended the plastic sheeting over a central ridge pole to the walls. Some did not receive poles at the same time as they receive the plastic sheeting. The refugees found the emergency poles and plastic sheeting insufficient and some purchased additional materials sheeting.

The majority of refugees constructed their **permanent shelters** themselves, generally to an acceptable standard. The policy for South Sudanese refugees in Uganda is that they construct their permanent shelters themselves, with the exception of families with PSNs. Many of the refugees arriving in the first 3 months of 2014 had the means to procure materials and skilled labour for shelter construction. Hence some refugees constructed shelters before receiving shelter kits from UNHCR, achieving an acceptable standard of construction in most cases. For other refugees, however, constructing a permanent shelter, was a major challenge. The poor level of protection provided by the emergency shelters also drove refugees to construct their own permanent shelters. A typical self-constructed shelter was a square tukul with mud-plastered stick walls and a eucalyptus frame to support the roof, which was thatched.

The refugees needed more support in obtaining **materials for permanent shelter construction.** Grass for thatching, in particular, is only available in the area between September and March, as the local practice is to burn off the grass at the end of the dry season in March. The host community often prevented refugees from cutting grass and trees. The construction of permanent shelters slowed to a halt after March with UNHCR and partners discussing the options well into 2015, instead of implementing a decision quickly. Plastic sheeting could have been provided for refugees to construct temporary roofs until grass became available again. Indeed, plastic sheeting under the thatching would provide additional water-proofing, as was observed in Gambella, Ethiopia, and could be considered for standard practice.

The **permanent shelter design for PSNs** was not sufficiently informed by refugee consultation.[95] Walls were constructed from mud bricks, as per local practice, which minimised the timber requirement and hence the environmental footprint. A round structure was selected largely on the basis of its surface area to cost ratio, but the impact of the shape on the use of space does not appear to have been considered. Many refugees that constructed their own shelters constructed square ones. The round shelters, however, are more popular amongst the host community.

[95] According to UNHCR, PSN consultations on shelter design took place, but no documentation was presented to give details of these consultations.

No shelter surveys were conducted on the type, condition and effectiveness of shelters. No quantitative data was available on the shelter conditions for each family (or a representative sample of families). Different actors gave varying estimates of permanent shelter coverage. A significant minority of households were unable to construct permanent shelters during 2014. Those that were unable to remained in inadequate and deteriorating emergency shelters or had to share overcrowded shelters with other families. Putting population figures to these different scenarios would have enabled UNHCR and partners to determine if course corrections were needed, such as additional permanent shelter support (e.g. assistance with selected materials) or provision of materials for and interim transitional shelter (additional poles and plastic sheeting to upgrade emergency shelters).

7. Education

Detailed inter-agency assessments on education led by the Government of Uganda took place within six weeks of the emergency response. No specific education strategy for South Sudanese refugee children was developed for the emergency and key informants were not aware of, nor guided by, UNHCRs existing education strategy for Ugandan refugee children. Key informants demonstrated some lack of understanding of UNHCR's education strategy and approach, especially the focus on life-long learning and integration into national systems. UNHCRs education portfolio was implemented through one implementing partner.

With 12%, UNHCR's education budget constituted a substantive amount of UNHCR's emergency response. A large part of the education budget was invested in physical infrastructure of schools and teacher accommodation in the three settlements, which was partly a result of funding coming in very late in the year that had to be spent by year end and could therefore not be invested in longer term teacher contracts or teacher certification and training.

Physical infrastructure was a large part of the education response, which requires a large investment in long-term quality teaching personnel and support in order to be sustainable, especially in a context where refugee schools are taken over by the Government of Uganda. Given that the majority of education interventions (early childhood for example) are funded directly by partner organizations and that donor funding has already started to decrease, the sustainability of the education investments not clear.

The evaluation found that after effective education coordination in the beginning of the emergency, Kampala level coordination on education remained weak throughout the year, even if education coordination mechanisms were set up in Arua. In other locations however, education coordination in 2014 was described as not effective by key informants. Overlaps existed in the provision of notebooks, teaching and learning materials, partners paid different amounts for the same functions (ECD), some gaps such as inclusive education were not addressed and there was an uneven coverage of education interventions between Arua and Adjumani. The remuneration and payment of examination fees for refugees caused friction between partners, as UNHCR (and the OPM) was not following the policy of Uganda and local standards in these matters. Cooperation on education with the OPM as well as the education district office remained strong throughout the response, but coordination between UNHCR and UNICEF was initially marked by policy differences.

The education response was shaped by the high number of school–aged refugee children. Based on the Ugandan Refugee Act, refugee children in Uganda have access to national schools. Overall, the response was in line with UNHCRs strategic vision to facilitate **refugee access to national schools**. At the same time, some policy approaches (payments of ECD personnel and examination fees) are not in line with Government policy and set standards that are higher than local education standards, which makes integration into national education more challenging and contributes to friction between refugees and local populations. Targeting approaches such as distributing textbooks and sanitary materials only to refugees in a context of ensuring that both refugees and local populations have access to quality education might not favour integration. Key informants agreed that children with disabilities have not been sufficiently integrated into schools and UNHCR's approach to take children with disabilities into boarding school outside the settlements was criticised.

The evaluation found that great efforts were made to avoid setting up parallel education systems, including through cooperation with the District Education Office. The physical and human resource capacities of schools in Northern Uganda were not, however, sufficient to absorb the large number of refugees (see table below) and additional schools for refugee children were established in line with Ugandan education policies and standards, and in principle, accessible to refugee and local communities. As a consequence, a parallel education system was largely avoided.

Table 10: Number of South Sudanese school-aged refugee children in Uganda, 2014

	August 2014	October 2014
3-6 years	**28,127**	**29,221**
7-14 years	**40,429**	**41,813**
15-18 years	**27,637**	**29,752**
Total	**96,193**	**100,786**

Source: UNHCR monitoring data

Because of the possibilities to access national schools, some refugee children started to go to local schools as early as February in Adjumani. In Kiryandongo, education programming started in the first months but children only started to go to school in April (2nd trimester). The education response focused on providing pre-primary education through early childhood development centres and primary education (grade 1-8). Very limited support for secondary school education was provided and the reasons for this could not be clearly established. Reasons provided were low absorption capacity of local secondary schools, high school fees and the need to prioritise in view of limited financial resources. There was a lack of understanding among partners on UNHCR's education strategy and the extent to which UNHCR also covers secondary education, but this does not explain why support to secondary education was very limited. Support to tertiary education of 5 South Sudanese students was provided through the DAFI scholarship programme.

Key interventions included renovating infrastructure of schools that were built for previous refugees but had not been maintained, building of schools, classrooms and teachers accommodation, recruitment of teachers, provision of text books and learning materials, teacher trainings and coordination with partners, including district government. Refugee parents financially contributed to primary education of their children. No accelerated learning classes were offered in 2014, the Government of Uganda does not promote these but rather wants to focus on increasing quality in schools.

The **primary schools** established for refugee children included both government and community schools, partly set up by the refugee community, which followed the same curricula as national schools but were not certified or recognized as government schools. In both schools, refugees follow the national Ugandan curricula and are taught in the Ugandan language of instruction, which is English. Teachers in the government schools were Ugandan teachers while refugees were recruited as classroom assistants. Refugee teachers were recruited in community schools. While these additional schools were open to local children and participation of local children was welcomed and encouraged, especially by the Government of Uganda, some of the schools were too far from local villages to receive local children. Material assistance related to schooling (textbook, sanitary materials for girl) was provided to refugee and local children.

Early childhood development (ECD) centres were set up for children in all settlements for the age group of 3-5 year old, mainly with funding from UNICEF. The physical quality of the centres varied with some centres not up to standard while others were well-equipped and spacious. Most of the ECD centres were housed in the same location as the child friendly spaces and personnel of ECD centres were mainly refugee volunteers. ECDs are open to local children, but because of their location they are too far for most local children to come to. Contrary to the policy of the Government of Uganda and local practice in the refugee hosting districts, UNHCR paid caregivers in ECD and supported examination fees of refugee children.

This practice did not create policy coherence among education partners and is of limited sustainability.

The response interventions established a link child protection and education for younger children with the objective to reinforce protection outcomes through education; however, older children and especially youth missed out of the response since most interventions focused on early childhood and primary education. **Post-primary education** was in principle open to refugee children and some refugee children attended local secondary schools. The main barriers were school fees and the absorption capacity of local secondary schools.

Overall, the education response was able to achieve a good **primary school enrolment rate** relatively quickly through a focus on access to education. Six months after the response, the primary school and early childhood enrolment was around 60% in Adjumani. Education indicators show (see Table 10) that enrolment and education efficiencies were relatively high around six months after the emergency but then declined towards the end of the year. Reasons for this were mainly found in renewed arrivals of refugee children. Detailed enrolment data for Kiryandongo and Arua are not available and education for refugees in Kampala is not tracked. Attendance is not regularly monitored.

The response set a learning continuum in motion, starting at early childhood education, which was established very quickly. Post-primary education remained a critical gap that may be affecting primary school completion rates in the long run. Education efficiency has improved greatly through infrastructure, teacher recruitment and learning materials. Focus group discussions, participatory assessments and reviews have highlighted that south Sudanese refugees regarded education as a priority, but that the education response in the first year was insufficient.[96]

The quality of education has not yet been emphasized and the recent Child Protection index study points to issues of violence and security in and around schools. In the evaluation survey, education was rated as the most problematic sector and almost half of the survey respondents did not find that for education the outcomes have been adequate and proportional to the response.

Table 11: Education indicators: January - December 2015

	January	**March**	**June**	**December**
Enrolment early childhood development	0	n/a	64.1%	59.8%
Enrolment primary school	n/a	n/a	66.9%	54.9%
Enrolment 2ndary school	n/a	n/a		9%
# or % or qualified teachers	n/a	n/a	n/a	n/a
Pupil/classroom ratio	n/a	n/a	158:1	252:0
Pupil/teacher ratio	n/a	n/a	n/a	1:74 Adjumani; 1:64 Arua
Pupil/textbook ratio	n/a	n/a	n/a	
Pupil/desk ratio	n/a	n/a	n/a	1:6 Adjumani 1:5 Arua
Pupil/latrine ratio	n/a	n/a	131:1	124:1
Completion rate	n/a	n/a		

Source: UNHCR monitoring data, UNHCR Kampala

[96] Source: findings of participatory assessment, focus group discussing, survey respondents of this evaluation, review of the regional child protection framework

UGANDA Conclusions and Recommendations

Effectiveness

Overall the Uganda response was effective in meeting the needs of refugees in a timely manner, despite the absence of recent contingency planning and minimal ad hoc preparedness for the emergency. The Ugandan Government and institutions, at a central and local level, played a crucial role in creating a very favourable operational context and protection environment. The UNHCR-led response effectively enabled the registration of all people of concern and by that, providing a pathway to protection and assistance. While UNHCR's leadership and coordination efforts were also instrumental in reaching the objectives, much credit also has to go to operational and implementing partners. Some specific protection activities, however, were affected by poor coordination and limitations in partner capacity that were not adequately addressed.

The sectorial responses largely met the needs of the refugees in a timely manner. Great strides were made in bringing health services up to satisfactory humanitarian standards and both communicable and non-communicable diseases have been addressed. The nutrition response effectively managed the burden of malnutrition in the refugee community although an early focus on nutrition programming was limited. A weak community outreach system is one of the main hindrances to effective nutrition programming. Most refugee children were enrolled into pre-primary and primary education through schools operating under the Ugandan national education system. Water and sanitation infrastructure was generally constructed to a good standard. Water quality and latrines for difficult environmental conditions were, however, not adequately addressed, and hygiene promotion was not sufficiently focused. Site identification was done relatively quickly despite challenges and site planning was done reasonably well. Emergency shelters did not afford an adequate level of protection, and the majority of refugees constructed their permanent shelters themselves, generally to a reasonable standard.

Relevance/Appropriateness

The design of the RRP and UNHCR's emergency response, including protection priorities and interventions, were relevant and appropriate to the needs of refugees also thanks to early, participatory, interagency assessments.

The protection priorities in the first year of the response were based on a range of needs assessments and were adequate to the needs of different groups of the refugee population. A relevant prioritisation was the focus on child protection, even though the actual response had gaps in programming and education for youth.

The health response plan was appropriate and based on multiple needs assessments with objectives and programming tailored to the operational context. The education response was similarly informed by sound assessments and adequately linked to and attempted integration into national services. The Shelter and Sanitation strategies were appropriate for a context in which the focus is refugee self-reliance, but required more consultation with and support to refugees. The water supply strategy was appropriate for the hydrogeological environment and guided by a clear set of targets, but hygiene promotion, on the other hand, included some inappropriate activities.

Coverage

The UNHCR coordinated protection and assistance intervention reached the vast majority of the beneficiaries in need. The geographic coverage was even across locations for registration, however uneven with regards to SGBV, Child Protection and security across the four locations hosting refugees. A policy of integration meant that the local population largely benefited from the services available to refugees and vice versa, although not always to the same extent.

Health services scaled up to meet the needs to the refugees however the community health system was essentially dysfunctional weakening disease surveillance, prevention of disease and malnutrition, and early identification of illness. After a slow initial start the WASH sector scaled up rapidly, and indicators of access to water and latrines were approaching or had

reached SPHERE standards by June 2014. Early childhood and primary education was established in all camps and achieved relatively high enrolment with marked variations across locations. Secondary and tertiary education response for the age group of 11-18 remained a critical gap area in 2014.

Coordination

UNHCR Uganda played a very positive, inclusive coordination role, according to the vast majority of key informants. Good coordination products and processes happened on a regular basis. The lack of an information management specialist until 2015 however contributed to UNHCR limitations in issuing technical, sector specific and demographic/statistical information products. The contribution by UN agencies, IPs and OPs was critical to the timely support but partner perception was that it was not sufficiently acknowledged in official reporting.

The cooperation with the Government of Uganda on protection was collaborative and strong at all levels with the Government in the lead of refugee protection. The UNHCR coordination promoted synergies among protection partners and mobilized appropriate partners but did not cover all gaps. Coordination on case management for child protection and SGBV remained insufficient. There was excellent coordination in the health response with a high level of partnership with national authorities. A collaborative spirit promoted partnership in nutrition through a well-coordinated response however there were some challenges in promoting synergies to prevent gaps and duplications. UNHCR's coordination role was effective in achieving primary enrolment rates for children and partially effective in mobilizing appropriate education partners promoting some synergies and avoiding some gaps. UNHCR provided the strong coordination in WASH that was required given a fluid situation and a large number of WASH partners, although the management and oversight of certain thematic issues, notably establishing regular water quality monitoring and developing a standard latrine design, was weak. The involvement of the district government in site identification and planning was limited in Adjumani and Arua Districts, and coordination between site planning and service provision sectors could have been better.

Connectedness

The large investment in service infrastructure (reception centres, health and educational facilities) could be challenging to longer-term sustainability and maintenance. The formulation of the ReHoPE strategy focusing on self-reliance and resilience of refugees and host communities, integrated service delivery, suggest that UNHCR and partners have started to address this issues.

The protection response was largely consistent with UNHCR's corporate protection priorities. Linkages with national systems at district and central level have been established and need reinforcement in order to ensure sustainability of the protection response. More linkages with national child protection services could have been beneficial for the sustainability of the response. The integration of education into national system is on its way and the response was delivered accordingly with parallel systems largely avoided. Linkages between the education response and child protection priorities were established and solutions oriented education decisions were taken. An operation and maintenance strategy for water supplies was yet to be developed at the end of 2014.

Impact

The emergency response provided protection to refugees by enabling unhindered, non-discriminatory access to Ugandan territory and registration and enabling access to protection services. It saved lives and enabled refugees to enjoy essential services and some degree of self-reliance.

The expansion and improvement of health services in the areas of operation had positive outcomes for both the host population and the refugee community. For the first few weeks of the crisis, environmental health conditions were poor in the reception centres, but conditions improved dramatically once UNHCR and partners began relocating refugees to settlements. Outbreaks of communicable diseases were largely avoided. The integrated nature of the response expanded nutrition services to both refugees and the host population increasing access to care. The education response enabled access to education for a considerable number of young children.

Recommendations

1. **Documentation, including birth registration, should be made a protection priority given existing national laws that facilitate documentation to all.** Critical protection outcomes are linked to registration, such as documentation. Steps should be taken to ensure that even after the handover to the Government the registration can still provide UNHCR with the required data and that a verification exercise is undertaken to serve as the basis for documentation provision.

2. Develop an integrated **community-based protection** and **community mobilization strategy** across sectors linked with consistent coordination on community incentive schemes and based on assessments (participatory, mapping of existing structures) across partners in order to create consistency and coherence.

3. **Strengthen case management for Child Protection and SGBV** through enhanced coordination, information sharing, finalisation of SOPs and capacity building of partners. Case management procedures should - to the extent possible - link to national systems, processes and be inclusive – this will also contribute to sustainability and coherence with UNHCR's ReHope strategy. Efforts have already been taken to increase utilization of SGBV response services, these efforts should continue.

4. **Harmonise policies and procedures for the identification, referral and follow-up on persons with specific needs across partners**. Put measures in place to ensure collaboration and coordination among partners dealing with people with specific needs.

5. **Strengthen and systematize accountability to affected populations as a cornerstone of the centrality of protection.** An action plan of how to implement accountability mechanisms based on the current structures and processes is required to ensure transparent communication and expectation management with people of concern, including participation in planning, implementation and monitoring across sectors.

6. **Operationalize and develop a fund raising plan for the ReHope strategy in order to ensure a solution orientation of the response as well as sustainability.** Efforts made in this regard need strengthening in light of expected resource decreases and ongoing conflict in South Sudan which makes return unlikely in the foreseeable future and the running costs of the various structures (reception, health, etc.) built by UNHCR and its partners difficult to sustain in the medium-term. The ReHope strategy with its focus on sustainable livelihoods for refugees and host communities and enhancing integrated social service delivery capacity in refugee hosting areas, is good platform, even if it still needs operational details and final approval from the Government.

7. **Fully operationalize the community health and nutrition outreach system.** UNHCR needs to provide strong leadership to resolve the issue around incentive payments for community volunteers. With a functional community system the full continuum of prevention and treatment of malnutrition could be realized as well as reducing the burden on the health system through community-level identification and treatment of diseases.

8. **Strengthen the prevention, early diagnosis and treatment of malaria**. By significantly reducing the burden on the health care system and lowering mortality rates related to the disease, this intervention could have wide ranging positive consequences on the overall health and nutritional status of the refugee population. Priority areas to focus on are ensuring that each household has mosquito nets in proportion to need and that there are hang-it-up campaigns; increasing the use of rapid diagnostic testing at the community level and strengthened community messaging.

9. **Conduct an analysis of the drug procurement process** in Uganda to identify the key points of delay in the lines of procurement. Create an action plan to implement changes required to streamline the procurement and delivery of drugs.

10. **Immediately begin regular water quality monitoring and develop an appropriate water safety plan for eachsettlement.** Water quality at every water point, plus a random sample of households' stored water, should be conducted regularly. Ideally a single partner should be designated in each camp to minimize coordination and accountability issues. Anonymised results of household tests should be shared as part of awareness raising activities. Sanitary surveys of water points should be conducted by trained water

committee members on a monthly basis. Where sanitary surveys or water quality testing indicate contamination of water facilities, intensified testing should be instigated until the issues is seen to be resolved.

11. **Develop a formal operation and maintenance strategy for water supply** that includes the phasing in of water user fees, tariff setting, management and maintenance. The strategy should be developed in close collaboration with the District Water Offices for Arua, Adjumani and Kiryandongo, UNICEF and partners involved in water supply provision. It must be compliant with Ugandan policy and regulations. A strong sensitisation effort and participatory planning involving the water committees should be undertaken as soon as possible, as budgets reductions take hold. UNHCR needs to engage more strongly with UNICEF on this.

12. **Revise the hygiene promotion strategy to focus on reinforcing priority public health messages through a more appropriate mix of communication channels**. House to house promotion needs to be reinforced with a mix of community events (discussions, competitions, drama etc.) and mass media (poster at strategic sites) that raise interest and awareness. The strategy should increase emphasis on linking behaviours to new facilities such as household latrines and hand-washing facilities.

13. **Finalise key indicators for hygiene promotion.** The roll-out of hygiene indicators has been delayed too long – a decision needs to be made. Indicators should be reviewed after 3 months to ensure that they are appropriate and measurable.

14. **Conduct a survey of the type and condition of shelters.** The survey should determine the proportion of refugees with adequate shelter and the types and frequencies of issues with shelter design and construction. The survey should also be used to assess the satisfaction of PSN's in particular with the design of their shelters. The unit of measure of the population-based survey should be the family, and the survey should also assess the number of people residing in shelters and the frequency of sharing between families.

15. **Develop a Shelter Strategy for Uganda**. The strategy development should be based on consultations with refugees from different areas and different age, gender and diversity backgrounds and should identifying different options to deal with local material shortages, refugee participation, shelter-related protection issues and monitoring requirements.

16. **Develop an action plan for strengthening access to post-primary education** for refugee children and adolescents in line with UNHCR's objective to achieve integration into national services and in light of possible durable solutions. The post-primary education action plan should be linked to the livelihoods and self-reliance programming, including vocational training.

17. **Streamline education data management across** locations and define key education indicators and data collection mechanisms. Set up education data management system and advocate for the integration of education data into district education information management systems.

18. **Strengthen coordination on education programming** and put measures in place that ensure that education policies and programmes of the response are agreed among partners and fully in line with national Ugandan policies.

ETHIOPIA Operational Context

Ethiopia ranked 173rd out of 187 in the Human Development Index 2014 with a life expectancy of 63.6 years, a Gross National Income of USD 1,302 per capita per year, 2.41 Mean Years of Schooling, a total population of 94.1 million and a population density of 97 inhabitants per square km. From an ethno-linguistic point of view Ethiopia is a very diverse country and since 1995 it is a Federal Republic with nine regional states largely defined on an ethno-linguistic basis. The Gambella Regional State is made up predominantly by two related, but distinct, ethno-linguistic groups: the Anuak[97] to the east and the Nuer to the west. The Nuer, although predominantly found in South Sudan, are therefore a cross-border ethnic group and given that they constitute the majority of the refugees from South Sudan (both historically and currently) it is difficult to distinguish them from local, Ethiopian Nuers.

Regarding the total number of refugees hosted in 2013, before the new influx from South Sudan, Ethiopia ranked 8th in the world with 433,900 refugees and 2nd in the world in terms of number of refugees per 1 USD GDP per capita, i.e. 336. The refugees originated mainly from Somalia, Eritrea, Sudan and South Sudan. By the end of 2014 Ethiopia ranked 5th with a total of 659,524 refugees and 1st in the world in terms of number of refugees per 1 USD GDP per capita, i.e. 440[98].

Like Uganda, Ethiopia has a long history of hosting refugees, particularly Nuer from (South) Sudan, who appear to have had an impact on the demography and ethnic balance of the Gambella region. “Beginning in the 1960s, but with much greater intensity since the late 1980s, the number of Nuer in Gambella has increased due to the arrival of refugees from southern Sudan … the Anuak population has also risen, but to a much lesser degree”[99]. This trend that might be described as “refugee sedimentation” seems to be confirmed by official Ethiopian statistics. According to the 1994 Housing and Population Census of Ethiopia[100], the Gambella region had a total of 162,397 inhabitants, of which 64,473 (40%) were Nuer and 44,581 (27%) Anuak. In 2007 the Census reported that there were 143,286 Nuer (46%) and 64,986 Anuaks (21%) out of a total population of 307,096. These changes in the ethnic balance have been exacerbated by the allocation of large tracts of Gambella regional state land to agribusiness private companies. According to one estimate, “In Gambella 42 percent of the total land area is either being marketed for lease to investors or has already been awarded to investors”[101]. Moreover, a lot of the land in the Gambella Regional State, particularly in the Nuer areas, is flood-prone.

These issues, namely cross-border Nuer ethnicity, the delicate Nuer and Anuak ethnic balance in a context of competition for scarce land resources and the very limited availability of land suitable for refugee camps or settlements, have constituted major external constraints on an otherwise relatively favourable protection environment, as we shall see later.

The UNHCR presence in Ethiopia included, besides the Representation in Addis, five Sub-offices, five Field Offices and several Field Units. There was a total of 420 UNHCR staff (international and national). The total available funds for all refugee programmes were USD105.7 million out of a needed total of USD192.9 million[102]. Crucially one of the Sub-Offices and a Field Office were in Gambella, opened in the 1980s since the first waves of refugees from southern Sudan. However the Gambella operation, including the Sub-Office,

---

[97] The name “Anuak” is also spelled in other ways such as “Agnuak” and “Anywaa”.

[98] UNHCR Global Trends/ Forced Displacement 2013 and 2014 http://www.unhcr.org/556725e69.html

[99] Dereje Feyissa. 2011. Playing different games: The paradox of the identification strategies of the Anuak and the Nuer in the Gambella region. New York: Berghahn Books.

[100] *Ibid.*

[101] Environmental Justice Atlas, https://ejatlas.org/conflict/gambela-agri-export-land-dispossessions-ethiopia

[102] UNHCR Global Report 2013

were in a down-scaling mode even if the 2013 was foreseeing an increase in new arrivals from Sudan and South Sudan.

In terms of partnerships, UNHCR worked with over 40 partners among governmental entities, UN bodies, local and international NGOs, including both implementing as well as operational partners. The main institutional partner is ARRA (Administration for Refugee and Returnee Affairs)[103], the *de facto* responsible body for the protection of refugees, including registration, refugee status determination, camp management, security and protection, but also some other sectorial activities such as health, education and food distribution. While the Government of Ethiopia has adopted an "out-of-camp" refugee policy for Eritreans, it expects South Sudanese refugees to reside in designated camps, but turns a blind eye to refugee movements and allows them to work in the informal sector but not to take up formal employment. The camps do not have enough land for cultivation except for very small-scale vegetable gardening.

ETHIOPIA FINDINGS

Strategic Planning

Contingency Planning and Preparedness

A **contingency plan** for South Sudanese refugee arrivals in Gambella Region was prepared by UNHCR's Gambella Sub Office in March 2013[104] but was out of date and grossly underestimated the scale of the influx and impact on land/site allocation. The worst-case scenario envisaged 25,000 to 40,000 new arrivals between March and June 2013. In terms of land for refugee camps it highlighted that the only remaining camp, Pugnido, had a capacity to accommodate only a further 25,000 refugees. The contingency plan involved hosting refugees in camps in Pugnido, despite the fact that their combined spare capacity of 25,000 was insufficient for the worst-case scenario. The plan therefore focused on existing partners in Pugnido camps extending their range of services to the new arrivals. The plan did not appear, therefore, to have been relevant to the actual events from December 2013, which saw over 100,000 new arrivals over the first four months, as per Figure 5, below. In an "Accountability Matrix"[105] signed on 20 November 2013 and applicable in 2014, UNHCR and ARRA already envisaged a new camp in Leitchuor with support of partners already operating in the area. The contingency plan was updated and expanded in April 2014[106], in the midst of the emergency, and contained Strategic Response Objectives, Overall Response Strategy, Objectives, Activities and Performance Indicators. The April plan appears to have been the result of a consultative process between UNHCR and its main partners, ARRA, UN agencies and NGOs. As part of the preparations for any emergency in Ethiopia, the Representation received support from donors to create a stock of Core Relief Items for 20,000 beneficiaries.

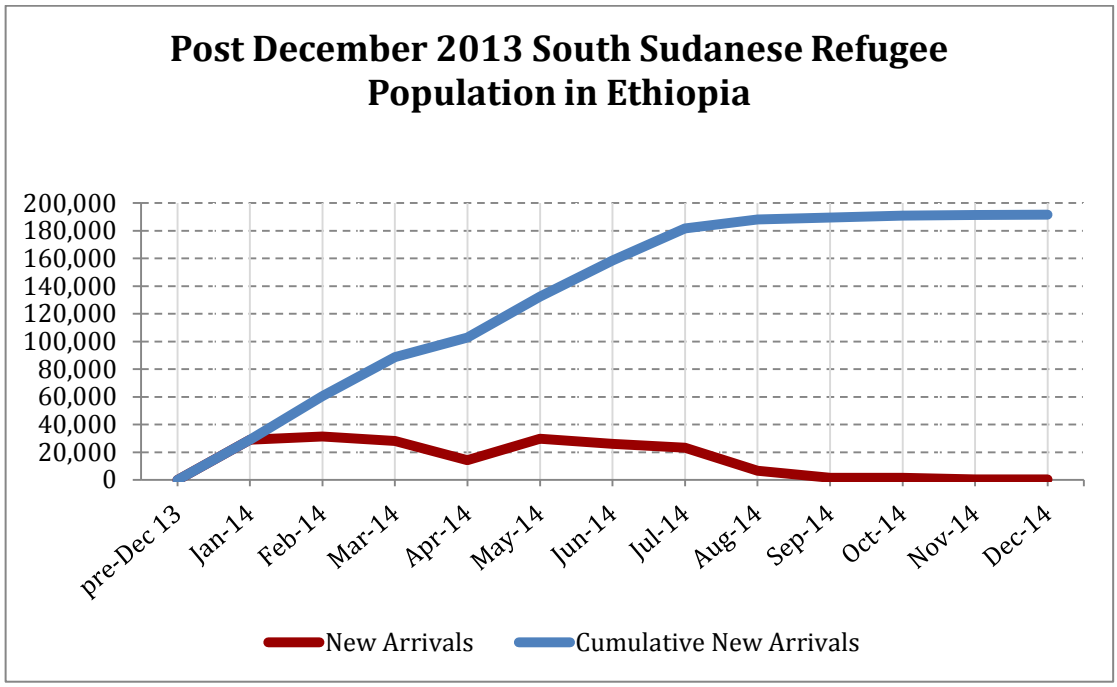
[103] Formerly a branch of the Ministry of Internal Affairs and currently of the National Intelligence and Security Services

[104] UNHCR Ethiopia (March 2013) Emergency Preparedness and Response Plan for a Possible Influx of Sudanese and South Sudanese asylum seekers to Gambella Regional State, Ethiopia Ababa

[105] Otherwise known as 3W Matrix, "Who does What, Where", see further under "Coordination and Partnerships" below.

[106] "South Sudan Situation Refugee Contingency Plan Gambella/Assosa April 2014".

Figure 5: New South Sudanese Arrivals in Ethiopia 2014



Source: UNHCR Gambella

Considering the downscaling mode of the UNHCR operations in Gambella and the underestimation of the refugee influx, there was **limited specific preparedness** for the South Sudanese emergency situation, and the magnitude of the influx having caught everyone by surprise because, as in Uganda, key stakeholders considered that ethnic and political tensions in South Sudan had already happened before without leading to substantial displacement.

One favourable development that played an important role in preparedness was the signature of a **Letter of Understanding (LoU) in June 2012 between UNHCR and UNICEF**. The LoU foresaw "operational activities and expert support to UNHCR and/or under the coordination of UNHCR … as mutually agreed during the emergency and post-emergency phases of refugee situations". It thus facilitated the rapid engagement of UNICEF and its regional line ministry partners. This followed from lessons learned from the Dollo Ado response. In the words of one donor representative, "The Dollo Ado experience was the best contingency planning for Gambella". A plan of action accompanying this LoU detailed specific contributions of UNICEF in the health, nutrition, WASH, education, and child protection sectors.

There were also some **mitigating factors** such as the fact that UNHCR in Ethiopia was fully operational since it was already involved in emergency responses for a refugee influx from Sudan, Eritrea and Somalia. This meant that even if UNHCR Ethiopia was stretched, it could immediately redeploy some key staff from the other more "mature emergencies" towards the Gambella theatre of operations. Another preparedness initiative - an emergency training for national staff, including from Gambella, in August 2013 – presumably had some positive impact on the effectiveness of these redeployments.

Response Strategy and Design

The Ethiopia section of the RRP contained many quantified targets under "Planned Response". The majority of respondents in the online survey do not agree that the RRP was based on sound assessment of the context and needs. This is further highlighted in the findings within the sectors, which found limited use of assessments and refugee participation in the planning of the design. Its main elements included: providing unhindered access to territory, Level 1 registration at border entry points and Level 2 registration in the camps (both with biometrics), child protection, SGBV, education, core relief items, emergency and permanent shelter in parallel, emergency health and nutrition assistance, WASH and

environmental protection. One key weakness was that even in July 2014, when the revised RRP was issued, the strategy foresaw the development of permanent ('transitional') shelters in Leitchuor, which at this point in time UNHCR knew was at high risk of flooding.

The April 2014 Refugee Contingency Plan contained strategic objectives focusing on protection, life-saving solutions and maximum utilization of existing national capacities and coordination. Another important aspect was "moving refugees from the border to the existing refugee camps and the newly identified sites of Kule and Leitchuor". Finally around May or June 2014 UNHCR developed a detailed (88 pages) "**Sub-Office Gambella Workplan**", broken down by sector and camps and including Action Points, Responsible Parties and Deadlines. We may highlight two points of this Workplan. First a strong emphasis on Nutrition and Food Security and second a concern about the risk of flooding in Leitchuor: "The identification of new suitable land remains the main challenge. It's a process that sometimes goes beyond the direct control of UNHCR, we are left in the limbo of the decision making process of our National Counterparts from Local level up to National level." Overall two-thirds of respondents to the online survey disagree that 'given operational and contextual constraints, satisfactory humanitarian conditions have been met' reflecting that the response was not satisfactory.

A true long-term strategic plan, linking host community and refugee service delivery for long-term efficiency and sustainability has been lacking as the response struggled to keep up with the various challenges presented by the crisis. The planning seemed to be always behind the steep curve of events and in August 2014 the beginning of the flooding in Leitchuor (see further below) prompted the UNHCR Addis Office to formulate an "Operations Continuity Plan "to maintain sustained services to affected areas in the face of reduced staffing, closed roads, and limited access, while simultaneously empowering the refugees to more actively manage the day-to-day aspects of assistance themselves".

However in the on-line survey, 80% of respondents disagreed that 'longer-term objectives and solutions have been given due consideration in the planning process and choice of interventions'. There have been specific isolated examples of longer term or more strategic thinking, such as the involvement of the RWB in the management of the water system for Tierkidi and Kule, but a wider strategy for linking host community and refugee service delivery for long-term efficiency and sustainability was, however, lacking.

Response Management

Coordination and Partnerships

The coordination of refugee emergencies in Ethiopia is primarily driven by the **relationship between UNHCR and ARRA**, which chairs the Refugee National and Regional Task Forces. In addition to its role as main institutional counterpart, ARRA also implements many sector activities in all refugee camps. In 2013, before the December emergency it was implementing almost all sectorial activities in Pugnido and had been reluctant to allow other actors to have an implementation role. Compared with previous emergencies (particularly the 2011 Somalia Refugee crisis in Dollo Ado), however, there was in this case a much greater timely inclusiveness and openness by ARRA to accept the presence of international NGOs who could contribute to tackle the emergency in the field.

The **coordination architecture** is formally quite inclusive and in Gambella the Coordination Task Force includes 7 UN agencies, 20 NGOs, line ministries and Refugee Central Committee representatives. Technical Working Groups for the range of sectors held separate coordination forums that reported back to the Refugee Coordination Task Force. The coordination architecture follows the principles of the newly introduced UNHCR "Refugee Coordination Model"[107]. There have also been good coordination products, such as regular

[107] See the "PPT Presentation on the "Refugee Coordination Model in Gambella" in Annex 4.

Operational Updates, maps and statistical information that were regularly posted in the UNHCR Web Portal accessible to the general public. UNHCR's approach to coordination was considered overall to be collaborative and responsive although opinion was widely divergent. Some UN agencies and donors praised UNHCR's leadership and coordination role ("great job"; "one has to give credit to UNHCR given the enormous constraints particularly associated with the land issue, the dialogue with the relevant authorities and partners continued both in Gambella and Addis Ababa level"). This was also echoed by some NGOs ("UNHCR and ARRA were fast in mobilizing NGOs"). But other NGOs, particularly international ones, were fiercely critical of the UNHCR-ARRA role and process in Operational and Implementing Partner selection in the "3W Accountability Matrixes", particularly with the arrival of new partners in connection with the opening of new camps in Gambella as the emergency unfolded in 2014.[108] In the online survey[109] 90% of respondents criticised UNHCR's coordination role**.** The following is a sample of comments on this topic, made by International NGOs:

- "The selection of IPs was another weak point where UNHCR failed to select the relevant IPs and this led to failure in many sectors including as example … education and health",
- "The coordination has been weak especially in the WASH sector. The management of the matrix is non transparent and results in delays in assistance",
- "There are visible gaps and duplications in Gambella. NGO partners have noted that UNHCR has left them to coordinate themselves…",
- "There is high level and unhealthy competition among implementing partners made worse by the confusion about which IP should work where resulting in utter confusion…the issue of accountability matrix and transparency of the process needs to be reviewed",
- "No true partnership, everything was opaque with no clear lines of authority and no idea about who was actually making or empowered to make decisions",

The evaluation team noted that partners' ability to plan and develop strategies was constrained by poorly coordinated and **opaque decision-making**. The Task Force, whilst a valued coordination forum, was too large a body for effective decision-making and decisions could not be taken on several occasions because ARRA was not present. Whilst UNHCR had a decentralised approach, with the Gambella Sub-Office managing the emergency response, some critical decisions, such as who would work where and implementing partner selection, were made in Addis Ababa. Partners cited difficulties in communication with UNHCR's Addis Ababa office, exacerbated by a lack of contact details provided as well as broken promises over funding.

A significant example of this was the decisions around the **accountability matrix** – who did what where – required the input and approval of ARRA and therefore had to be made at Addis Ababa level. Some of the decisions about which agency was designated to work in which camp were questioned by various stakeholders, as was the lack of transparency around how they were arrived at. Developing the matrix for a camp would take too long and in some sectors arguably too many partners were put in one camp[110], which made monitoring and gap identification more difficult. A clear process for making changes to the accountability matrix was also lacking. The evaluation team could not find evidence of any accountability matrix signed and sealed by UNHCR and ARRA between the beginning of the emergency and the end of 2014, but only several drafts with changes in partners at the camp and sectoral level. There was no evidence that due process was followed in the selection and retention of partners even in the second half of 2014 and in particular on the right of partners

[108] The Jewi camp matrix, signed on 24 March 2014, was a focus of discontent.

[109] Not a representative sample

[110] For example in October 2014 there were in Kule 4 partners for WASH, 4 for Food Security and Nutrition, and 3 for Health, while in Tierkidi 4 for WASH, 3 for food Security and Nutrition and 4 for Health (Map on South Sudan Emergency, Sectoral Partners in Gambella Region as of October 2014 in the UNHCR South Sudan Information Portal)

to be informed on the rationale of specific decisions on selection or retention[111], let alone to have a partner co-leading some technical sectors[112]. **Implementing Partner selection**, was conducted in Addis Ababa and without the participation of technical staff in the Gambella Sub-Office. This deprived sector coordinators in Gambella of the ability to make changes where implementing partners where overstretched or performing poorly. Such changes would have been appropriate in some cases.

This real or perceived **lack of transparency** may be at least partially explained by three factors. First, the UNHCR operation was under-funded and both UNHCR and ARRA had to rely on NGOs who had bilateral funds of their own and it was difficult to turn them away. Second, there was a lack of continuity and varying quality of UNHCR leadership in the technical sectors, which constrained UNHCR's ability to select and retain the best partner in a given sector. Third, there is a disconnect between the theoretically decentralized UNHCR operational management in which Heads of Sub-Offices have a delegated authority to make decisions, and the centralized approach to coordination adopted by ARRA in Addis. But the result was that by the end of 2014 there were multiple partners in the same sectors in the same camps, leading to different approaches for example in shelter and sanitation.[113]

In terms of partnerships, the most noteworthy development was the **LoU with UNICEF** that covered health, nutrition, WASH, education, and child protection (more details under the sectorial sections). The LoU 'foresees enhanced collaboration between the parties with respect to refugee assistance' in multiple sectors including health and nutrition. This was to include a) joint advocacy, b) expert support to UNHCR and c) collaboration in joint resource mobilisation. Under this LoU UNICEF seconded several technical staff to UNHCR who was fully integrated within UNHCR. In spite of a few glitches, this cooperation worked very well according to the overwhelming majority of interviewees and was instrumental to provide the necessary sectorial expertise for the emergency response. One donor commented that perhaps there was "over-reliance" by UNHCR on UNICEF to secure the timely deployment of technical staff.

Information Management

One strong point of the UNHCR Gambella operation that contributed to coordination was the availability of a professional **Information Management officer** hired via fast-track in July 2014 which enabled the operation to populate the Ethiopia section of the UNHCR online South Sudan situation Information Sharing Portal, with numerous quality documents (approximately three times more than the Uganda section), including demographic/statistical updates, camp profiles and a Sectors Indicators Matrix with colour coding that would show if standards have been met or not. This matrix was a useful and effective tool to assess performance in various sectors across the camps and an action plan was developed for those indicators that did not meet the standards in Health, Food Security/Nutrition and WASH[114]

Within **sectoral information management**, challenges remained, both with process and with data quality. For example the WASH sector had different actors for a specific subsector in the same camp. An analysis of coverage and gaps therefore required a more detailed look across the zones of the camps, for which coordination meetings and other discussions were

[111] As per the Implementing Partnership Management Guidance Note #1 on "Selection and Retention of Partners for Project Partnership Agreements" of July 2013

[112] "In the spirit of partnership and recognizing the rich experience and expertise of partners, the UNHCR office, in concurrence with the relevant technical unit at HQ and in consultation with agencies active in the response, may invite a partner to co-coordinate a sector to address the protection and solutions needs" , UNHCR Emergency Handbook

[113] South Sudan Emergency: Sectoral Partners in the Gambella Region October 2014: http://data.unhcr.org/SouthSudan/documents.php?page=1&view=grid&Country[]=65&Type[]=1

[114] "Strengthening Health, Nutrition and WASH Response", UNHCR Gambella, September 2014

required. Within the Health sector, the evaluation team has concerns over the validity of some indicators collected – most notably the mortality data. The figures reported through the UNHCR information management systems are artificially low and this has yet to be flagged and addressed through the information management tools and coordination meetings (see Health Outcomes section). Information management for protection was established only six months into the emergency and more consistency between indicators in UNHCRs data portal and internal monitoring tool is yet to be fully established.

Human Resource Management

In Ethiopia the first line of response was the **redeployment of staff** involved in "maturing emergencies" such as the Somali influx in Dollo Ado, a redeployment that lasted well into mid-2014.The redeployment included Supply (P4 and P3), Field Officers (international and national), Program (international and national), Community Services, Registration (P3 and national); ICT, Administration Officers. However UNHCR Ethiopia made only belated use of the various available emergency deployment schemes. By the end of February 2014 there was only one deployee from the Emergency Response Team (ERT), an Administration and Finance Officer, and none from the Nairobi regional support hub (RSH). The bulk of the staff from the ERT arrived in April (3-4 months after the start of the emergency), and was made up mainly by P3 Protection Officers. Technical staff (WASH, Site Planning, Public Health and Nutrition) also arrived only at the end of April.

The evaluation team found the structuring of the **senior management team in Gambella** was initially weak struggling to adequately manage the emergency. Instead of requesting an Emergency Coordinator from the Emergency Section, however, in addition to the internal redeployments mentioned above, an Operations Manager from the HQs East and Horn of Africa department was deployed to reinforce the Head of Sub Office Gambella from June to September 2014. During the period between January and June 2014 the Deputy Representative had to undertake almost weekly missions to Gambella in order to further support the management of the emergency. The position of Head of Sub-Office Gambella was eventually advertised under the Fast Track was filled in only in October 2014.

UNHCR Ethiopia in total requested 6 positions by end-March, 6 by end-May (including a crucial post of Information Management Officer) and 7 by end-July. A position of Senior Protection Officer was initially not requested, however, and a dedicated Senior Protection Officer to coordinate the Protection emergency response (even if none of the senior Gambella-based staff had a protection background) was only deployed in mid-July for 2 months, followed by another deployment at the end of 2014 which left a critical gap during the peak of the emergency and led, together with other factors to a piecemeal approach to protection that lacked overall protection vision, according to many key informants.

UNHCR experienced **high turnover** during the emergency response in some sectors, with a negative impact on its ability to coordinate an effective response. Poor handover exacerbated the impact and resulted in delays in developing and implementing strategies and plans, and negatively affected monitoring. The site planning and shelter sectors were particularly affected (three site planners and three shelter specialists within 2014). Site plans were sometimes changed when new site planners came on board and a huge gap in permanent[115] shelter need was not closed. UNHCR also experienced two changes in Representative during 2014. Finally, because of bureaucratic problems, staff welfare needs, particularly in terms of accommodation, were not adequately met as highlighted by several mission reports, and contributed to the high turnover.

[115] Transitional shelter in Ethiopia and permanent shelter in Uganda are both equivalent to what would commonly be referred to locally as a 'tukul', i.e. an adobe or mud brick but with a thatched roof. The terminology used in this report is that used in each country. Permanent or semi-permanent would be the more accurate term, as transitional shelter, strictly speaking, refers to shelter that can be dismantled and moved.

Protection staffing for the emergency response was characterized by a series of short-term deployments for specific areas of protection (child protection, SGBV) and by protection staff performing non-protection functions such as reporting, leading to some discontinuity of approaches and initiatives as well as a piecemeal approach to protection. Deployments drew on a variety of sources, including from within Ethiopia and from partners. For example, the rapid large scale recruitment of more than 100 affiliated work force (mainly UNOPS) staff (in total, not at one time) for registration was partly enabled through the re-recruitment of some affiliated work force who had participated in a recent verification exercise in another part of Ethiopia. The LoU with UNICEF facilitated secondments from UNICEF to UNHCR in protection in 2014 which was seen as a very positive mechanism to inject expertise while at the same time strengthening the coordination mechanisms.

Despite the large-scale emergency and the prominent protection concerns **a Senior Protection Officer** was only recruited in mid-July for 2 months, followed by another deployment at the end of 2014. No UNHCR registration staff member was based in Gambella until July 2014. The most senior protection staff during the response was a dedicated officer on SGBV under an initiative 'Safe from the Start'. The evaluation team found that in the case of the emergency response in Gambella, deploying a Senior Protection Officer for one specific area of protection (SGBV) in the absence of a senior staff on wider protection issues led to an imbalance among protection areas and did not strengthen overall protection within the emergency response. A Senior Protection Officer was only deployed in mid-July 2014, followed by another deployment at the end of 2014;key informant interviewees consistently mentioned that the lack of a Senior Protection Officer through large periods of 2014 contributed to a protection gap in the response.

Human resources for the **nutrition response** were covered by the UNHCR Addis Ababa public health officer who was deployed for the first 3-4 months and a re-deployed UNHCR staff from another area. UNICEF rapidly seconded a nutritionist to support in coordination, provide technical assistance and set up standards and an affiliated workforce deployee completed the team. There were no noted nutrition human resource gaps for UNHCR during the response although it is important to note that it was reliant on external technical support. There was limited use of UNHCR regional support hub (RSH). It is notable that there was no dedicated Addis level nutrition focal point for strategic guidance until a position was created and filled in 2015. This gap can be seen in the response management which remained primarily reactive with limited strategic thinking around longer term strategies and sustainable programming. Within UNHCR the nutrition response was fairly well funded at 65% of the requested amount, although this does not reflect the significant contributions of operational partners.

In the **health response**, UNHCR prioritized deploying the UNHCR health officer based in Addis Ababa to lead the response for the first 3-4 months. He was supported by additional re-deployments of staff from other operational areas in Ethiopia as well as with UNICEF secondees and affiliated workforce. There was no indication that there was lack of technical health staff for the response, although there was limited use of regional support hub (RSH) or emergency response team (ERT) resources. However, the deployment of staff from their regular positions in Ethiopia to cover the Gambella response meant that there were capacity gaps within the other operations.

UNHCR's emergency response deployments and staffing requests did not include **education** positions; UNHCRs education response was coordinated and implemented by one internal redeployment from another operation in Ethiopia, two sequenced deployments (1.5, respectively 6 months) seconded by UNICEF and Save the Children, supported strongly by the UNHCR office in Addis. The national education officer in Addis Ababa provided strong support throughout the response; however, one national education position in capital is not sufficient to adequately support large scale operations with a significant number of children. The education staffing levels fell short of the education programming needs resulting from the high number of refugee children.

Programme Management

Out of the total requirement (all agencies) of USD 210.9 million in the Revised 2014 RRP for Ethiopia, of which USD 90.7 million for UNHCR, USD120.5 million was funded in total (57%), out of which USD 53.5 million for UNHCR (59%). However UNHCR, using other source of funding than the RRP (e.g. un-earmarked), managed to increase the budget (authorized expenditure level) to USD72.3 million by the end of 2014, which is USD 378 per refugee, slightly higher than the cost per refugee in Uganda. The amount received per refugee is almost double if we consider the funds received by other agencies involved in the response.

The following table gives an overview of UNHCR Ethiopia's authorized budget and expenditure for South Sudanese refugees in 2014 by "Rights Groups", while more detail at the level of "objectives" can be found in Annex 3.

In terms of sector budgets, the lion's share went to "basic needs and essential services" and in particular to shelter (the largest objective, with 25% of the whole budget and 26% of expenditure), WASH, domestic items, public health, and education. We may note that in Ethiopia the budget for shelter and infrastructure was more than twice the equivalent for Uganda (USD 20 million vs. USD 8 million) even if the number of beneficiaries was only 30% higher because of the greater assistance provided to refugees in the construction of their tukuls (while in Uganda it was pure self-help), but also as a consequence of the Leitchuor flooding.

Table 12: Authorized expenditure level and actual expenditure for South Sudanese refugees in Ethiopia in 2014 by Rights Groups

RIGHTS GROUPS	2014 Authorized Expenditure Level	% Against Total A.E.L.	2014 Actual Expenditures	% Against Total Actual Exp.
Favourable Protection Environment	235,397	0.28	319,259	0.40
Fair Protection Processes and Documentation	8,650,760	10.38	5,467,277	6.86
Security from Violence and Exploitation	3,243,619	3.89	3,317,817	4.16
Basic Needs and Essential Services	57,143,056	68.58	53,744,126	67.40
Community Empowerment and Self-Reliance	2,046,502	2.47	1,572,857	1.98
Durable Solutions	217,397	0.26	201,053	0.25
Leadership, Coordination and Partnerships	216,977	0.26	185,283	0.23
Logistics and Operations Support	11,567,813	13.88	14,927,513	18.72
GRAND TOTAL ETHIOPIA	**83,321,521**	**100.00**	**79,735,185**	**100.00**

Source: MSRP, accessed on 01/09/2015

Delays in, and piecemeal availability of, funding limited the ability of partners to plan and also negatively affected their staff retention. The funding did not come in one go, but in as many as 11 subsequent instalments, the first of which was actually transferred to the Ethiopian operation on 8 January 2014 (by USD 1.6 million) and the last on 8 December 2014 (by USD 5 million for the relocation from Leitchuor and the development of the new camp). Likewise, the time-frame between the submission for budget increases by the Africa Bureau and the decisions by the Budget Committee was relatively short, less than one week on average, but

also in this case many key actors (including senior managers) complained that the process is cumbersome. The expenditure rate was 97%.

This **piecemeal incremental approach** meant that IPs had to pre-finance their first emergency interventions and OPs who do not receive UNHCR funds, such as UNICEF, MSF, ACF, were crucial for life-saving activities at the very beginning of the emergencies. In addition to requesting implementing partners to begin operations and the requisite expenditure on Letters of Mutual Intent (LOMIs), UNHCR at times requested them to do so on verbal promises, which were either not backed up in writing when request, and were occasionally broken. Second, the 11 budget increases implied constant revisions of Project Partnership Agreements (some of which with a duration of only three months) at times involving revising hundreds of budget lines and dozens of objectives. This process is therefore very time-consuming both for UNHCR and IP programme staff (distracting them from other activities such as monitoring and coordination) and was the object of many complaints to the Evaluation mission by IPs. Furthermore the revision of partner and negotiation between UNHCR and IPs over budgets were often prolonged, and UNHCR's decision-making process was felt to lack transparency by IPs. The process could have been streamlined through the judicious use of bilateral meetings involving the technical specialists of UNHCR and partner.

Furthermore, some interviewees from IPs complained that UNHCR's **management of agreements and budgets** for implementing partners exposed them to financial risks and was based on "an oral culture"; for example one international NGO said that they received substantial funds late in November and were promised an extension of the implementation period up to March, a promise which was not upheld, allegedly because it was turned-down by HQs Geneva. The Evaluation mission could not find evidence that the request was submitted to HQs while, on the contrary, all requests were approved, even if belatedly (29 January 2015)[116]. This development resulted in the return of some funds and a qualified audit for the concerned partner.

1. Protection

The emergency protection response was guided by several assessment and planning processes which focused mainly on sub-areas of protection, such as registration and child protection, for which a country as well as a regional framework were developed. UNHCR or partners did not undertake specific protection assessments on protection needs and risks of different segments of refugees. Selected safety audits were conducted for refugees and some protection issues were assessed in multi-sectoral assessments. Planning for protection was consequently done for specific areas of protection and not holistically for the response and across sectors. **No overall protection strategy** was developed for the emergency to guide protection priorities across sectors including protection areas for different protection risks and needs which according to many key informants, contributed to a gap in the overall protection vision and led to a segmented protection approach focusing on sub-areas of protection. Although anecdotal information was shared on protection considerations in sectoral planning, no documented plans for mainstreaming protection across sectors were made. As a result, the evaluation found that the emergency response was not underpinned by a strong protection vision, framework and priorities.

Implementation modalities for protection interventions varied: some areas were delivered by ARRA (security, government registration, medical services to SGBV survivors and others), UNHCR directly implemented other protection interventions such as registration and documentation (proof of attestation), and partners delivered large parts of the child protection and SGBV response.

[116] Email from the Implementing Partnership Management Team of 29 January 2015.

Protection coordination both with the Government of Ethiopia and with partners was an important component of the response with the cooperation between UNICEF and UNHCR being critical to the child protection response through deployments and technical support. There seemed to be diverging information on whether a protection working group had been set up or not, indicating a lack of clarity over protection coordination mechanisms. A protection working group existed at the level of Addis Ababa. At the Gambella level, inter-agency coordination focused mainly on specific protection areas such SGBV and child protection for which specific task forces were established (for example on family tracing and information management). Information sharing was mentioned as the most important success of coordination meetings as opposed to it being a decision making forum. To ensure a consistent and coordinated approach to protection programming, UNHCR developed standard operating procedures for a range of protection areas (ex-combatants, child ex-combatants, nationality screening, SGBV and child Protection). Partners were included in the development of the SGBV and Child protection SOPs and form the basis of cooperation in 2015. The SOPs on ex-combatants, child ex-combatants and nationality screening remained in draft format in 2014 (and still in mid-2015) with no information available by the Government of Ethiopia on when and how these can form the basis for refugee protection.

Key informants stated that the **division of roles and responsibilities** between protection teams at Regional Hub, the Representation in Addis and the Sub-Office in Gambella was not sufficiently clarified. While the Regional Hub was leading regional efforts on child protection including a regional information sharing protocol for tracing, the interest of the Representation was to maintain coherence of protection policies and approaches within Ethiopia, which was sometimes challenged by interventions initiated by short-term deployees in Gambella. Overall, the role of the protection team in the Representation was appreciated but was found not to be not as strong as it could and should have been, partly because the Representation was not involved in defining protection deployments or fast track positions. The protection coordination and centrality of protection was weakened in the overall response by not having a dedicated Senior Protection Officer during long periods – or senior emergency staff and management with explicit protection expertise- who could have been instrumental in strategic planning for protection across the response and in ensuring protection wide coordination among partners. Furthermore the protection team of the Representation was not empowered to fill this gap and ensure strong protection leadership. By not being part of UNHCRs Senior Management in Ethiopia, the Assistant Representative Protection has reduced influence on protection wide issues from a structural perspective.

Within UNHCR, 15% of the budget was allocated to dedicated protection interventions (registration, documentation, SGBV and Child Protection). The budget allocation of 2% for child protection and 2% for SGBV programming seems to be comparatively small in a context where 69% of refugees are children and SGBV has been recognized as a serious protection risk for the refugee population.

No overall protection framework was put in place to guide the sectoral response, but some sectoral assessments and plans included references to protection considerations. However, protection priorities were less visible in the implementation of interventions and gaps were identified in some areas and some locations. In the camps, approaches in site planning (for example location of services in inaccessible areas, demarcation of land), shelter strategies and food distributions created **protection gaps and risks**. Examples include community latrines not separated for women and men, sequencing of shelter constructions not guided by protection priorities, leaving people at risk without shelter and the fact that only one food distribution point existed in some camps which meant at times an 8 kilometre walk both ways, mostly by women and children.

Choices in response planning, such as the flood prone Leitchuor site, and the long stays in transit centres had a strong impact on the protection situation of refugees. The negative protection consequences of selecting flood-prone site for camps were high – access to services was impeded and shelter was destroyed. At entry points/transit centres, lack of services in nutrition, WASH, food and health, lack of shelter, poor conditions and overcrowding had severe protection implications, for examples refugees searching for edible

plants in the unsafe border area and SGBV incidents of unaccompanied and separated children involving men from the host communities.

Overall, the evaluation team found that protection considerations were partly integrated into the response **but weak in some areas relating to sectors such as site planning, shelter and food distribution as well as health, nutrition, shelter and WASH at the transit centers.** Sectoral approaches and interventions therefore only partially contributed positively to protection outcomes and, in some cases, may have exposed people of concern to unnecessary protection risks.

Accountability to affected population: Creating accountability to persons of concern is a central aspect of UNHCRs protection and Age, Gender and Diversity approach. UNHCR put some mechanisms in place to facilitate the participation of people of concern in protection planning and implementation: UNHCR and partner staff interacted regularly with refugees in the camps and in most entry points to understand needs and respond to ad-hoc complaints. A range of focus group discussions has continuously taken place but no formal participatory assessment was conducted in 2014. Specific participatory assessments have been undertaken for children and additional efforts have been put in place to strengthen children's participation.

Participation of refugees in the design of sectorial interventions was encouraged in shelter but overall remained limited – partly understandably in an emergency context and especially one that is marked by on-going crisis such as the flooding and the relocation. Refugees were free to use their own designs for their emergency shelters but were consulted on their preferred permanent shelter design, for example. Only anecdotal information was available on the extent to which the response design and programming adopted an age, gender and diversity approach and on how effectively UNHCR informed communities about its programms, targeting criteria and priorities.

Although some ad-hoc feedback and complaints mechanisms were established in some camps (for example in some schools and in the child friendly spaces in Kule 2), no systematic system for soliciting and responding to feedback and complaints from refugees were set up. Most existing feedback and complaints mechanisms were not child-friendly, excluding a large part of the refugee population from this feedback mechanism. Respondents of the evaluation survey noted that participation of refugees in planning, monitoring and implementation was very low in 2014. Needs of refugees were partly assessed and refugees participated to some extent in planning of some strategies and interventions. Participation in monitoring and evaluation was not reported. In conclusion, the evaluation team found that some but not sufficient accountability mechanisms had been set up with the biggest gap in participatory monitoring and evaluation.

Throughout the emergency response, **community-based mechanisms** for planning, management and implementation of interventions were set up and took a variety of different forms (committees, incentive workers, social workers, outreach workers, promoters etc.). Community mechanisms were used across the response in all sectors, including health, nutrition, shelter and WASH. Although some quality and process standards were put in place, that aimed to ensure consistency across community mechanisms, for example, on remuneration of contracted refugees, key informants highlighted that the overall effectiveness of these mechanisms remained limited because of the relatively high number of mechanisms set up and the lack of a comprehensive approach to community-based structures. UNHCR Gambella is currently addressing this challenge by developing a community mobilisation strategy that builds on existing community structures.

Access to asylum, registration and documentation

An **open border policy** allowed South Sudanese fleeing their country to seek access to asylum in Ethiopia without restrictions. Due to the mass influx of South Sudanese into

neighbouring countries, 'prima facie[117]' refugee status was granted to people fleeing South Sudan. Borders remained open throughout 2014 and no case of South Sudanese asylum seeker being sent to back South Sudan ('*refoulement*') was reported. Once relocated to camps, refugees and asylum-seekers were subject to the Government of Ethiopia's encampment policy and free to move within the designated areas with prior approval.

South Sudanese crossed into Ethiopia through three main entry points, one of which (Akobo) was only accessible by boat or plane, and stayed at entry points and transit centres in Burbeye, Matar and Pagak. The evaluation found that UNHCR established timely processes and procedures for **registration** of people of concern by rapidly recruiting staff, procuring materials and putting processes in place. Refugees were registered on household basis (biometric level 1 registration) by the Government of Ethiopia and UNHCR at these entry points and received "fixing tokens' which allowed for collection of food at the border (when there were ad-hoc distribution at the border) before being relocated to camps. Once relocated into camps, the Government of Ethiopia and UNHCR conducted detailed registration (biometric registration at level 2). Upon level 2 registration, 'fixing tokens' could be exchanged into Ration Cards. More than 6000 refugees who were registered at the entry points were absent for the level 2 registration, with reasons for this being unknown.

Registration was set up as the first step in a protection pathway by screening for the civilian character of asylum, identifying people with specific needs, including Unaccompanied and Separated Children (UASC) through specific protection registration desks, providing urgent health and nutrition screening as well as medical and nutrition services. Registration procedures documented that 14% of refugees from South Sudan have specific needs.[118] According to key informants, relocation exercise was often chaotic and did not sufficiently take vulnerable children into account.

Table 13: Refugee influx (new caseload) at end of 2014 - Gambella region

New arrivals in Gambella region		**191,698**
Breakdown:		
Cat.1	1. Cumulative camp population	159,624
Cat.2	2. Population awaiting transfers from entry points and transit centres	13,593
Cat.3	3. Unwilling to move from border entry locations - refugees with large livestock herds as well as traders and other categories	12,353
Cat.4	4. Absentees for level 2 registration at Kule (3652) and Tierkidi (2476)	6,128
Total of all categories		**191,698**

Source: UNHCR Gambella

The **nationality screening** of refugees before registration (in order to exclude Ethiopian Nuer from registering as refugees) also slowed down and partially halted the registration process. (see Table 15). As a matter of principle and in order to maintain a credible asylum system and facilitate solutions later on, UNHCR strongly supported the nationality screening. . However, the procedure – besides causing protection concerns - negatively affected the efficiency of registration and reception conditions by slowing down the process and leading to repeated suspension of the registration at entry points. Instead of 48 hours, asylum-seekers and refugees remained at entry points up to several weeks, partly un-registered, without receiving

[117] "Prima facie' ("in absence of evidence to the contrary") refers to the process of group determination of refugee status, as opposed to individual determination, which is usually conducted in situations where a need to provide urgent assistance or other practical difficulties preclude individual determination, and where the circumstances of the flight indicate that members of the group could be considered individually as refugees. UNHCR Resettlement Handbook, 2011

[118] Regional Child Protection Framework Review, Ethiopia

any - and later on limited - services during a period when entry points were recurrently flooded. As a result of the nationality screening, ration cards were confiscated from some refugees and 2000 people were identified to be Ethiopian nationals and excluded from refugee status. UNHCR pro-actively attempted to ensure that all refugees have access to asylum through drafting Standard Operating Procedures; the SOPs are still under the review by the Government of Ethiopia. The evaluation concluded that while the SOPs are an important tool in this process, the cross-border ethnicity and nationality screening will remain a key sensitive issue in the future that requires dedicated approaches.[119]

A characteristic of this emergency response was the extremely large numbers of refugees crossing the border and the limited land to relocate them to (see site-planning section). UNHCR's technical processes of registration worked effectively and enabled quick relocation, but only until the end of February to Leitchuor camp which was rapidly filled up. After February, **registration of refugees was suspended** by the Government of Ethiopia several time, for several weeks which led to a situation in which refugees were grounded at entry points/transit centres with no or minimal food, and health, wash and other services. The reasons for the registration suspensions were the lengthy and complex process of land allocation and nationality screening.

Table 14: Suspension of registration at entry points, 2014

Entry point(s)	Start	End	Date of suspension	Days of suspension
Burbiey	Mar-14	Active	27-Oct-14 to 4-Nov-2014	9 (1.5 weeks)
Akobo	Jan-14	Active	29-Apr-14 to 22-May-14	24 (3 weeks)
Pagak	Jan-14	Active	8-Apr-14 to 28-Apr-14	21 (3 weeks)
Pagak			Aug-14 to Sep-14	60 (9 weeks)
Pagak			24-Oct-14 to 30-Nov-14	37 (5 weeks)
Total number of weeks				**21.5 weeks**

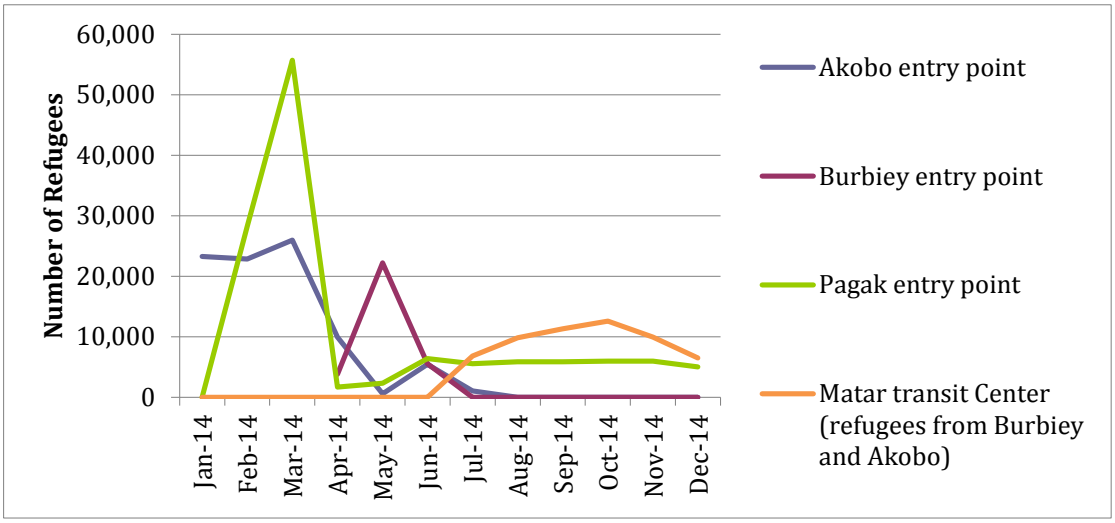
Source: UNHCR Gambella

This resulted in extreme **overcrowding of the reception and transit centres**, where at one point there was even 55,000 refugees assembled at Pagak transit centre (See Figure 6), and presented a major challenge for the response. According to all key informants who were present at these times, the conditions at the transit centres during these influxes were appalling with open defecation/overflowing latrines, overcrowded sleeping hangars or no shelter at all, limited and/or poor quality water, insufficient food, no child-friendly spaces or child protection services, no protection safeguards and overwhelmed health and nutrition services – and partly flooded between June and October. Because of the lack of services, including food, refugees were forced to search for food outside the entry points or possibly move back to South Sudan. Because registration was stopped several times by the Government of Ethiopia, refugees lived under these conditions for several weeks at a time. The Government restricted the delivery of services - including food- at entry points. The reason for this restriction was that the entry points should not develop into 'attractive' sites where refugees would have liked to stay and the entry points should not develop into a pull-factor to attract more refugees crossing the border. As a result, the **reception conditions** were kept to an extremely low level, compromising dignity, safety and protection outcomes. When the evaluation team visited one of the reception centres in June 2015 (Pagak), the reception conditions were only slightly improved – more than 6000 people were staying in hangars or huge tents in sub-standard conditions.

[119] Similar challenges of cross-border ethnicity of refugees are experienced in other parts of Ethiopia, making this a broader issue for ARRA and UNHCR in Ethiopia.

The evaluation found that the effectiveness of protection response relating to registration, reception and relocation was limited. Even though borders had remained open throughout in 2014, the lack of decisions on suitable land allocation, the way nationality screening was conducted and the suspension of registration without adequate provision of services at entry points considerably reduced the de facto access to protection and asylum for refugees.[120]

Figure 6: Population at Entry Points, Gambella Ethiopia 2014



Source: UNHCR Gambella

Despite the encampment policy, refugees enjoyed relative freedom of movement and no cases of refugees being stopped have been reported. The provision of **legal documentation** – one of the protection objectives of the Regional Refugee response plan under the responsibility of the Government– was partially met. No refugee identity cards were issued in 2014 and documents made available to refugees – non-legal birth notifications, ration cards and since September 2014 household proof of registration, provided minimal legal protection, but were sufficient to access refugee specific services (but no national services). For UASC, the ration card was only sufficient to receive food, but no other services. The ration cards and the household proof of registration did not enable freedom of movement beyond designated areas – additional documentation was required for this.

UNHCR's approach to managing the **civilian character of asylum** – to the extent to which UNHCR is involved in this State responsibility - was appropriate and timely. Early on, and in line with UNHCRs Guidelines on the Application in Mass Influx Situations of the Exclusions Clauses of Article 1F, UNHCR established procedures as part of registration to identify combatants and ex-combatants and register these as asylum-seeker instead of refugees. No information is available as to whether the registration procedures identified persons that would be considered for exclusion of refugee status as per Exclusion Clauses of Article 1f. Anecdotal information points to the fact that the procedures were not fully adequate in identifying all ex-combatants. UNHCR provided the Government of Ethiopia with adequate and relevant guidance (Standards Operating Procedures) for the screening and management of ex-combatants, including child-soldiers, however, those still remain under review by the Government of Ethiopia in mid-2015. As numbers of ex-combatants were found to be small (between 300 and 400), and no separate facilities for ex-combatants existed, the Government of Ethiopia and UNHCR took a practical approach and located registered ex-combatants camps alongside other refugees. No reports on how this impacted the security situation were available, indicating that this practical approach was adequate in the given context. In one

[120] The evaluation team found similar challenges in 2015, indicating that the response was not able to contain the protection challenges relating to managing entry points.

instance, where UNHCR was evacuating heavily wounded fighters from South Sudan who had crossed the border into Ethiopia under the principle of neutrality, the Government of Ethiopia obliged UNHCR to end the support.

Security from Violence, abuse and neglect

In Ethiopia, the Government has primary responsibility for the **security and safety** of refugees of which was ensured through posting security personnel in camps. The security situation in the camps was reported as relatively stable in the first six months with deterioration reported in two camps in the last quarter of 2014 linked to accidents, substance abuse and alleged food poisoning. The efficiency of the camp police and community-based police is impeded by low numbers and inefficient equipment. To increase the effectiveness of the police, federal police (rather than regional) was deployed in the camps, which was a wise but insufficient move.

The **Sexual and Gender Based Violence (SGBV)** response started about 6 months after the emergency in July 2014 through one implementing partner and was approached comprehensively with both response services as well as prevention interventions established in the majority of the camps. No SGBV specific services were established at entry and transit points. The cornerstone of the response were legal, psycho-social and medical services. No safe house was established. Although the start of the SGBV response was delayed, key informants indicate that UNHCR was able to provide a minimum of SGBV services, although not in all locations and with no data collected to analyse services. The evaluation team found that assessments and audits, especially in the 2nd half of 2014, adequately reflected SGBV prevention considerations and risks. Information from key informants indicate that the quality of SGBV services remained weak with insufficient capacities of SGBV partners , health providers not trained on Clinical Management of Rape and no functioning community based mechanisms relating to SGBV and security in place.

Contrary to UNHCR's global standard practice, UNHCR in Gambella decided not to collect, document and share data and information on SGBV services and reported SGBV incidents, including from implementing partners. As a result, no information on provided SGBV services or reported cases is available for 2014, except for anecdotal information collected during community dialogues and through the health information system on medical services on post-exposure prophylaxis following rape incidents.

UNHCR's SGBV response was partly shaped by the *Safe from the Start*[121] deployment scheme after September 2014. UNHCRs SGBV response was based on regular assessments and SGBV audits: as part of prevention, UNHCR conducted safety audits and included safety and protection issues into assessments and sectorial planning and provided guidance, training and coordination to partners. UNHCR drafted Standard Operating Procedures for SGBV services with clear roles and responsibilities for referrals but the SOPs remained unsigned until mid-2015 and no data sharing agreement was signed between partners. SGBV case management remained incomplete in 2014. Despite this, key informants reported that case referrals were taking place, yet the scope, timeliness and results of these remain unclear. Key informants reported that the flooding increased the risk of SGBV and SGBV incidents during collection of firewood were reported.

Child protection

With almost 70% of refugees under the age of 18, the scale, coverage and challenges for child protection were enormous. UNHCR adequately labelled this emergency 'a child emergency' and prioritised child protection at a strategic regional level through the development of a regional child protection framework which defined five child protection response priorities in four countries (registration, child friendly procedures, protection from violence, support for children with specific needs and education).

[121] *Safe from the Start* is a US funded initiative to strengthen SGBV prevention and response at the onset of emergencies.

The UNHCR-led child protection programming covered registration, identification and referral of vulnerable children and children at risk, referrals and case management, including care arrangements and services, trainings of partners and social workers, ensuring child friendly procedures, setting up child friendly spaces and strengthening a systems approach for child protection. Responsibilities for child protection were assigned to implementing and operational partners on a geographical basis – different partners covered different camps.

As part of the response, all children were **registered on an individual basis** at registration point**s. Documentation for children remained limited in 2014**– children were included in the ration cards of their parents (and later on in the household proof of registration) or, in the case of UASC, received individual ration cards. **No birth registration** documents other than the non-legal birth notifications for children born in health centres were issued for children in 2014 which may have considerable protection implications in the medium to long-term.

To identify and follow up on children with specific needs, child protection desks were established at all registration points. **13% (18 000)** of the 69% refugee children **were unaccompanied or separated children. Because of this high number,** UNHCR and partners focused on identifying and supporting UASC through case management, training of service providers, foster families, community based structures, and provision of child friendly spaces. Overall, the UNHCR led response had set up effective mechanisms to **identify UASC** during registration at entry points and initiate referral mechanisms. Challenges arose during relocation from entry points to camps because of coordination and communication issues between partners and once in the camps through lack of timely follow up, lack of information sharing protocol among partners and administrative issues with the CP-IMS (Child Protection Information Management System).

While the strong focus on supporting UASC was necessary because of the high number of UASC and their specific protection needs, it also meant in practice that UNHCR and partners focussed less on other children at risk or with vulnerabilities (disabled children, married children, survivors of SGBV and others). Key informants shared the consensus that the UNHCR-led response did not develop a comprehensive approach to the **identification and referral of vulnerable children** - this was beyond the capacities of all parties involved. The review of the regional child protection framework for Ethiopia notes, that in 2015 "*there exists no specific system for the identification, registration and targeted follow up of other vulnerable children at risk*". Limited partner capacities at entry points was available to identify children at risk or specific vulnerabilities and limited referral mechanisms were set up. Key informants also highlighted that, children with vulnerabilities were not adequately considered during relocation exercises due to insufficient processes, lists and coordination among partners and not prioritised for assistance.

The **child protection case management** system involved a number of organisations working on child protection who shared child protection responsibilities in different camps and entry points. Standard Operating Procedures for referral mechanisms were established in April 2014 and a CP-IMS was set up. Only a limited number of cases were recorded in the CP-IMS and coordination was hampered by the lack of an agreed information sharing protocol among partners. Technical challenges relating to the CP-IMS versions and applications dominated the discussions according to some partners and there was a reluctance to fully set up clear roles and responsibilities on the CP-IMS. Capacities of partner staff – both in terms of number of staff as well as skills, remained insufficient and the capacities of social workers were reportedly very low[122]. The ratio between social workers and children was very high which meant that less children could be reached. In addition, even where social workers were available, it was physically challenging to locate vulnerable children and especially UASC. UNHCR did not have the addresses of about 60% of the UASC because of missing or incorrect shelter and demarcation information at the point of registration. As a result, the

[122] Review of Regional Child Protection Framework

overall **child protection case management system** remained insufficient and contributed to some extent to a low number of child protection cases that were identified and received targeted support and the insufficient inclusion of child protection consideration in sectorial responses. In terms of **coverage**, the response reached only a portion of children with specific needs or at risk. 18 months after the emergency (June 2015), only 29% of UASC had been assisted or included in case management, indicating that the number must have been considerably lower by the end of 2014.

Child friendly spaces were set up in most camps (not at entry points) and reached about 15% of children, pointing to a relatively low coverage and a required stronger link between child protection and education programming. **Family foster care arrangements,** based on traditional kinship system among South Sudanese, were set up for a large number of children (about 4500), often spontaneously by refugees themselves. While the coverage of foster care was large, concerns over the quality of foster care arrangements were raised early on during the response and remained throughout the first year.

Key informants highlighted that UNHCR spent a disproportionately long time clarifying UNHCRs role and responsibility with regard to **family tracing and reunification** of UASC. Because of the high number of UASC, there was pressure and interest to do family tracing and reunification, however, it took the UNHCR office a very long time to understand the reunification needs and possibilities of those children whose parents had stayed back in South Sudan and who could therefore not be reunified. Once UNHCR had clarified its position, priorities were set accordingly. Because of the limited reunification prospects and the strong kinship care, overall, tracing and reunification outcomes remained limited. At a regional level, UNHCR and partners spent several months in clarifying the nature and scope of a regional data sharing protocol for child protection, which was eventually signed by only a few child protection partners. The extent to which this protocol enhance child protection outcomes is to be established in 2015.

Summary: Protection

Overall, although critical protection approaches and interventions were applied and initiated, for example on registration and child protection, the evaluation found that the overall emergency response was not sufficiently guided by clear protection priorities and strategies. Protection considerations were partly integrated into the response but weak in sectors such as site planning, shelter, food as well as health, nutrition, shelter and WASH at the transit centers, exposing people of concern to unnecessary protection risks. Accountability to people of concern was given some consideration.

The protection response enabled refugees from South Sudan access Ethiopian territory with registration procedures facilitating asylum and assistance with the caveat that the way nationality screening was conducted and land allocation issued reduced access to protection and asylum. The civilian character of asylum was largely remained while reception conditions were not adequate in most cases. The response achieved the individual registration of all refugees, although registration outcomes were negatively affected by intermittent breaks and nationality screening. Land allocation challenges, lengthy nationality screening issues and intermittent registration and unfavourable reception conditions reduced protection outcomes for people of concern. Most of these issues were outside the control of UNHCR. In addition, the continuous flooding of two camps and several entry points had negative effects on the protection of people of concern and their coping mechanisms.

Registration efficiently provided a protection pathway for people with specific needs, but some sectorial interventions were insufficiently guided by protection considerations and follow up on people with specific needs. Sexual- and Gender based violence and Child protection were prioritised within protection through staffing (not budgets), yet the decision on data collection and sharing on SGBV does not allow to draw conclusions on the scope of interventions and response services provided. Child protection interventions focused strongly on unaccompanied and separated children and insufficient case management and discussion around family tracing reduced the effectiveness of the child protection response. Community-based mechanisms for protection, services and support were fragmented and weak.

Table 15: Overview of key protection indicators, January – March 2014

Key protection indicators	January	March	June	December	Standard
Access to Asylum					
# of known cases of *refoulement*	0	0	0	0 [123]	0
% of persons of concern registered				100%	100%
Civilian character of asylum maintained	Yes	Yes	Yes	Yes	Yes,
Extent reception conditions meet minimum standards	Low	Medium	Low	Medium	High
Security from violence, abuse and neglect					
# of police in camps	n/a	n/a	n/a	12 per camp	n/a
# of UASC	n/a	n/a	n/a	18 000	n/a
# of Child protection social workers			179	138	n/a
# of children attending child friendly spaces	0	n/a	6,752	15,424	n/a
% of children with specific needs identified receiving appropriate services	n/a	n/a	n/a	50%	n/a
# of PoC trained on SGBV prevention and response	n/a	n/a	34	468	n/a
# of community-based committees/ groups working on SGBV prevention and response	n/a	n/a	8	8	n/a
# of awareness raising campaigns on SGBV prevention and response conducted	n/a	n/a	15	47	n/a

Source: UNHCR Ethiopia monitoring data.

2. Health

3580 The contextual Ethiopian operational environment informed the health response strategy with the focus on developing specific dedicated health services for refugees in camp settings. There was limited to no specific health assessments or interagency assessments with a health component to inform the strategy. The interventions were shaped by the UNHCR Global Strategy for Public Health and the Ethiopia Refugee Strategic Plan for the Public Health Sector (2014-2018). This, in addition to lessons learned from previous large-scale refugee influx in Ethiopia, informed the design of the Gambella specific Strategic Guideline on Health, Nutrition and Food Response. The **objectives of the health response were relevant and appropriate** to meet the needs of the refugees.

3590 UNHCR in liaison with ARRA and partners developed a **health strategy with emergency guidelines and Standard Operating Procedures (SOPs)** to support and promote a coordinated health response in the refugee camps and entry points. It was developed by UNHCR, ARRA and partners to provide a harmonized package of health and nutrition services, assure compliance standards, provide guidance on coordination dynamics and

[123] With the caveat that some of the persons that were identified as nationals in the nationality screening may have been refugees from South Sudan.

provide clear performance indicators/benchmarks.[124] The health guidelines defined the key nutrition interventions and the target group, mapped out those interventions by geographic area, and defined monitoring indicators and minimum standards. Accompanying SOPs for Community Outreach Response were developed to support the strategy of decentralized health care and a harmonization of outreach services. Working arrangements between partners, priority activities and joint training package was all a part of the overall objectives.[125] SOPs to guide medical referral of refugees to Secondary and Tertiary Health Care facilities in Ethiopia were in place as well as a TB/HIV referral pathway.

The pre-defined **strategic partnership with UNICEF** was crucial to a timely and efficient response. The 2012 Letter of Understanding (LoU) between UNICEF and UNHCR allowed the response to build upon. UNICEF's pre-existing regional presence in Gambella and relationship with the Regional Health Bureau (RHB) - a critical factor contributing to a timely and effective response. Moreover UNICEF rapidly seconded staff to support in coordination, provide technical assistance and set up standards. The close partnership and collaboration between UNHCR and UNICEF in this response was exemplary.

As of early as mid-January 2014 UNHCR was leading the coordination of the public health response with a mapping out of the thematic areas, geographic areas of intervention, capable responding agencies and gaps.[126] A **Health and Nutrition Coordination Working Group at the Gambella level** was established very early in the response and as of at least mid-April there was a regular Health and Nutrition Sector update that was circulated containing current key information on mortality, morbidities, health and nutrition services, and food distribution. Likewise at the capital level in Addis Ababa a weekly sectoral coordination meeting (Public Health, Nutrition and Wash Technical Inter-Agency Coordination for Influx of South Sudanese Refugee into Ethiopia) was established with the objectives of 'sharing of information, coordinating of action for effective use of resources, avoid duplication while ensuring complementarity and ensure that standards and guidelines are applied'. The evaluation team found repeated confirmation that the health coordination was effective, that there were no notable gaps in leadership, and that the information sharing and collaborative engagement was a positive element of the response.

The UNHCR **Health Information System (HIS)** was introduced in Gambella in February 2014. Data collection first began with a handful of select basic indicators for mortality, morbidity and malnutrition and these were collated in weekly Basic indicator Reports (BIR). Quite late, around June 2014, regular reporting through the HIS with the full set of indicators was in place. The evaluation team noted that the double burden of reporting (partners having agency specific reporting and then UNHCR requested reporting) was a challenge and key informants noted that it took a while to streamline reporting formats.

According to an evaluation done in August 2014[127], despite the many challenges inherent to complex humanitarian crises, UNHCR, ARRA, and its current partners have demonstrated an exceptional commitment to providing health surveillance services to South Sudanese refugees in Ethiopia. During this large-scale crisis, these partners have worked together to overcome significant challenges through a continuous cycle of self-assessment, adjustment, and reassessment. Some challenges were identified including infrequent HIS trainings and supervision, lack of standardized operating checklists, understaffing at Gambella and camp level, high turnover of key health staff, and lack of standardized data quality assessment.[128]

---

[124] Strategic Guideline on Health, Nutrition and Food Response, Gambella Emergency Programs, Ethiopia. Joint UNHCR/WFP/UNICEF/ARRA/Humanitarian Partners. April 2014

[125] Standard Operating Procedures for Community Outreach Response, Ethiopia. April 2014.

[126] South Sudan Refugee Influx Public Health Update 25 Jan 2014

[127] Strengthening Health Surveillance in the South Sudanese Refugee Crisis, Gambella August 2014. Prepared by Centre for Disease Control (CDC) Atlanta.

[128] *Ibid.*

UNHCR organized a training in October 2014 to improve the quality of reporting[129] and UNHCR provided on-job training and mentoring to partners in order to improve submissions of data to the HIS. The evaluation team found that challenges remained with the quality of data related with specific note of mortality data (see health outcomes section) and vaccination coverage. The registered number of refugees was commonly known to vary quite substantially from the actual numbers present and hence caused problem with accurate estimation of coverage.

The UNHCR-led humanitarian response to the large refugee influx in Gambella struggled to bring services up to satisfactory humanitarian standards within the public health response in 2014 (see Table 16). In the online survey, there was an equal split between those who agreed 'the health intervention outcomes have been adequate and proportional to the response' and those who disagreed. This perhaps reflects the unequal quality of care being provided at different locations and the achievements in some programming areas with constraints in others. Provision of primary health care was within the adequate range as seen through the outpatient utilization rate, although access to secondary health care remained a challenge (see references to Gambella hospital below). Few women received complete antenatal care and women of reproductive age were affected by anaemia. Despite extensive efforts for comprehensive measles vaccinations the coverage still remained below the desired standard. Trends in the high morbidity diseases improved over the course of 2014 but not very dramatically. The results from the online-survey indicated that approximately one-third of respondents agreed and one-third disagreed that the health response met the needs to the refugees in a timely manner.

The UNHCR HIS **mortality data** for Gambella is artificially low never even reaching the level of an expected stable baseline population. Where baseline mortality is not known, the figure of 0.5deaths/10,000/day (1/10,000/day under five) is used in developing countries.[130] In emergency situations emergency thresholds are calculated by doubling that baseline mortality rate. Reasons given to the evaluation team was that the HIS data relied on a combination of health centre based deaths, refugee self-reporting, and collection of household level mortality by community outreach actors. As community reporting on mortality is low, it is difficult to determine mortality rates accurately.[131] Refugees may be reluctant to report deaths as it is associated with reduction in benefits provided and the community outreach system is understood to not have a very comprehensive coverage. A retrospective mortality survey (as part of a nutrition survey in June 2014) reported that both crude and under-5 year mortality rates were significantly above emergency thresholds (see Table 16). This would support the finding that in 2014 the mortality rates were most likely higher than reported via HIS. The main cause of mortality was malnutrition and related complications including respiratory infections and diarrheal disease, of which there is a high burden in the population.

[129] Terms of Reference for Health Information System (HIS) Training organized by UNHCR and ARRA

[130] UNHCR Emergency Handbook, Chapter 17 Health, p. 345.2007

[131] Rapid Assessment of Health, Nutrition and WASH at Kule and Leitchuor Refugee Camps in Gambella, 21-26 April 2014. WHO Ethiopia.

Table 16: Selected health indicators* for the Gambella refugee response, 2014

Indicators	March 2014	June 2014	December 2014	Emergency Standard
Outpatient Utilization Rate (new visits/ refugee/year)	3.2	1.9	1.9	1.0 - 4.0
Coverage of complete antenatal care	0%	20%	17%	100%
% Births Attended by Skilled Health Worker		81%	46%	Greater or equal to 90%
Anaemia Prevalence Women 15-49yrs	Not Available	21.7%** (Combined)	16%-37%*** (Kule, Tierkidi)	n/a
Measles Vaccination Coverage	Not Available	77.6% ** (Combined)	77%-93%*** (Kule, Tierkidi)	Greater or equal to 95%
CMR (deaths/1,000/month)	0.20	4.68 ** (Leitchuor) 4.96 ** (Tierkidi)	0.20	Less than 0.75/1,000/month
U5MR (deaths/1,000/month)	0.00	12.37 ** (Leitchuor) 17.15 ** (Tierkidi)	0.41	Less than 1.5/1,000/month
Measles Morbidity (Crude)	48%	37%	32%	n/a
ARI Morbidity URTI (Crude)	45%	32%	32%	n/a
Diarrheal Disease (U5)	58%	52%	56%	n/a

*Data is from HIS unless otherwise specified.
** Nutrition and Mortality Survey, Gambella, June 2014 (mortality figures converted into deaths/1,000/month)
*** Nutrition and Health Survey, Gambella, June 2015

Control of Communicable Diseases

Control of communicable diseases was a priority for UNHCR who, with partners, developed in April 2014 an **emergency preparedness and response plan (EPRP)** including resource mapping matrix for outbreak prone diseases including measles, malaria, cholera, meningitis, Hepatitis E and polio. Partners had resources in Gambella and were prepared to respond to any possible outbreak.[132] Overall much effort was given to **proactive prevention activities** in line with the early action interventions as detailed in the overarching Ethiopia refugee public health plan.[133]

As of 6 January RHB vaccination teams, supported by UNICEF, were delivering **measles vaccinations** at the border entry points. With the growing influx of asylum seekers a small campaign targeting asylum seekers was implemented early February 2014. Despite these

[132] Emergency Preparedness Response Plan for South Sudan Influx and Master EPRP Resource mapping document, 13th April 2014.
[133] Ethiopia Refugee Program Strategic Plan Public Health Sector 2014-2018. UNHCR/ARRA

efforts the first suspected case of measles was reported on 14 February 2014 at the same time as a large influx (over 5,000) arrived on the border at Pagak crossing point. Accordingly, a further mop-up campaign alongside initiation of systematic vaccination services for new arrivals started at Pagak entry point as well as within the relevant camps, to ensure all eligible children were reached. [134]UNICF/RHB continued routine vaccination for measles and polio with provision of Vitamin A and deworming throughout 2014 with vaccination teams integrated within the registration teams to ensure coverage of all new arrivals.

Despite the measles vaccination preparedness measures, a **measles outbreak** in the reception/transit centre of Pagak occurred in March and April 2014 with 214 confirmed cases.[135] As the refugees were re-located this then spread into the camps: in Leitchuor measles were present from March through July with 267 confirmed cases and a case fatality rate of 6%[136] and in Tierkidi there were 63 confirmed cases from April through July with a case fatality rate of 3%[137]. Two mass measles vaccination campaign were completed in Pagak and Leitchuor in February and March. Permanent teams of vaccinators were stationed at Pagak, Leitchuor and Tierkidi to continue to screen and vaccinate all new arrivals and relocated refugees. [138] To complement these efforts the RHB, with support by UNICEF, conducted a region-wide measles and polio mass vaccination campaign in March-May for the host population.

From April 2014 the South Sudan Ministry of Health declared an outbreak of cholera. In the past, Gambella had been clearly identified as an entry point of cholera cases between South Sudan and Ethiopia. The continued arrival of refugees from South Sudan made the risk of cholera in the region imminent. In May 2014 a **specific preparedness and response plan for acute water diarrhoea** in Gambella refugee camps was initiated by ARRA and UHNCR with a support from partners.[139] A mass **oral cholera vaccination campaign** was organised by ARRA/RHB/UNHCR with MSF as they key partner in mobilizing resources, organizing and implementing the OCV campaign. The overall coverage of beneficiaries receiving the two doses of the cholera vaccine was 71% in the refugee community and 36% in the host community (and the overall coverage for the first dose was estimated at 99% in refugee communities and 83% for the host community).[140] There was no outbreak of cholera in 2014.

Between mid-June and early November there was an **outbreak of Hepatitis E** in Kule (332 cases) and Tierkidi (107 cases) camps, partially as a direct reflection of the Hepatitis E outbreak within South Sudan. There was a preparedness plan for a Hepatitis E outbreak[141] from June 2013 that was updated in July 2014, however the evaluation team was unable to assess how much this plan was used in the response. Mitigating response efforts were put in place such as distribution of soap, education on sanitation and hygiene and screening. Additional training was given to COWs and the Gambella WASH sector working group was requested to increase the WASH standards.[142]

Overall, 22% of admissions in MSF-France facilities were due to lower respiratory tract infections (LRTI), and approximately 30% of all in-hospital deaths were attributed to these

[134] Measles immunization activity for S/Sudan influx- Gambella. Update 12 April 2014

[135] Measles Outbreak Report 23 February Pagak Reception Site

[136] Measles Outbreak Report 1 March Leitchuor

[137] Measles Outbreak Report 30 March Tierkidi

[138] UNHCR Ethiopia South Sudan Emergency SitRep 27 Februry-6 March

[139] Preparedness and Response Plan for Acute Watery Diarrhoea in Gambella Refugee Camps, May 2014

[140] Oral Cholera Vaccination Campaign Gambella Ethiopia, Juy-August 2014 MSF External Report 15 October 2014

[141] Plan of Action for Hepatitis E Virus outbreak Preparedness and Response in Refugee and Host Communities in Ethiopia June 2013 and July 2014

[142] Summary of Acute Jaundice Cases in Gambella Region v.2, July – November 2014

same infections.[143] Due to the high burden of morbidity and mortality represented by LRTI, and the numerous risk factors contributing to spread the disease in the refugee camps (i.e. low vaccination rate in South Sudan, deteriorated nutritional status, high density of population in the camps etc.), MSF-France carried out a Pneumococcal conjugate (**PCV) vaccination campaign** in Leitchuor, Kule and Tierkidi, as well as in the entry points and transit sites.[144] This approach was included in the Gambella Health and Nutrition Strategy and rolled out in partnership with UNHCR, ARRA and partners in November 2014.

Control of Non-Communicable Diseases

The response to the refugee influx can be categorized as focusing primarily on the preventive and curative emergency response actions required in the first stage of a response to prevent excessive morbidity or mortality. There was some engagement in activities for the post-emergency phase but with limited depth and breadth.

Starting in May 2014 an UNHCR implementing partner, IMC, began two community-based programs in Kule, Tierkidi and Leitchuor camps, for **mental health services and reproductive health services**, a commendable initiative in the early stages of the emergency. The community-based programming for RH was to complement the comprehensive clinic based RH activities being provided by the health providers MSF and ARRA. Information and coordination around these subject areas occurred in the general health and nutrition coordination meetings. The evaluation team noted that it was felt this did not give enough attention to a comprehensive RH package compared to the life-saving health and nutrition programming. The mental health project was designed for integration into the public health system and this presented a challenge in the camps where MSF was providing the interim health services. Additionally family planning was challenged by the cultural values of the South Sudanese population and the politicized view of population control.

Attention to **chronic diseases** was primarily limited in this response to a specific focus on TB and HIV. The fact that MSF provided emergency health services in most of the refugee locations and ARRA is not in position to provide TB/HIV treatment meant that there was a wide gap in terms of access to TB and HIV treatment services in the first phase of the emergency.[145] Around May 2014 UNHCR, ARRA and partners developed the TB/HIV Referral Pathway guidelines that outlined responsibilities and service provision. Access to continuum of care for patients who had already started treatment/medications for TB/HIV, in the country of origin was established within the camps health facility or through referral to local health facilities. Referral, if needed, was supported by ARRA and the regional Gambella Hospital although this was noted as a weak spot in the continuum of care because the regional hospital and ARRA lacked the capacity and the medical resources to adequately manage all cases.

Provision/Utilization/Coverage

A great collaborative effort went into the health response for the refugees in the Gambella region. The evaluation team heard from a wide number of key informants that the **Gambella Regional Health Bureau (RHB), with the support of UNICEF, was instrumental in the health response** for the refugees at the border points and transit centres. The involvement of an Ethiopian regional government in a refugee response is a positive finding. The strategic partnership with UNICEF, as noted previously, can be seen as a contributing factor to this success. UNICF had an existing sub-office in the Gambella region with a close partnership with the regional ministries and was in a strong position to support first response even in early January 2014. The strong collaboration UNHCR/ARRA and the regional government continued throughout the response.

---

[143] Proposal for Preventive Strategies in humanitarian emergency introducing PCV and Hib containing vaccines, MSF France, Gambella Region, May 2014.

[144] 2014 Activity Report. MSF-France Intervention. Gambella Region, Ethiopia.

[145] TB/HIV Referral Pathway for Refugees in the New Camps. May 2014

Previous efforts of UNHCR to ensure that 'UNHCR and ARRA will continue to work with partners with proven experience and capacity to mobilize own resources in shortest time for emergency response like MSF among others[146]' proved to be a good strategy. With UNHCR sectorial coordination, MSF collaborated rather openly and successfully with ARRA and other partners. MSF was a critical health partner in this response providing both primary and secondary care in refugee camps and transit centres. MSF mobilized rapidly and a project agreement was signed between MSF, ARRA and UNHCR already on the 24th January 2014. Their early presence bolstered the efforts of the RHB and UNICEF for example through setting up in early March mobile clinic service alongside RHB in Pagak to strengthen the services provided to the growing numbers of refugees. Through numerous interviews and document reviews the evaluation team triangulated that the **interventions provided by MSF were critical** and formed the backbone of health care for the refugees. It is important to note that MSF was an operational partner, meaning that they operated entirely on their own budget without funding of UNHCR. In this situation the partnership worked well and the needs of the refugees were met in a timely manner; however, it should be noted that UNHCR's predictability of an adequate and appropriate health response is dependent on partners contributions.

An **early focus on establishing community outreach system** with household level standardized messages on health, nutrition and WASH (with contribution of personnel from the different sectors who then received a common training) was an appropriate and essential element of the health response. Overall it was found that the outreach system needs reinforcing in order to improve utilization of health services and coverage (for example as evidenced by low antenatal care rates and low health care utilization rates). A majority of key informants noted that case finding and community-based referrals were inadequate. Additionally the outreach system is responsible for collecting key baseline information such as deaths in the community and a weak outreach system has been referred to in reference to the low mortality rates (under-reporting of deaths). Furthermore, an assessment done in late 2014 found that instances of unnecessarily high number of visits by different agencies are not uncommon and yet some of the respondents could not remember the messages as expected.[147] The evaluation team noted that the separation of the WASH component in mid-2014 was not seen as a positive development for the health sectors point of view given that the poor WASH conditions had a direct impact on the health status of the population and that common systems would have promoted more synergies.

Medical referrals of refugees to secondary and tertiary care centres were formalized with Standard Operating Procedures (SOPS) for referrals. The main secondary hospital was in Gambella town. Of the 195 hospitals in Ethiopia, Gambella region only has one. Tertiary care had to be referred to Addis Ababa hospitals. The evaluation team repeatedly noted that the provision of adequate health care was affected by the **limited capacity of the regional hospital.** The hospital structure and planning was to serve the host population however. One key health interviewee reported that Gambella Hospital is supposed to serve 200,000 but now it serves a population figure of 500,000 with most of the occupancy by refugees. It is so overcrowded that patients sleep in the corridors, in temporary tents provided by UNICEF, and outside in the open. There is a shortage of human resources, all medical supplies and equipment (for example, no blood bank, no operating room tables, no x-ray machine, no ultrasound). Moreover the hospital is facing a serious shortage of water supply which disrupts most services and frequent disruption of power supply impairs activities each day.[148] Key informants engaged in the health response indicated that more could have be done to support the hospital through joint advocacy – such as harnessing the power of 'Delivering of One' and the engagement of development partners.

[146] Ethiopia Refugee Program Strategic Plan Public Health Sector 2014-2018. UNHCR/ARRA

[147] Ethiopia Joint Assessment Mission (JAM). ARRA/UNHCR/WFP and Partners. December 2014

[148] Gambella Hospital Assessment: Capacity and Gaps December 2014

In recognition of the hospital limitations, MSF-France reinforced the RHB-run Itang health centre by establishing and supporting additional services including OPD, 24-hour ER and stabilization room for emergency and critical cases, IPD with intensive care unit (ICU), stablisation centre for the severely malnourished, IPD for adults and children, and isolation. This served as the first referral centre for Pagak, Kule and Tierkidi and reduced the burden on Gambella hospital. This is positive for the care continuum of the refugees but perhaps not the most sustainable solution once MSF stops operating in this response. As recommended in the late 2014 UNHCR/WFP/ARRA joint Assessment Mission, 'Equipping health facilities to the level of UNHCR standard and improving services is needed. UNHCR and ARRA should strengthen referral linkages between the refugee health services and host community health facilities (health centre and hospitals)'.[149]

MSF was the main provider of emergency primary health care in this response and as such **medical supplies** within these centres was not a concern. As the other main provider, ARRA's primary health care centres had shortages of medical supplies including items such as beds, bandages and medicines and medicines. The RHB was a key contributor to the health response through provision of vaccination services and to this regard supplies were sufficient through the support of UNICEF. The RHB however did experience challenges with most medical supplies at the main Gambella referral hospital, including shortages of medications for chronic diseases such as TB and HIV/AIDs.

With reference to ARRA's role as the primary health care service provider in camps, reception centres and transit centres[150] the evaluation team found repeated confirmation that there were challenges faced in terms of quantity and quality of **human resources** available. Qualitative information collected in interviews indicates that ARRA facilities are under-staffed, have a high turnover of staff, and generally attract relatively in-experienced medical staff. According to a key informant medical service preformed with ARRA does not count as formal experience as far as the Ethiopian MoH is concerned thereby contributing to the the high-turnover and the proliferation of junior medical staff. There is no formal link between the MoH and ARRA which complicates the sustainability of health services provided and contributes to the creation of parallel systems. The evaluation team also heard from a key informant that a substantial portion of the ARRA budget as received from UNHCR goes to the provision of health care whilst the quality remains substandard. This has been highlighted by donors over a decade ago before that 'ARRA has with UNHCR's financial support built up a parallel health system for refugees. This now absorbs about 60% of ARRA's budget, yet UNHCR is not entirely happy with the quality of health care offered, and it is unclear how the health personnel will be able to re-integrate back into the MOH structure when ARRA contracts its activities in the Somali Region' [151]. Furthermore refugee focus groups highlighted the inequality of care depending on the service provider. For example in August 2014 ARRA provided health services in Tierkidi with an average of 158 consultations/day with 39 consultations/clinician/day. MSF-Holland health post in Zone C of the same camp had an average of 223 consultations per day with 74 patients/clinician/day. [152]

3. Nutrition

The **objectives of the nutrition response were relevant and appropriate** to meet the needs of the refugees. The large population movements, the distances walked, and the high numbers of children and women served as a warning sign. An initial rapid assessment at Pagak reception/transit centre served to jump start the funding and programming for nutrition.

[149] Ethiopia Joint Assessment Mission (JAM). ARRA/UNHCR/WFP and Partners. December 2014

[150] TB/HIV Referral Pathway for Refugees in the New Camps. May 2014

[151] Dfid Field Review Of Unhcr's Programme For Somali Refugees In Ethiopia, January 2000.

[152] Health Nutrition and WASH Sector Update Gambella Refugee Camps Week 34, August 16-22 2014.

Based on that assessment an interagency response plan[153] was developed spelling out the immediate priority actions. A follow-up nutrition and mortality survey in June 2014 was critical to informing continued programming. The application of lessons learned in prior emergencies in Ethiopia regarding the need to identify and prioritize the nutritional needs of the refugees in rapid refugee influx emergencies was repeatedly conveyed to the evaluation team and was also a key element in shaping a comprehensive and timely nutritional response. These key events informed the design of the Gambella specific **Strategic Guideline on Health, Nutrition and Food Response**.[154] The nutrition guidelines defined the key nutrition interventions, mapped out those interventions by geographic area of assistance, monitoring indicators and minimum standards.

Although this particular emergency was not predicted, the UNHCR Ethiopia had been active in some **specific preparedness measures** that informed this response. For example, the development of the **Nutrition Harmonization Note** was a proactive modality to ensure that there was an agreed operational platform from which all nutritional actors could operate. It laid out in detail management of different nutrition programs including specifying target groups, admission and discharge criteria and treatment products and methods. This preparatory work meant that time was not lost in the emergency response discussing and agreeing upon these issues. Furthermore, a pre-defined **strategic partnership with UNICEF** was crucial to a timely and efficient response. The 2012 Letter of Understanding (LoU) between UNICEF and UNHCR 'foresees enhanced collaboration between the parties with respect to refugee assistance' in multiple sectors including health and nutrition. This was to include a) joint advocacy, b) expert support to UNHCR and c) collaboration in joint resource mobilisation. This was a well thought out strategic partnership building on lessons learned from earlier emergency responses in Ethiopia. The close partnership and collaboration between UNHCR and UNICEF in this response was exemplary.

The flooding in Leitchuor and Nip-Nip damaged some nutrition sites, disrupted outreach programmes, destroyed food stocks, and cut off access by road for much of the relief supplies. To mitigate the effect, UNHCR in liaison with ARRA and nutrition partners drafted food security and nutrition flood response nutrition action plan that was updated into the **interagency operational continuity plan for the flood response**. This process enabled coordinated food security and nutrition flood response and enabled food security and adaptive mechanisms that scaled up access to the affected refugees and host communities. The roll out of emergency plans were done a week before the floods and as such did not allow enough time for donors and actors to effectively and efficiently mobilise for response.[155]

UNHCR's **coordination** of the nutrition response was consistently reported to the evaluation team to have been timely, with good partnership and collaboration. A Health and Nutrition Coordination Working Group at the Gambella level was established very early in the response and as of at least mid-April there was a regular Health and Nutrition Sector update that was circulated containing current key information on mortality, nutrition services, and food distribution. Likewise at the capital level in Addis Ababa a weekly sectorial coordination meeting was established with the objectives of 'sharing of information, coordinating of action for effective use of resources, avoid duplication while ensuring complementarity and ensure that standards and guidelines are applied'. The evaluation team found that UNHCR had been proactive in this emergency response, sharing information at an early stage within the standing Refugee Taskforce in Addis Ababa and encouraging existing partners from other areas within Ethiopia to visit the crisis areas in January and February in order to develop response programming. For example ACF was requested to visit the reception centre Pagak in early February 2014 and, with the support of UNHCR, UNICEF, ACF, regional health staff

[153] Interagency Health Response Plan as of 24th February.

[154] Strategic Guideline on Health, Nutrition and Food Response, Gambella Emergency Programs, Ethiopia. Joint UNHCR/WFP/UNICEF/ARRA/Humanitarian Partners. April 2014

[155] Ethiopia Gambella: NipNip Area and Leitchuor Camps 2014 Food Security and Nutrition Post Flood Impact Assessment. UNHCR, ARRA and partners. Jan 2015

and ARRA, conduct a nutritional assessment of the new arrivals. The alarming results helped to mobilize the response both in terms of giving a focus to nutrition sector activities but also it served as a warning flag for the severity of the context.

Nutrition indicators were collated and captured in the UNHCR **Health Information System (HIS)** was introduced in February 2014. Data collection first began with a handful of select basic indicators for mortality, morbidity and malnutrition and these were collated in weekly Basic indicator Reports (BIR). Around June 2014 regular reporting through the HIS with the full set of indicators was in place although the quality of data remained a challenge (see Health Sector Leadership). In the weekly coordination meetings detailed indicators and trends were presented and shared including admissions, screening data, performance indicators and food distribution information. Overall information was available and was widely shared.

The prevalence of malnutrition remained high throughout 2014 and into 2015 (see Table 17). Initial estimates 37% GAM rates in February 2014 was brought down significantly by June to 13.4% GAM but still remained below international standards. Nutrition programming was established early on in the response and the quality of programming was fairly good with death rates and recovery rates up to standard by the end of the year. However, coverage rates for nutrition programmes was extremely poor as noted by the majority of key informants and the coverage rates reported[156]. The main constraints listed were weak preventive measures, limited community involvement and a weak outreach system with limited active case finding. In the on-line survey 60% of respondents[157] agreed that 'the nutrition intervention outcomes have been adequate and proportional to the response' with only 20% disagreeing (the remaining did not know).

[156] It should be noted overage indicators reported in HIS and nutrition surveys are not an entirely adequate measure however they give a picture of whether expected numbers are being treated and a measure of enrollment. They confirmed key informant reports about poor coverage.

[157] The sample size is not representative however.

Table 17: Nutrition indicators* for the Gambella refugee response, 2014

Indicators	February 2014	June/July 2014	December 2014	Standard
GAM	Not Available	28.1%**	21.3%-28.3%***	Less than 10%
	37.1% **** MUAC	13.4%** MUAC	8.5%-10.4%*** MUAC	
SAM	Not Available	7.9%**	5.2%-8.6%***	Less than 2%
	11.1% **** MUAC	4.6%** MUAC	2%-3.8%*** MUAC	
Recovery Rates for SAM	Not Available	60%	97%	Greater than 75%
Death Rates for SAM	Not Available	0%	2%	Less than 10%
Coverage of OTP	Not Available	300%	29% HIS or 22.2-36.7%***	Greater than 90%
Coverage of SFP	Not Available	58%	45% HIS or 14.3-14.7%***	Greater than 90%
Vitamin A supplementation	Not Available	69.4%**	80%-91.5%***	Greater or equal to 95%

*Data is from HIS unless otherwise specified.
** Nutrition and Mortality Survey, Gambella, June 2014
*** Kule and Tierkidi Camp data, Nutrition and Health Survey, Gambella, June 2015
**** Pagak Assessment February 2014

General Nutritional Support

In Gambella refugees had access to a full food basket (cereals, pulses, vegetable oil, CSB+, salt and sugar) provided by WFP on a monthly basis through the project implementing partner, ARRA. The **general food ration** received by refugees provided 2,100 kcal per person and per day in the form of take home dry food. According to secondary data and focus group discussions with refugees, food assistance was the primary source of food security. The 2014 WFP/UNHCR Joint Assessment Mission (JAM) indicated that food is also, more generally, the major source of income. A substantial portion of the food is sold or bartered in order to cover other unmet needs. The lack of income to purchase food is the major challenge that prevents refugees from diversifying their diet. [158] In Kule the average number of days the general food distribution (GFD) ration lasts was 20 (out of the planned 30) and in Tierkidi it was 23 days.[159] The lack of scooping tools and scales, group distribution as opposed to individual family distributions, centralized distribution centres in camps, and the lack of vulnerable group listing for prioritization of distribution[160] were identified by key informants and refugee focus groups as constraints in appropriate and effective food distribution.

[158] Ethiopia Joint Assessment Mission (JAM). ARRA/UNHCR/WFP and Partners. December 2014

[159] Final report Joint Nutrition and Health Surveys Refugee Camps in Gambella Region Ethiopia. Conducted 9-25 March 2015, Report June 2015. UNHCR, WFP, ARRA and UNICEF

[160] Food Basket Monitoring Report, WFP Gambella Sub-Office March 2015

High-Energy Biscuits (HEB) were provided to all refugees in the transit centres at border entry points regardless of nutritional status initially for the 3 days that was planned that refugees would remain in transit centres before relocation. No cooked meals were provided, despite this being the standard in transit centers. The rationale given to the evaluation team by a wide range of sources was that the sanitary conditions were too poor to conduct mass cooking and that the Ethiopian government did not want the food to create a pull factor thereby drawing more South Sudanese across the border. As refugees remained in reception centres for significantly longer WFP increased the distribution of HEBs to cover all time spent in transit. In March it was recognized the refugees stayed in transit centres for significantly longer periods awaiting relocation and WFP started provide food items (sugar, salt, sorghum and oil) to the refugees in Pagak.[161] The Nutrition Strategy for the response was updated to reflect if relocation is to take between 3 to 7 days after arrival, a 7 day ration should be provided in addition to the 3 days of HEB. If relocation is to take place between 7 to 10 days after arrival, a 14 day ration should be provided in addition to the 3 days of HEB.[162] However food distribution at the transit centres was ad hoc and seemed to operate on request basis for which the conditions were not fully clear. Furthermore, the women were required to forage for firewood and cook using their own limited cooking utensils and in poor sanitary conditions.

Blanket supplementary feeding for all children under-five years and pregnant and lactating women at the entry points and in the camps for all beneficiaries was essential in minimizing deterioration of the cases of malnutrition and sustained calorie intake for groups with increased dietary needs.[163]

Correction of Malnutrition

The nutrition services and activities in the camps were appropriate and included:

- Routine MUAC screening conducted by community outreach agents
- Targeted supplementary feeding programmes (TSFP) for moderately malnourished children 6-59 months, pregnant and lactating women and patients with chronic illnesses such as TB and HIV
- Outpatient and inpatient therapeutic feeding programmes for severely malnourished children and infants
- Blanket supplementary feeding programme (bSFP) for all children 6-59 months and pregnant and lactating women
- Infant and young child feeding support and promotion activities.

The evaluation team found that nutrition services were scaled up in a timely manner in the camps and that the services were fairly well integrated with one agency/NGO managing the full package of nutrition services in a camp, except for the stabilization centres that are operated through the health centres. This integration of services facilitates case follow-up and graduation, and promotes general oversight of nutritional programming quality and needs. However numerous key informants noted that coverage of nutrition programmes remains a challenge (see nutrition outcomes section). A weak outreach system means that there was inadequate nutrition counselling and active case finding which leads to late presentation of malnutrition.

Additionally, nutritional services were available in reception/transit centres with routine screening to identify the malnourished. These individuals were then immediately referred to the relevant nutritional program for treatment and prioritization for relocation to a camp settlement. The evaluation team heard repeatedly from key informants that HEBs and a

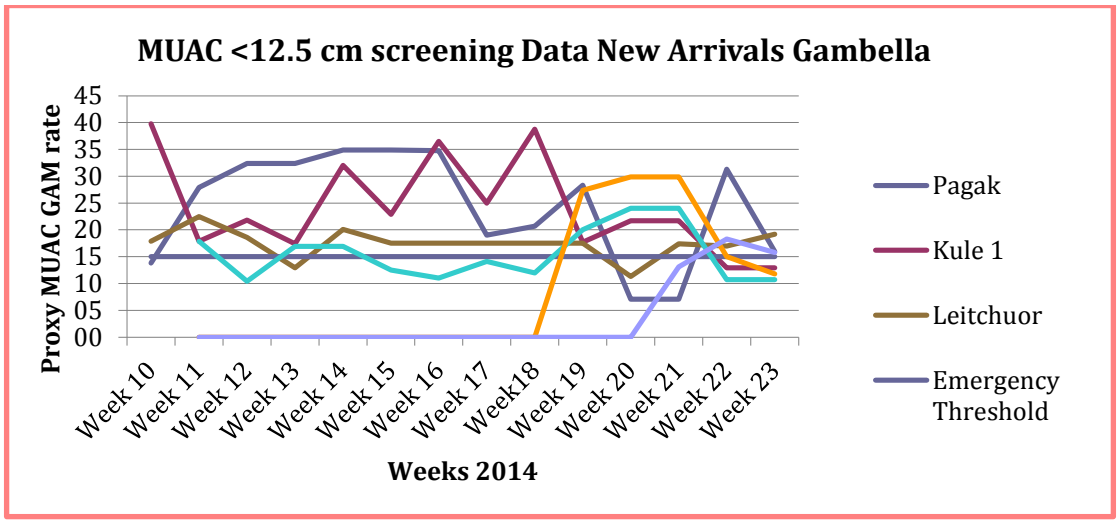
[161] UNHCR Ethiopia South Sudan Emergency SitRep 7-12 March

[162] Strategic Guideline on Health, Nutrition and Food Response, Gambella Emergency Programs, Ethiopia. Joint UNHCR/WFP/UNICEF/ARRA/Humanitarian Partners. April 2014

[163] Health, Food Security and Nutrition Update for new arrival in Gambella, 19 May 2014.

supplementary or therapeutic commodity distribution appeared to protect the refugees from falling in to a worsened state as they awaited relocation. This can be evidenced by the Pagak transit centre screening information which shows how the GAM rates in the new arrivals was alarmingly high however it remained stable or decreased (see Figure 7) even though populations were at times waiting within the transit centres for weeks or months. Given the high numbers of arrivals, the lengthy waits in the Pagak transit centre and the extremely high burden of malnutrition it would not have been unusual to see high mortality rates. The evaluation team heard anecdotal reports that mortality was high but was unable to confirm this through triangulation with other sources (refer to the health outcomes section). It is clear that accurate mortality estimates were extremely challenging in the first months of the response and rates were difficult to verify as community reporting on mortality was low and the dead were buried on the South Sudan side.[164]

Figure 7: Prevalence of GAM in New Arrivals in Gambella 2014



Source: UNHCR Gambella

4. WASH

The WASH strategy in the RRP focused on achieving adequate access to potable water and latrines at transit centres and camps for the first three months, followed by the roll out of a more comprehensive minimum WASH package. The strategies for each subsector are elaborated in more detail in the UNHCR WASH Strategic Operational Framework for Camps dated June 2014[165], which gives the emergency response phase as March to August, followed by a 10-12 month transition phase.

UNHCR used the **LoU with UNICEF** and humanitarian space opened by ARRA to maximize the engagement of WASH partners. This helped speed up the immediate response but resulted in inefficiencies later on due to fragmentation of services. The LoU facilitated the rapid mobilisation of UNICEF emergency stocks and the engagement of the Regional Water Bureau RWB in the immediate and longer-term response. UNHCR and ARRA accepted proposed interventions by all partners arriving with funding. Initially this was important in scaling up the response, but during the course of 2014 it made monitoring and harmonisation of approaches more difficult: different agencies using different designs were facing different environmental challenges in different camp zones. Some overlapping of agencies efforts was reported, for example in hygiene promotion in Kule.

[164] Basic Indicator Report, Week 13 2104. Pagak Reception Site, Ethiopia.

[165] UNHCR WASH Strategic Operational Framework for Camps. June 2014

UNHCR provided good coordination and promoted a culture of collaboration. Frequent coordination meetings facilitated the real-time information sharing and coordination required to adapt assistance to the rapid refugee influx and opening of several new camps. Partners generally collaborated well and readily shared available WASH equipment. Efforts to harmonise latrine design, however, were insufficient to overcome the combination of environmental challenges and multiple actors in each camp with differing opinions and differing levels of performance.

WASH at Transit Centres at Border Entry Points

At **transit centres such as the one near the Pagak border entry point,** open defecation was widespread for several months and refugees were resorting to drinking untreated river water for the first month. Whilst safe water supplies were installed in January 2014, the quantity of safe water available was below the amount specified in the Sphere Minimum Standards (7.5 l/p/d) at 3.5 l/p/d for Akobo and 5.7 l/p/d for Pagak through late March 2014[166]. A lack of jerry cans also limited the ability of the refugees to treat and store water at the entry points. The temporary nature of residency in the transit centres was an impediment to exclusive and proper latrine use as the residents were not concerned for a deterioration of an environment they would soon move out of[167]. A proliferation of flies was brought under control only in April. A focus of the early response was to relocate people from the transit centres at border entry points as soon as possible, to camps where proper services could be provided, however at periods throughout 2004 refugees were in transit centres for extended periods of time (see protection section) **WASH conditions deteriorated with each significant wave of refugees** and even at the time of the evaluation visit in mid-2015 conditions were poor, at significant variance with the policy that transit centres should "provide a habitable covered living space, ***a secure and healthy living environment with privacy and dignity to people of concern for a short period (2-5 days)"***[168].

Water

Average water availability appears to have reached around the Sphere standards of 15 l/p/d in camps once the camp populations were settled. However the mean daily quantity of water being used per person reported in the sector indicator matrices was below Sphere Minimum Standards for most of year, averaging around 9 to 10 l/p/d in the camps up until July, before slowly improving to just under 15 by the end of the year (see Table 1). Evidence from various surveys, however, points to higher water availability in reality, reaching around 15 l/p/d for most of the population in the second quarter of 2014.[169] The following table gives an overview of key WASH indicators.

[166] WASH Update on SS Asylum Seekers in Ethiopia dated 8th and 15th March 2014 k

[167] Minutes of Technical Coordination meeting on Pagak, Gambella. 21st February 2014

[168] Contained in the new UNHCR Emergency Handbook available at https://emergency.unhcr.org/entry/60632/site-planning-for-transit-centres

[169] A nutrition survey in March found that three-quarters of households in Tierkidi and around 40% in Kule were collecting at least 15 l/p/d of water, whilst rapid household surveys in late April in Tierkidi and Leitchuor found mean water consumption of 16.7 and 20.9 l/p/d, respectively. A Knowledge, Attitudes and Practices (KAP) survey169 in August gave figures of 14.8, 16.3 and 20.9 l/p/d for Kule, Tierkidi and Leitchuor, respectively, although 40% of Kule respondents were getting their drinking water from ponds.

Table 18: Key WASH Indicators[170] in Gambella, Ethiopia tracked by UNHCR

End Month (2014)	Entry Points				Camps				Overall			
	Population	Water consumption l/p/d	Person per latrine	Person / hygiene promoter	Population	Water consumption l/p/d	Person per latrine	Person / hygiene promoter	Population	Water consumption l/p/d	Person per latrine	Person / hygiene promoter
January	23,247	4	269						23,247	4	269	
February	51,473	3.1	377		18,691	9	81		70,164	4.7	298	
March	81,650	8	231		18,691	9	138		100,341	8.2	214	
April	17,406	**16.6**	**50**		101,078	10.4	152		118,484	11.3	137	
May	25,984	11.5	234		109,601	10.2	83		135,585	10.4	112	
June	18,910	9.1	94		154,002	9.7	60		172,912	9.6	64	
July	13,372	**39.5**	62	**100**	154,382	10.2	60	**500**	167,754	12.5	60	**468**
August	18,263	9.4	95	523	154,531	11.7	71	**484**	172,794	11.5	74	**488**
September	19,831	**18**	71	**310**	150,354	12.1	56	**479**	170,185	12.8	58	**459**
October	21,118	**16**	76	**309**	150,705	13.3	52	**480**	171,823	13.6	55	**459**
November	18,413	12	90	**297**	152,704	13	53	**480**	171,117	12.9	57	**460**
December	13,593	**31**	**43**	**297**	159,624	14.7	**37**	**480**	173,217	**16**	**37**	**466**

Source: UNHCR Gambella and Regional Support Hub

The Gambella Regional Water Bureau (RWB) was engaged in the construction and management of the **permanent water system for Tierkidi and Kule** to facilitate long-term sustainability, although the decision was also driven by finances. UNICEF was able to source sizeable development funds for the 10km joint pressure main required for the 2 camps by including Itang town in the system. Once the pressure main is completed, separate implementing partners will operate the two camp distribution systems. The RWB will provide them with water from the pressure main and charge based on the volumetric usage as recorded by bulk water meters for each camp. This strategy is well justified by the size and likely longevity of the camps, which will essentially become urban populations. It should also provide a tangible improvement for Itang town (population approx. 30,000). UNHCR and/or UNICEF will need to invest considerably in building the capability and responsiveness of the RWB for it to succeed in managing the scheme (Gambella hospital, for example, does not have a reliable water supply and Itang town had a water supply system operated by RWB but it fell into disrepair).

[170] July – December data taken from UNHCR Gambella's monthly Sector Indicators Matrices; January – June data taken from the Regional Support Hub's weekly water and sanitation access tracking, using figures from the closest date to the end of the relevant month.

Tierkidi and Kule camps were still relying on **water trucking** at the end of 2014, due to the relative complexity of the project required for a permanent water system. Successful boreholes were finally drilled 10km from the camps following failure to get a sufficiently productive borehole closer to the camps where groundwater potential is low. The design and construction of the pressure main experienced delays due to multi-stakeholder discussions over the design approach, and due to delays on the part of the contractor, such that it was still not completed in June 2015 (versus a planned completion date of March 2015). These delays are, however, consistent with the number and diversity of partners (UN agencies, NGOs, RWB, consultants) involved, the location and the relatively low private sector capacity in Ethiopia. An option of constructing a temporary pressure main to the vicinity of Kule and Tierkidi to minimise the water trucking distance was considered but eventually rejected based on a cost-benefit analysis.

Sanitation

Efforts to control open defecation were moderately effective in the refugee camps, but gaps existed. Communal latrines were the dominant means of excreta disposal in the camps throughout 2014. The latrines were gender-segregated, although a lack of pictographic signage and a slightly greater number of male latrines than female ones led to concerns over female access[171]. Sanitation scouts were hired to patrol open defecation areas to monitor and discourage open defecation. In the August KAP survey[172], open defecation was reported to be moderate in Tierkidi (16%) and Kule (7%), but high in Leitchuor (44%) where latrines were reported to be less hygienic. The ratio of latrines to people was the selected key indicator for sanitation reported in the sector indicator matrix each month (see Table 1 for monthly results), with a target of a maximum of 50 people per latrine. Given the size of the camps in Gambella and the challenges experienced in some zones of some camps, achieving this target (which occurred in December when the ratios were 43:1 and 37:1 for entry points and camps, respectively) does not guarantee that there are not substantial populations without latrine access.

Progress on **latrine construction** was slowed down by environmental and social challenges and variable partner performance, reaching the target of less than 50 persons per latrine only at the end of 2014. A system of target setting and monitoring for latrine construction was set up at the end of March. Some partners were meeting weekly targets, whereas others were falling short. High water tables and, in a few areas rocky ground, made digging latrine pits with adequate depth and longevity (many latrines were shallow and/or used by many people and filled quickly) difficult, and presented a challenge to family latrine construction. Refugees were reluctant to contribute to household latrine construction. Differences in policies around monetary incentives provided to households by different partners and the fact that the majority were still living in emergency shelters are likely discouraging factors. Latrines made from local materials (mud-plastered bamboo walls) were often damaged during the rains. Refugees expressed satisfaction with the communal latrines as a reason not to construct household latrines[173].

The WASH Technical Working Group did not succeed in rolling out an agreed **latrine strategy with agreed standard designs**. The development of a harmonised latrine strategy began during the first few months of the emergency response, but partners were still using different approaches to household/family latrine construction and refugee participation towards the end of 2014[174]. Some partners interviewed stated that many partners did not stick to various approaches and designs agreed via the coordination mechanism (some had

[171] Week 50 - Gambella WASH Coordination Meeting, Agreed Action Points

[172] UNHCR Kule, Tierkidi, and Leitchour Refugee Camps, Gambella Region, Ethiopia. Knowledge, Attitude and Practice Survey Report on Water, Sanitation and Hygiene (WASH). October 2014.

[173] Minutes of WASH Technical Working Group meeting, 6th November 2014.

[174] Minutes of WASH Technical Working Group meeting, 6th November 2014.

already purchased materials for prior designs). Partner agencies conducted focus groups discussions with refugees, which identified issues but the sector coordination and monitoring was not strong enough to bring about agreement and enforcement on solutions. More extensive stakeholder participation including full engagement of refugee hygiene promoters could have helped resolve the impasse. This would require a solid resource allocation, as would efforts to promote participation, which, as a number of interviewees noted, should not be seen as a cost-free activity.

Medical Waste Management

A comprehensive set of medical waste management facilities were presented in all the health facilities inspected, but were not being properly operated in all health centres. In Itang Health Centre, for example, syringes were floating in a flooded pit (assumed to be the ash pit), rather than disposed in the sharps pit.

Hygiene Promotion

Integration of **community outreach activities** in hygiene, health and nutrition placed constraints on hygiene promotion. This strategy, rolled out in April 2014[175], attempted to harmonise outreach activities in the face of multiple actors for each sector in many camps, thus avoiding duplicating of efforts and standardising the messages and approaches to be used. Hygiene Community Outreach Agents (HCOA) were hired by and reported to the different agencies responsible for hygiene promotion. The emphasis in the health sector on household health data collection and health referral meant that outreach workers were selected largely on the basis of their numeracy and literacy however hygiene promotion required promoters that could communicate effectively, especially with the key target audience of mothers (as carers of young children). WASH actors raised concerns about the effectiveness of HCOAs[176] and insufficient hygiene messages and did not consistently follow the integrated outreach strategy. Hygiene promotion messaging should have been harmonised with hygiene-related health activities through coordination and feedback mechanisms. The August KAP survey found that refugees got virtually all their hygiene information from household visits by hygiene promoters, and very little from campaigns and IEC materials. Most partners interviewed volunteered that hygiene promotion coordination and leadership was weak.

Hand washing facilities at latrines were inadequately promoted or rolled out. Hand washing stations were seen to be absent at most latrines during the evaluation visit, although this did not involve visiting a representative sample. One partner reported theft of hand washing facilities installed at latrines, resulting in reluctance on the part of their team to install hand-washing facilities. The KAP survey in August found few respondents reporting washing their hands at or inside the latrine, although the question appears to have been asked in such a ways as to only allow one answer. The majority reported washing hands in the home, where the majority of households were found to have soap.

5. Site planning

Site planning was reliant on short-term affiliated workforce personnel and suffered high turnover, but site plans were completed in good time and to a reasonable standard. Insufficient handover exacerbated the impact of the high turnover, resulting in poor communication between UNHCR and partners on the details of site plans. Changes of site planner followed by changes in site plans that necessitated additional discussions with partners regarding the locations of specific infrastructure and services.

[175] Community Outreach response guidelines; Gambella refugee camps emergency response, Ethiopia (April 2014)

[176] Minutes of Emergency WASH Coordination Meeting, 1st August 2014.

Site plans were reasonably well done, and utilised GIS to mould the settlements around the topography, although the location of some communal services was sub-optimal. Generally, communities comprised of two lines of household plots with a sanitary corridor between them (for showers and latrines). Blocks of communities were generally arranged around a central space, but most households faced other households across a dividing corridor and some households were separate from the central 'community' space by a sanitary corridor. Some water points were located in the central spaces where possible, but many were located on the paths and roads that divided blocks and zones. The food distribution centres and police posts were located peripherally, far from many camp residents, as were health facilities, although this was later remedied when a health partner opened up auxiliary clinics. Site planning for replacement areas for zones C and D in Tierkidi was delayed, resulting in delays in construction of permanent shelters.

Obtaining suitable sites was extremely difficult due to strong national and local political, economic and social factors. The selection of the first refugee camp for the emergency response, Leitchuor, was resisted by UNHCR, which knew it to be flood prone. Tierkidi and Kule were identified more expediently as the scale and speed of the influx became apparent and UNHCR intensified its dialogue with ARRA and the Gambella Regional Government. Jewi was only identified in October after Leitchuor experience serious flooding, but was only approved 5 months later after intense UNHCR advocacy demarches at the HQs and Addis levels. The total population of refugees in Gambella was approaching that of the local host population at the end of 2014, and had shifted the ethnic balance further in favour of the largest community in the Region (Nuer). Hence there was a reluctance to allow refugees to settle in land of the Anuak community, which was on higher ground and less flood prone. The government had also allocated large tracts of land in Gambella region to agribusiness investors, reducing the availability of land. The Regional Government also had interest in bringing development to specific underdeveloped areas, which were therefore favoured for refugee camps for the infrastructure development they would bring.

The flooding risk in Leitchuor camp was studied and well understood by UNHCR but, given the lack of alternative sites on offer from the Ethiopian Government, moving refugees from the crowded entry points to Leitchuor was the only option available to UNHCR that would facilitate the provision of acceptable living conditions and an acceptable level of services to the refugees. Within the first few months of the response it was clear that Leitchuor camp was at high risk of flooding and evidence was presented to UNHCR and ARRA[177] [178]. Despite efforts by UNHCR to identify alternative sites, ARRA and the Gambella Regional Government did not approve any alternative sites. The rains and flooding that occurred in 2014 were well above normal levels and the banks of the Baro River burst in August. Even after Leitchuor flooded it took 5 months to get a new site approved. Some key informants felt that UNHCR could have pushed more strongly for an alternative site, perhaps with the support of other key UN agencies and donors. However the evaluation team heard in no uncertain terms that site selection is a prerogative of the Government which made the decision and therefore it is unclear whether there was enough negotiating space for a better site. Nevertheless it is clear that UNHCR and ARRA should learn the lesson and avoid at all costs similar occurrences in the future.

Flooding increased the vulnerability of the refugee population in Leitchuor and reduced their access to services by physically blocking access and destroying some facilities. 75% of the completed latrines were destroyed and 22 out of 33 water points became inaccessible to the refugees[179]. 590 permanent shelters (out of 2,900 under construction or completed) had been handed over the to refugees prior to the flooding, whilst 7,250 emergency shelters (tents)

[177] Evaluation of the flooding potential of Leitchour camp. Cippà Andrea, WASH Officer, Gambella, Ethiopia. 12 March 2014

[178] Murray Burt Mission by the Senior Regional WASH Officer (Nairobi) To Ethiopia from 11 to 14 March 2014

[179] UNHCR Gambella. A Year In Review. January - Dec 2014 Volume 1, Issue 1. 2015

were in place in Leitchuor[180]. Many of these were destroyed by the floods. Hence many refugees were now also preoccupied with finding new living spaces or constructing shelters. Given the high proportion of women and children, this put many families at risk. In addition, community structures were disrupted as the refugees became more dispersed upon self-settling on higher ground[181].

Whilst some flood mitigation actions were taken, there was **no planning for the worst-case scenario in Leitchuor**, crucially for shelter but also for other sectors. Refugees and water tanks were moved to less flood prone areas in Leitchuor in April[182] and the permanent water system was designed (to place the water points along the roads) in response to more detailed topographical analysis. Whilst the level of flooding could not be accurately predicted, it was foreseeable that flooding of refugee shelters to the point that they were no longer habitable was a distinct possibility resulting in displacement. The maximum number of people moving would obviously be the total camp population, although assessing the distance they would be displaced to any degree of accuracy would be unrealistic. UNHCR could therefore have attempted prepositioning of emergency shelter materials for those that had moved to permanent shelters, as well as an allowance for emergencies shelters damaged beyond the point of recovery for reuse. It could have also considered more carefully the wisdom of investing millions of dollars in durable shelter and infrastructure in a site that it knew was at high risk of flooding.

6. Shelter

A **shelter strategy** was developed early on and permanent shelter design informed through consultation with refugees. After consultation, the refugee's representative composed of elder, women and youth selected the square model tukul on the basis that it provides more space for storage and can be easily partitioned according to the needs. The square model is also more amenable to a production line approach. A mud brick structure was rejected due to the difficulty in curing bricks during the rainy season, which was approaching at the time the strategy was being developed.

The Gambella Shelter Strategy[183] contained elements that might have reduced the impact of flooding in Leitchuor, but were not implemented. The strategy identified a need to maintain a stock of tents and emergency shelter materials for 6,000 families to buffer against continued high influx and climatic events. An upgraded emergency shelter, utilising additional poles and plastic sheeting, might have been more appropriate form of 'transitional' shelter (and in fact would be a true transitional shelter rather than the permanent shelter referred to in Ethiopia as 'transitional') as it would have been more amenable to removal, relocation and reuse in the event of flooding.

At the **transit centres at border entry points**, refugees were housed in hangars, although the limited availability meant that hangers were overcrowded and some refugees went without shelter. Upon relocation to camps, vulnerable families were provided with a tent, whilst others were given plastic sheeting, poles and rope to construct an 'A'-frame shelter. The long-term shelter solution was a 'tukul' with timber and mud plaster walls and a thatched roof. This was referred to as 'transitional' shelter.

The rate of the refugee influx challenged the ability of the response effort to provide adequate **emergency shelter** on a timely basis. Progress in establishing emergency shelters was impeded by delays in plot demarcation and short-term shortages of some construction

[180] *Ibid.*

[181] ARRA/UNHCR Interagency Flooding Assessment Mission to Leitchuor and NipNip Camps Gambella Region, Ethiopia 26 August, 2014

[182] Minutes of Gambella Emergency Response WASH Coordination Meeting, 18 April 2014

[183] UNHCR Shelter & Settlement Strategy Gambella Refugee Program – Ethiopia 2014

materials. Untimely and incomplete communication from UNHCR to partners on the dates and numbers of refugee population relocations to camps resulted in shelter gaps. In Tierkidi, refugees were in hangars for up to a week whilst their emergency shelters were being constructed.

Whilst upgrading of emergency shelters was provided for in the shelter strategy, it did not take place and most refugees remained in **A-frame emergency shelters** during 2014. **Tents** were provided to vulnerable families when stocks were available, whereas most families received plastic sheeting and a eucalyptus frame to make an A-frame shelter. A-frame shelters were fast to erect and much cheaper than tents but did not provide sufficient protection from the rain or sufficient covered living area to meet the SPHERE and UNHCR standard of 3.5m^2 per person for the majority of families. Tents, on the other hand, provided better rain protection and sufficient covered living area for most families, but were expensive (USD 850, including set-up). A need to improve the **flood resistance** of the emergency shelters, including a raised threshold to prevent run-off entering, was identified in mid-2014. The A-frame design was revised to a trapezoidal design. This **revised design**, however, was not used in 2014 but was later introduced in Jewi in 2015. Refugees were not involved in the design of the emergency shelter, but were free to adapt the constructed shelter so long as they kept within their allocated plot.

Infrastructure in reception and transit facilities was inadequate given that refugees were spending considerable time there before being relocated. Refugees were often waiting at entry points and transit centres for several weeks or more, during which they lived in hangers. The hangers were not subdivided for privacy, were overcrowded and lack concrete bases or flooring. Communal infrastructure in temporary and transit facilities should be of higher construction quality than that of refugee camps[184], but infrastructure investments in these facilities were restricted by the Ethiopian Government to avoid creating a pull factor. Public health concerns should have been given pre-eminence.

The **progress of durable shelter construction** did not keep up with the rate of the refugee influx owing, *inter alia,* to insufficient budgetary resources and technical capacity, and UNHCR acted late to engage additional partners. At the end of 2014, 87% of the refugee population was still living in emergency shelter. During the course of the year the issue of slow progress was raised repeatedly in coordination meetings and other forums, and it was clear that the existing shelter partners were overwhelmed. Only at the end of 2014 did UNHCR engage one additional partner. According to key informants the reluctance appears to have stemmed from an early impression that a key shelter partner was experienced, flexible and responsive, and also from push back from the same partner at the suggestion of sharing some of its workload. The recruitment of new shelter partners however led to differences in refugees' participation in shelter construction, in particular the amounts paid to refugees to collect and prepare grass for thatching..

Quality control of durable shelters was inadequate. Common problems with the permanent shelters were related to leaking roofs (poor quality thatching) and poor quality mud plastering. In Tierkidi a 281 shelters collapsed during a storm. The main cause was identified as insufficient manpower for construction supervision on the part of the implementing partner. Refugee households fixed leaking roofs by covering them with plastic sheeting, tents or parts of tents. Durable shelters constructed during the 2014 rainy season, when no thatching grass was available, were initially covered with plastic sheeting, with thatching being laid on top later. Placing plastic sheeting underneath thatching was then adopted as standard practice to prevent leaking roofs.

Refugee participation in durable shelter construction was low and variable in the absence of an agreed comprehensive participation strategy. Refugees were expected to participate in shelter construction but in the end daily labourers did most of the work. The capacities of the

[184] UNHCR Emergency Handbook (2007)

refugee families - in particular the female-headed households that formed the majority - for permanent shelter construction were not systematically assessed. Paying women to collect grass for thatching of their own shelters resulted in better quality thatching material being supplied by vendors. There was no strategy, however, to ensure that women could safely and legally collect thatching grass, or that they could do so without neglecting childcare and other essential activities. Alternative contributions, such as preparation of meals for labourers or provision of child care for people contributing labour or materials collection, do not appear to have been considered. Refugees participated in mud-plastering of their houses, but took much longer than labourers and the quality was variable.

7. Education

While no significant education preparedness measures were foreseen as part of the 2013 contingency plan, the LoU between UNHCR and UNICEF proved to be an important preparedness tool that enabled UNICEF to second education expertise to UNHCR several months into the emergency. The education response was based on several inter-agency assessments carried out in March, May and July 2014 that reviewed capacities and needs in a collaborative spirit. A draft education strategy was developed in August 2014 by UNHCR but remained in draft format only and had limited impact on inter-agency programming for education. The regional South Sudanese education strategy developed at the end of 2014 was found to be too general to guide context specific education priorities.

The majority of education interventions in 2014 were implemented through operational partners of UNHCR, both UNICEF and non-governmental partners through their own funding. Compared to the number of children in need of education, the number of partners working on education was small. Their roles and responsibilities were relatively clearly defined by camp and type of education services (pre-school, accelerated learning programme, upper primary etc.) Out of the 7 education actors in Gambella, UNHCR had implementation partnership agreements with two[185], one of which was for the old South Sudanese caseload. UNICEF and one operational partner supported education programming for the host communities.

Given the number of operational partners engaged in education with their own funding, **coordination for education** became key. Inter-agency coordination for education started about 3-4 months after the beginning of the emergency and was transformed into a more structured coordination mechanisms by the end of July. Regular education meetings at the Gambella level were found to be effective for information sharing and roles and responsibilities among partners seemed clear albeit some level of unwillingness to be coordinated was reported by organisations. Non-governmental partners highly appreciated the close collaboration between UNHCR and UNICEF although initially there was some confusion on reporting lines considering that one of the UNHCR education staff was a UNICEF secondee. From a UNHCR perspective, UNICEFs cooperation through technical education expertise, deployments, material support as well as complementary role in supporting education in host communities was catalytic and critical for the education response.

To track education results and support education coordination, UNHCR set up basic education information management tracking enrolment (GER) and two education efficiency indicators. Attendance is not systematically tracked.

Within UNHCR, education was not prioritized as part of life-saving interventions in the first six months of the emergency: budget allocation for education remained minimal, education staffing was not included in emergency deployment and staffing requests and coordination

[185] Operational partners on education: UNICEF, Plan international, World Vision, NRC, Save the Children. Implementing partners on education: ARRA, DICAC (partner before 2014 for old South Sudanese caseload).

mechanism were set up rather late. UNHCRs operational capacity on education was therefore small and UNHCRs main role in the education response was coordination and process facilitation.

With more than 70% of refugees being children, the education response was faced with a tremendous challenge of setting up learning opportunities for a very large group of children. The number of school-aged refugee children (3 to 18 years) increased to 75 000 children in August and 105 000 the end of December 2014[186] See Table X).

Table 19: Number of South Sudanese school-aged refugee children in Gambella, Ethiopia 2014

	August 2014	**October 2014**
3-6 years	27 825	38 323
7-14 years	38 807	54 013
15-18 years	8 459	13 047
Total	**75 091**	**105 383**

Source: UNHCR Gambella

While the mandate of formal **primary education** for refugees in Ethiopia lies with ARRA, there was a need to provide fast tracked education opportunities before formalised primary education could take place. At the end of March 2014, first education interventions were started by one operational partner for a limited number of children and with very limited infrastructure in one camp (Leitchuor). A critical scaling up of education interventions focusing on Early Childhood and lower primary education commenced only after the first six months of the emergency in July 2014. By the end of August, education activities were ongoing in the three camps (Leitchor, Kule, Tierkidi) for early childhood education (age 3-5) and lower primary education (age 6-10) implemented through two partner organizations. While the education response was characterized as ad-hoc and chaotic at the beginning, it became more structured and systematic after August once interventions were scaling up and partnership and coordination mechanisms had been agreed upon.

Education activities for **upper primary education (**grades 5-8) started in October 2014 in one camp by one organization and after negotiations with ARRA in Addis Ababa. In addition to schools, the response offered accelerated learning classes for over-aged students at the end of 2014, following the national Alternative Basic Education programme. No secondary education was provided[187] and education services were not offered at entry points and transit centres in line with the overall response policy not to offer services but rather relocate persons of concerns to camps. The evaluation could not fully establish the reasons why no or very limited education opportunities beyond grade 4 were established. Some key informants pointed to decisions and policies of ARRA in this regard, whereas others mentioned the need to prioritise in view if budgetary constraints. The response did not succeed to create education opportunities for older children (11-18) and youth which in turn increased the risk of negative coping mechanisms such as recruiting young men into armed forces and child marriages. The operation reported an increase in child marriages and SGBV in 2014 and early 2015, but there is no evidence based causal link with the lack of education opportunities.

Identifying and securing adequate **physical infrastructure for education** was challenging due to the large number of school-aged children, limited partners and limited early focus on education, which is known to further activation of services. The initial education interventions were taking place in emergency tents and for the second half of 2014 emergency tents and temporary structures were the main shelter option for education. In mid-2014, plans were made to gradually replace temporary structures with semi-permanent options and this was

[186] UNHCR Gambella camp level population data.

[187] Secondary education was offered in Pugnido for the old refugee caseload from South Sudan.

partially achieved in one camp. Torrential rains and flooding destroyed some temporary infrastructure in some camps and delayed the building of semi-permanent structures in other camps, leading to interruption of schooling. Some arrangements with host community schools enabled partners to utilize host community schools for afternoon school shifts but these arrangements remained ad-hoc and were of limited sustainability.

For **teacher recruitment** UNHCR and partners successfully tapped into existing capacities within the refugee community, some of whom had been trained as teachers during previous displacements in Ethiopia. The majority of refugee teachers had completed secondary education and did not have a teaching certificate. While partners were not able to recruit female teachers, classroom assistants were predominantly female. Recruitment of teachers included written and oral test and some teachers received additional training from partners and UNHCR. A standardized incentive scale for refugees in the camps was set up and included standardized remuneration of teachers and classroom assistants. Refugees repeatedly communicated that they highly value education; attendance is affected mainly by poverty levels (for example, children do not have clothes to go to school) or family coping strategies (children needing to take care of the house while the mother works or is absent). School enrolment and attendance are free of charge.

The selection of the **education curricula and language of instruction** were dealt with in a forward looking and solutions oriented way: after initial confusion and a disjointed approach on curricula and material, it was decided to use the Ethiopian curricula to ensure education continuity and link to national education services, certification, materials and resources. Although refugee parents and teachers preferred English as the language of instruction, the Ethiopian policy for language of instruction was adopted which foresees that teaching takes place in the local language until grade 4 (Nuer in the case of Gambella) and then switches to English. This policy created some challenges since some refugee children from other ethnic background did not speak Nuer and refugee teachers – while speaking Nuer in the classroom – were not necessarily able to speak and write in Nuer. Even though the refugee schools are not officially recognized schools by the Ethiopian Ministry of Education, efforts were made to ensure education certification for refugees: in 2015, refugee students in grade 8 took the Ethiopian primary school leaving exams supervised by Government officials.

While the overall education responses started late, once it began enrolment figures were high: Monitoring data show a considerable increase of enrolment in primary education and an increase in pre-primary education after the emergency[188], with boys enrolment consistently higher than girl's enrolment. Education efficiency data show a high pupil/teacher as well as pupil/classroom ration, which is not according to recommendations but expected within the first year of an emergency. Specific interventions to increase access of children with disabilities have not been undertaken; data on enrolment of unaccompanied and separated children was not available. Data on pupil/latrine ratio and water points in schools was not available, but camp observations concluded a very high pupil/latrine ratio[189]. In the evaluation survey, education was rated as the most problematic sector and almost half of the Survey respondents did not find that for education the outcomes have been adequate and proportional to the response.

Overall, UNHCR, through its coordination and partners, achieved the planned education response relating to pre-primary and primary education, establishment of learning spaces and recruitment of teachers as set out in the South Sudan Regional Refugee Response plan. In moving forward, in order for education interventions to contribute to protection, sustainable education options for refugee children beyond lower primary education as well as a focus on quality of education will be critical for the protection of children. UNHCR and partners made the right choices regarding long-term solutions and education continuity through the choice of

[188] The UNHCR country office suggests to use this data with caution given the number of over-aged children and the lack of systematic collection of attendance data. Actual net enrolment rate is therefore suggested to be lower.
[189] Sphere guidelines suggests the following ratio for latrines: 1:30 girls, 1:60 boys.

the education curriculum, language of instruction, refugee teacher recruitment and cooperation with the Ministry of Education.

Table 20: Education indicators

	March	June	August	December	Standard
Pre-primary:					
Enrolment pre-primary	0		11%	34%	100%
Pupil/classroom ratio	0	n/a	206[190]	107	
Pupil/facilitator ratio	0	n/a	106 (2 camps)	101	40:1
Primary:					
Enrolment primary school (GER)	0		28.6%	84%	100%
Pupil/classroom ratio	0	n/a	127:1	143:	
Pupil/teacher ratio	0	n/a	119:1	107:1	40:1
Enrolment secondary school	**0**	**0**	**0**	**6%**	
# or % or qualified teachers	n/a	n/a	n/a	n/a	

Source: UNHCR Gambella

ETHIOPIA Conclusions and Recommendations

Effectiveness

In spite of the limited usefulness of the contingency plans and the limited preparedness, the UNHCR-coordinated response on a whole was timely and effective in saving lives and met the RRP's broad objectives. This was partly thanks to support received through the crucial UNICEF partnership and from other partners who intervened with their own funds, in addition to ARRA's openness to early international interventions. There were, however, significant shortcomings. In particular, the timeliness and effectiveness of the protection response was primarily limited by external constraints on which UNHCR had limited control, such as delays in site selection and in the opening of new camps, owing mainly to the scarcity of suitable land, and several suspensions of the registration which meant lengthy periods in which the refugees were held in sub-standard transit centres. The 100% Level 2 refugee registration of those refugees who settled in the camps was however a significant achievement.

The immediate life-saving health response was effective despite the fact that controlling communicable diseases was a challenge and scaling up the wider range of public health services remained limited. The nutrition response met the nutritional needs of the refugees in a timely manner and had a large immediate impact. Access to water and sanitation improved quickly once the refugees were relocated to camps, but environmental conditions made establishing long-term solutions so that difficult that Tierkidi and Kule camps were still relying on water trucking at the end of 2014. The roll out of family latrines was slow and uneven. Permanent shelter construction was slow and quality of permanent shelters varied, but was on a whole inadequate. The education response met the objectives of the RRP; however, education needs of refugees were met with delays.

Relevance/appropriateness

The design of the RRP and UNHCR's emergency response were largely relevant and appropriate and the protection response was guided by relevant priorities in most areas, although implementation was challenging. With the exception of nutrition and education, however, there is no evidence of early, participatory, interagency assessments. The nutrition response was guided by lessons learned from previous major emergencies in Ethiopia, with specific reference to harmonization of interventions and the timely engagement of partners. The objectives of the health response were appropriate and were shaped by the UNHCR

[190] Information only for 1 camp; information from other camps was not available.

global and Ethiopia specific public health strategies, although there was a limited assessment of need. The WASH strategy was largely appropriate to the context, focusing on establishing water trucking and communal latrines initially, followed by permanent water systems and household latrines and supplemented by rehabilitation and new installations of hand pumps. A wider array of messaging methods could have increased the effectiveness of hygiene promotion. A shelter strategy was developed early on and permanent shelter design informed through consultation with refugees.

Coverage

On a whole the UNHCR-coordinated emergency response ensured a good coverage of the refugee population, although there were some significant gaps, such as in shelter and latrines. Registration was established in all entry points and camps and conducted for all refugees on an individual basis. Child protection and SGBV programming was established in all camps but programming for children focused on most urgent cases to the exclusion of the wider caseload. Protection considerations were only partly mainstreamed into sectorial responses.

Refugees did not have equal access to quality primary health services owing to different standards of care provided by health partners and there were gaps in terms of expanded primary health service and provision of secondary health care. Integrated nutrition programming was established in all camps and reception centres, but despite early initiation of outreach activities, community based coverage remained weak. Coverage for water and sanitation overall was reasonable, but in some camp zones refugees suffered lower access due to environmental and social challenges. Access to adequate shelter was generally low due to the slow rate and quality of permanent shelter construction and UNHCR acted late to engage additional partners. Early childhood and lower primary education was established in all camps and achieved high enrolment but with uneven coverage across camps. Education response for the age group of 11-18 remained a significant gap that needs further emphasis to ensure long-term protection outcomes.

Coordination

Compared with previous emergency responses (notably that of Dollo Ado in 2011), the coordination of the emergency response was much more collaborative and inclusive. The strategic partnership with UNICEF, and ARRA's openness to early NGO intervention opened up the humanitarian space, and played a crucial role. The selection and retention of IPs and OPs however, was not transparent and not based on clear criteria. This is partly explained by the fact that some NGOs who intervened with their own funds could not be turned away and partly by the disconnect between UNHCR's theoretically decentralised approach and ARRA centralized approach. This led to an excessive fragmentation of partners in several sectors in several camps, which in turn made leadership and coordination more difficult. In addition the quality of sectorial coordination varied substantially. Good information management products were issued regularly which facilitated coordination.

The coordination of protection was marked by a lack of a protection vision, partly due to the lack of a senior protection officer for most of the time, piecemeal protection programming and a comprehensive protection strategy. Coordination on case management for child protection and SGBV remained insufficient. UNHCR's coordination of the health and nutrition sectors was timely and promoted information sharing and joint action, and avoided gaps and duplications. In WASH the coordination with UNICEF was instrumental for an early intervention, but the fragmentation of partners and the lack of a thorough gap analysis led to some gaps and duplications. There was minimal coordination in the shelter sector in 2014, with only two implementing partners, neither of which showed much appetite to being coordinated. In the education sector, UNHCR mobilized appropriate partners, promoted synergies and avoided duplications. The education programming would not have been possible without UNICEF and coordination with UNICEF was critical.

Connectedness

Within the timeframe under evaluation there was limited strategic thinking to longer-term sustainable programming and very few resources devoted to livelihoods and self-reliance. The nutrition response was consistent with UNHCR corporate strategies as well as in line with

Ethiopian national guidelines. Longer-term health sector objectives and solutions were given limited consideration and sustainability of the health response remains an open question. In particular, there is little linkage with the national health system, both at the central, and local level (Gambella hospital), partially because of ARRA's role in implementation. By contrast, the Regional Water Bureau, through UNICEF, was engaged in the construction and management of the permanent system for Tierkidi and Kule to facilitate long-term sustainability, although the decision was also driven by finances. Some linkages between the education response and protection priorities were established and solutions oriented education decisions were taken. Steps towards access to national education systems were also made. However, longer-term sustainability of the education response remains an open question.

Impact

Protection outcomes were affected by land allocation choices, nationality screening, suspended registration and insufficient case management. Scarcity of suitable land for refugee camps and the slow pace of nationality screening [191] reduced thewell-being of refugees who were held for lengthy period of time at border transit centres with partly limited services, including food. The UNHCR-coordinated response and the Ethiopian Government's strict adherence to the principle of *non-refoulement* facilitated access to territory and enabled life-saving activities to be implemented, rapidly decreasing the high levels of malnutrition and along with it the associated mortality however the collection of mortality data needs to be strengthened.

Negative health outcomes were mitigated through timely provision of primary health service and prevention/management of infectious diseases outbreaks. However an increased demand on secondary health services had a negative outcome on health provision for host populations. The nutrition response had positive outcomes with a reduction in the prevalence of malnutrition, although indicators remained close to emergency thresholds. Reasonable volumes of safe water were made available to the refugees, but gaps in sanitation and hygiene likely contributed to high diarrhoea mortality and a hepatitis E outbreak. Although delayed, the education response achieved access to education for a high number of young children, but still fell substantially short of the standard of 100% enrolment in primary education and did not address education beyond the age of 10, leaving young people largely out of the response.

Recommendations

1. **Conduct a performance review of the current IPs per sector and camp**, in line with the UNHCR policy on Selection and Retention of Partners for Project Partnership Agreement. The Addis Ababa Representation, with support from the Bureau, DPSM and UNHCR Ethiopia technical specialists, should carry-out a review of the comparative advantage and operational capacity of IPs per sector and camp with a view to rationalising presence and reduce the current fragmentation.
2. **Define protection priorities for the ongoing response and align protection and sectorial interventions under an overall protection chapeau.** This includes a mapping of protection coordination requirements at all levels and a review of protection staffing and responsibilities.
3. **Invest in strengthening SGBV service provision and improve data collection and analysis through the roll-out of GBV-IMS** with service providers through partner training, functioning case management, community mechanisms and awareness raising campaigns.

[191] While nationality screening particularly in a context of cross-border ethnicity such as the one in Gambella is a delicate exercise but absolutely essential for a credible refugees status determination system, the delays and suspensions in the exercise at times lasting 9 weeks kept the asylum-seekers in a limbo in sub-standard conditions and therefore *de facto* had a negative impact on their well-being.

4. **Advocate strongly for the rapid processing of nationality screening procedures** in order to quickly decongest transit centres. UNHCR must support nationality screening and to the extent possible, harmonize approaches on nationality screening across operations in Ethiopia and establish a monitoring mechanism and procedures in cooperation with appropriate partners for tracking the application of nationality screening.

5. **Streamline child protection case management** and facilitate child protection standards and coordination among partners. Simplified procedures, agreed data sharing protocols, child protection programming standards and clear roles and responsibilities among child protection partners should be established through UNHCRs coordination.

6. **Implement a response wide community mobilisation strategy** that builds on community structures, avoids parallel new structures and is effective in supporting protection (child protection, SGBV) and sectorial programming (health, wash, shelter).

7. **Establish an accountability mechanism to persons of concern** through the development of systematic feedback and complaints mechanisms across UNHCR and partners, systems for communicating back on feedback received and participation of refugees in planning and monitoring of interventions across sectors.

8. **Improve the infrastructure and services at transit centres at border entry points** (in consultation with the concerned authorities). Considering the frequent overcrowding and extended duration of stay, additional hangars with solid and waterproof flooring should be provided with a minimal level of privacy and dignity in line with recent guidance[192]. Ensure adequate water, safe latrines and food distribution with adequate cooking facilities, utensils and fuel.

9. **Advocate for, coordinate and provide support to the regional Gambella hospital** to account for the increased demand by the refugee population and the limited existing capacities. An action plan, with attached funds, to address immediate priorities to bring services up to acceptable standards is an essential first step. Longer-term planning and solutions need to be initiated including the Government of Ethiopia and development partners.

10. **Facilitate the development of strategic linkages between the national Ministry of Health and ARRA** with the intent to improve the quality of health services for refugees including areas such as accreditation of ARRA health facilities by the MoH. Hand in hand with this, a thorough review UNHCR's funding stream to ARRA for provision of health services should be conducted and the results of this should inform UNHCR's decision making for longer term sustainable support to national health programmes for refugees.

11. **Strengthen hygiene promotion activities, with a particular emphasis on exclusive latrine use and hand-washing at critical times.** Poor results in rolling out household latrines and hand washing facilities point to a need for stronger promotion on these issues in particular. Safe water handling and safe food management are also important. House to house promotion should continue but should be reinforced with community activities (discussions, competitions, drama etc.) and mass media (posters at key locations) to increase awareness and interest.

12. **Undertake a detailed capacity assessment of the RWB for the management of the Tierkidi/Kule water system** and put in place a plan to address capacity gaps. Ensure that a detailed contract is in place detailing how bulk water tariffs will be determined, how often they will be revised and how service provision will be regulated.

13. **Speed up the upgrading of refugee shelter conditions, by putting in place milestones for the development of semi-permanent tukuls or suitable upgrade shelters, as well as actions to be taken if milestones are not met, especially in Kule**

[192] According to the recently released Emergency Handbook, transit centres should "provide a habitable covered living space, a secure and healthy living environment with privacy and dignity to people of concern for a short period (2-5 days) while they wait for new settlements to be constructed or until shelter can be found in other accommodation or host villages".

and Tierkidi. Permanent shelter construction should be accelerated reviewing the selection and number of implementing partners engaged and/or by undertaking a DPSM mission to evaluate the need for an upgraded emergency shelter option including its design, if relevant. Monitoring should be improved with progress delays and quality issue triggering specific course correction measures.

14. **Standardise shelter support, including refugee participation, and ensure that protection principles are fully incorporated.** Refugee participation should be standardised, and should be designed such that it does not impact negatively on their safety or essential family and childcare of female-headed households. Resources should be invested, where necessary, in organizing and support refugee participation mechanisms. This might include, for example, community and/or block meetings to organize sharing of tasks between neighbouring households according to ability.

15. **Ensure that there is high quality supervision and coordination in the shelter sector with the necessary continuity** ideally at the Addis and the Gambella levels in view of the high budget and expenditures in the sector and the impact on the well-being of refugees. Co-coordination by a partner, in concurrence with the relevant technical unit at HQ and in consultation with agencies active in the response, could also be envisaged.[193]

16. **Explore opportunities for strategically steering UNHCR's education programming towards integrating refugee children into national education systems** as UNHCR's strategic and long-term direction for refugee education that will give refugee children a longer term perspective.

17. **Utilize UNHCR's existing education strategy in Ethiopia to its full potential so that it can** be applicable in emergency situations as early as possible by further expanding education opportunities beyond the first four years in primary and facilitating partner support and buy in into this strategy. Develop action points on how to gradually expand access beyond the first four years of primary education and expand learning to capture more youth and adolescents.

18. **Strengthen education programming as part of UNHCR's comprehensive protection strategy and delivery to increase an integrated programming response**, further building longer term education capacities within the UNHCR office in Gambella.

Systemic Recommendations

1. **In an L3 emergency, consider appointing a dedicated Regional Refugee Coordinator to be co-located in the region with peers from other UN agencies**, instead of the current practice of "dual hatting" HQs-based Deputy Directors and Regional Refugee Coordinators. While in the South Sudan emergency the dual hatting did not constitute a serious obstacle to coordination, opportunities for greater and more consistent partnerships may have been missed owing to the fact that the RRC was not based in Nairobi.

2. **Explore how to further simplify Budget Committee submissions and processes** in line with a recently instituted Working Group. While in the case of this emergency the decision-making process by the Budget Committee for OL increases (increase in authorized budgets) was relatively quick, all the involved actors complained that the process remains cumbersome and time-consuming. The Working Group could also try to tackle the issue of earmarked funds arriving late in the year for construction or services that cannot be implemented before the closure of the financial year with a view to having a more predictable and timely (i.e. before the end of the year) decision on an extension of the implementation period.

[193] As per guidance contained in the recently issued UNHCR Emergency Handbook, in line with the Refugee Coordination Model.

3. **Embed the centrality of protection further in UNHCR's emergency response and ensure that UNHCRs mandate in adequately reflected in staffing, resources and assistance programmes.** Guidance on the centrality of protection needs to part of the emergency response package and protection mainstreaming guidelines need to be developed and put in place for large-scale emergencies and applied across sectors.

4. **In collaboration with other relevant actors, and as a part of on-going research where possible, conduct operational research on the measurement of malnutrition** and calculation of prevalence in anthropometrically unique populations such as the Dinka and Nuer from South Sudan. This could be an effective regional initiative with programmatic implications for nutrition caseloads in the region.

5. **Develop a latrine strategy for environments with high water tables and rocky soils**, which are commonly encountered in refugee settlements. The strategy should include guidance on how to manage the increased cost of latrines in these difficult environments and whether it is acceptable to allow a higher persons-per-latrine ratio. Standard designs and bills of quantity should be developed to facilitate rapid budgeting and decision-making during emergencies.

6. **Put in place organisational standards, mechanisms and procedures on education programming in emergencies** to ensure that education is an essential and timely intervention with adequate staffing and resourcing. UNHCR to develop staffing benchmarks for education that inter alia take into account the number of children for which education programming is required.

7. After the first phase of the emergency (3-6 months) **ensure that there is high quality supervision with the necessary technical and coordination skills and continuity (at least one year) for "technical" sectors, particularly if they have high budgets.** Co-coordination by an experienced partner, in concurrence with the relevant technical unit at HQ and in consultation with agencies active in the response, should also be institutionalised, in light of recent guidance.

8. **Carry-out an assessment on the utilization of the Affiliate Workforce** including contractual arrangements with a view to understanding the drivers leading to excessive turn-over which hampers the necessary continuity to ensure quality coordination and leadership particularly in the technical sectors.

9. **Ensure that updated Contingency Plans are in place with a realistic assessment of sites of an adequate size to receive the forecasted refugee influx.** Prior to the crisis when drafting Contingency Plans site pre-identification should be carried out in cooperation with governmental authorities.

4810 **ANNEXES**

Annex 1: 2014 South Sudan Refugee Response Plan Comparative analysis [194]

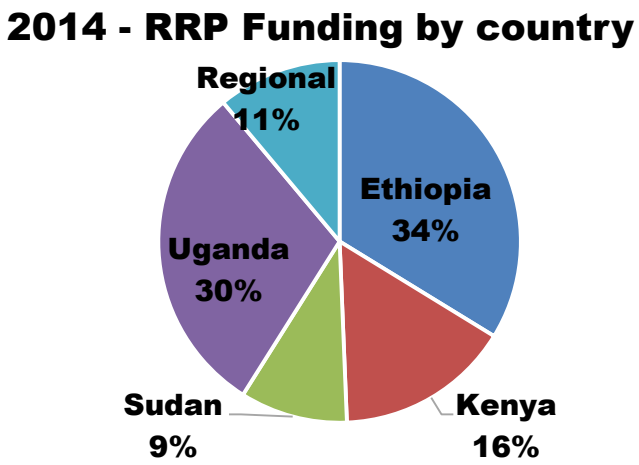
Requirements:	657,669,609
Funding:	357,159,825
% funded:	**54%**

Partners:	*34 agencies + NGOs in Uganda*
Countries:	*4 countries*
Time-frame:	*12 months (Jan-Dec 2014)*
RRP versions:	*initial RRP issued in March 2014 (total ask was USD370m)*
	revised version in July 2014 (total ask increased by USD287m)

By country

	Requirements	Funding	% funded	% of tot funding	Target population	Actual population
Ethiopia	210,975,801	120,544,064	57%	34%	300,000	191,698
Kenya	108,824,008	55,731,089	51%	16%	100,000	45,627
Sudan	113,565,811	34,283,087	30%	10%	165,000	119,709
Uganda	224,303,989	106,961,550	48%	30%	150,000	136,507
Regional		39,640,036		11%		
Total	**657,669,609**	**357,159,825**	**54%**	100%	**715,000**	**493,541**

Main donors:	US | UK | CERF | EU | Netherlands | Japan



[194] Produced by UNHCR/Donor Relations and Resources Mobilisation Service, Geneva

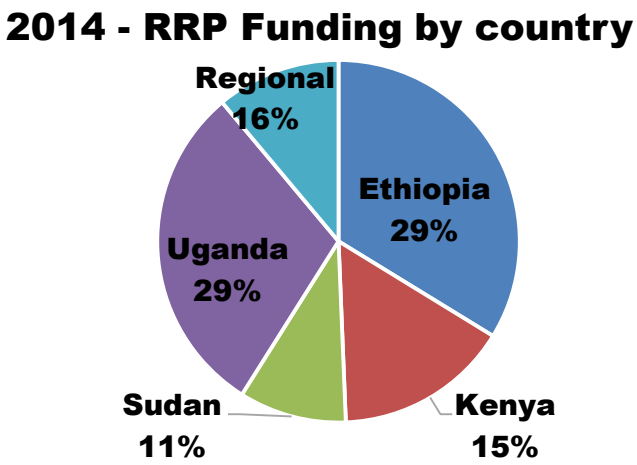
2014 - UNHCR ONLY

Requirements	329,390,527	*(50% of RRP total requirements)*
Funding	183,635,033	
% funded	**56%**	

By country

	Requirements	Funding	% funded	% of tot funding	Target population	Actual population
Ethiopia	90,707,304	53,515,064	59%	29%	300,000	191,698
Kenya	61,074,465	26,579,358	44%	14%	100,000	45,627
Sudan	54,441,602	20,453,688	38%	11%	165,000	119,709
Uganda	123,167,156	53,917,241	44%	29%	150,000	136,507
Regional		29,169,682		16%		
Total	**329,390,527**	**183,635,033**	**56%**	100%	715,000	**493,541**

Main donors: US | UK | CERF | Netherlands | EU | Sweden



Annex 2: 2014 UNHCR Uganda 2014 Authorized Expenditure Level and Actual Expenditures by Objectives

UGANDA	Column1	Column2	Column3	Column4	Column5
RIGHTS GROUPS	**OBJECTIVES**	**2014 Authorized Expenditure Level**	**% Against Total Authorized Expenditure Level**	**2014 Actual Expenditures**	**% Against Total Actual Expenditures**
Favourable Protection Environment	Access to legal assistance and legal remedies improved	646,793	1.26	343,899	0.72
	Access to the territory improved and risk of refoulement reduced	0	0.00	1,705	0.00
	Law and policy developed or strengthened	11,643	0.02	11,466	0.02
Rights Group Total:		**658,437**	**1.28**	**357,071**	**0.75**
Fair Protection Processes and Documentation	Reception conditions improved	1,119,053	2.18	1,252,502	2.64
	Quality of registration and profiling improved or maintained	635,926	1.24	851,966	1.80
	Level of individual documentation increased	11,643	0.02	8,734	0.02
	Civil registration and civil status documentation strengthened	23,988	0.05	18,137	0.04
Rights Group Total:		**1,790,610**	**3.49**	**2,131,339**	**4.49**
Security from Violence and Exploitation	Protection from crime strengthened	1,783,697	3.47	1,617,524	3.41
	Protection from effects of armed conflict strengthened	577,990	1.13	386,196	0.81
	Risk of SGBV is reduced and quality of response improved	2,845,558	5.54	1,725,177	3.64
	Protection of children strengthened	722,809	1.41	546,797	1.15
Rights Group Total:		**5,930,054**	**11.55**	**4,275,693**	**9.01**
Basic Needs and Essential Services	Health status of the population improved	4,739,931	9.23	5,603,983	11.81

	Population has optimal access to reproductive health and HIV services	481,828	0.94	416,084	0.88
	Nutritional well-being improved	877,719	1.71	478,248	1.01
	Food security improved	127,048	0.25	110,079	0.23
	Supply of potable water increased or maintained	2,944,708	5.74	2,726,798	5.75
	Population lives in satisfactory conditions of sanitation and hygiene	1,420,347	2.77	2,172,588	4.58
	Shelter and infrastructure established, improved and maintained	8,054,278	15.69	7,415,032	15.62
	Population has sufficient access to energy	115,405	0.22	113,970	0.24
	Population has sufficient basic and domestic items	3,362,354	6.55	3,513,754	7.40
	Services for persons with specific needs strengthened	927,186	1.81	683,593	1.44
	Population has optimal access to education	5,948,219	11.59	5,334,018	11.24
Rights Group Total:		**28,999,022**	**56.49**	**28,568,148**	**60.20**
Community Empowerment and Self-Reliance	Community mobilization strengthened and expanded	425,523	0.83	374,108	0.79
	Peaceful co-existence with local communities promoted	267,105	0.52	202,458	0.43
	Natural resources and shared environment better protected	1,143,956	2.23	946,903	2.00
	Self-reliance and livelihoods improved	1,627,652	3.17	1,461,939	3.08
Rights Group Total:		**3,464,236**	**6.75**	**2,985,409**	**6.29**
Durable Solutions	Potential for integration realized	11,643	0.02	8,733	0.02
	Potential for resettlement	0	0.00	729	0.00

	realized				
	Potential for voluntary return realized	11,643	0.02	8,758	0.02
Rights Group Total:		**23,287**	**0.05**	**18,221**	**0.04**
Leadership, Coordination and Partnerships	Coordination and partnerships strengthened	46,573	0.09	34,934	0.07
	Camp management and coordination refined and improved	127,048	0.25	101,345	0.21
	Donor relations and resource mobilization strengthened	46,573	0.09	34,934	0.07
Rights Group Total:		**220,194**	**0.43**	**171,213**	**0.36**
Logistics and Operations Support	Emergency management strengthened	0	0.00	8,733	0.02
	Logistics and supply optimized	3,988,299	7.77	2,416,388	5.09
	Operations management, coordination and support	6,257,891	12.19	5,643,027	11.89
	Instalments to Implementing Partners	0	0.00	882,851	1.86
Rights Group Total:		**10,246,191**	**19.96**	**8,950,999**	**18.86**
GRAND TOTAL UGANDA		**51,332,031**	**100**	**47,458,092**	**100**

Source: MSRP accessed on 01/09/2015

Annex 3: 2014 UNHCR Ethiopia Authorized Expenditure Level and Actual Expenditures by Objectives

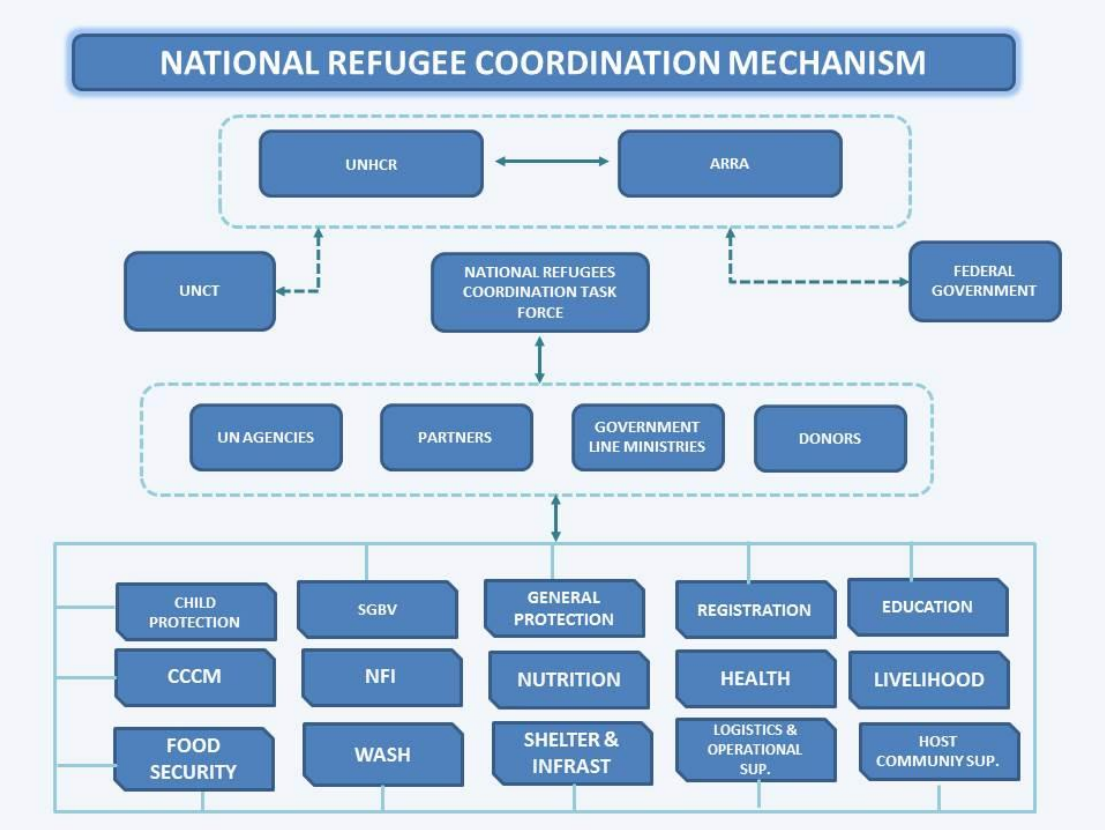
ETHIOPIA	Column1	Column2	Column3	Column4	Column5
RIGHTS GROUPS	**OBJECTIVES**	**2014 Authorized Expenditure Level**	**% Against Total Authorized Expenditure Level**	**2014 Actual Expenditures**	**% Against Total Actual Expenditures**
Favourable Protection Environment	Public attitude towards persons of concern improved	235,397	0.28	319,259	0.40
Rights Group Total:		**235,397**	**0.28**	**319,259**	**0.40**
Fair Protection Processes and Documentation	Reception conditions improved	5,938,974	7.15	3,430,522	4.31
	Quality of registration and profiling improved or maintained	2,376,204	2.86	1,722,634	2.17
	Access to and quality of status determination procedures improved	23,829	0.03	21,403	0.03
	Level of individual documentation increased	70,079	0.08	83,289	0.10
	Civil registration and civil status documentation strengthened	49,357	0.06	54,462	0.07
	Family re-unification achieved	192,318	0.23	154,967	0.19
Rights Group Total:		**8,650,760**	**10.41**	**5,467,277**	**6.87**
Security from Violence and Exploitation	Protection from crime strengthened	193,768	0.23	164,216	0.21
	Risk of SGBV is reduced and quality of response improved	1,231,432	1.48	1,647,090	2.07
	Protection of children strengthened	1,818,419	2.19	1,506,511	1.89
Rights Group Total:		**3,243,619**	**3.90**	**3,317,817**	**4.17**
Basic Needs and Essential Services	Health status of the population improved	4,537,464	5.46	4,239,558	5.33
	Population has optimal access to reproductive	1,260,464	1.52	1,100,695	1.38

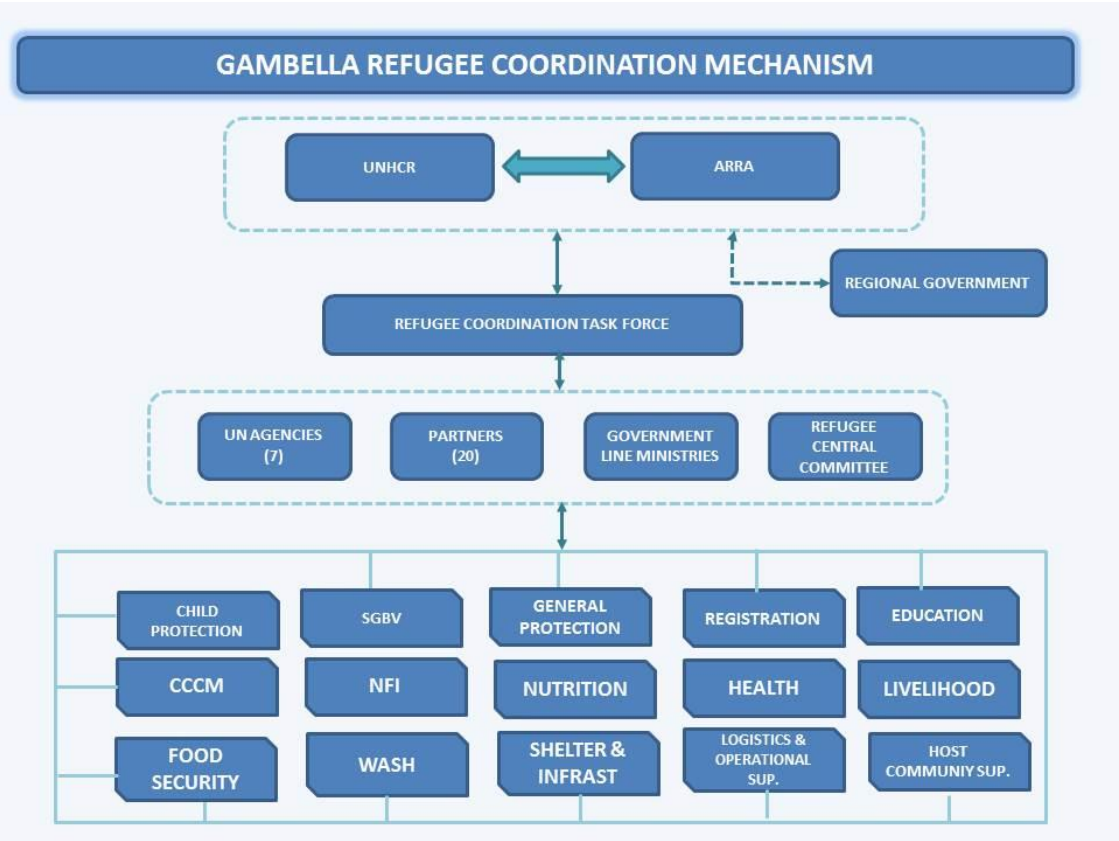
	health and HIV services				
	Nutritional well-being improved	1,698,336	2.04	1,546,180	1.94
	Food security improved	23,829	0.03	27,231	0.03
	Supply of potable water increased or maintained	6,754,795	8.13	4,515,328	5.68
	Population lives in satisfactory conditions of sanitation and hygiene	5,236,589	6.30	4,445,851	5.59
	Shelter and infrastructure established, improved and maintained	20,677,463	24.88	20,913,372	26.29
	Population has sufficient access to energy	2,229,782	2.68	1,896,324	2.38
	Population has sufficient basic and domestic items	8,251,429	9.93	9,160,390	11.52
	Services for persons with specific needs strengthened	1,713,139	2.06	1,549,434	1.95
	Population has optimal access to education	4,759,766	5.73	4,349,763	5.47
Rights Group Total:		**57,143,056**	**68.76**	**53,744,126**	**67.56**
Community Empowerment and Self-Reliance	Community mobilization strengthened and expanded	235,589	0.28	198,626	0.25
	Peaceful co-existence with local communities promoted	23,829	0.03	27,231	0.03
	Natural resources and shared environment better protected	739,639	0.89	682,266	0.86
	Self reliance and livelihoods improved	1,047,425	1.26	664,734	0.84
Rights Group Total:		**2,046,482**	**2.46**	**1,572,857**	**1.98**
Durable Solutions	Potential for resettlement realized	193,568	0.23	173,822	0.22

	Potential for voluntary return realized	23,829	0.03	27,231	0.03
Rights Group Total:		**217,397**	**0.26**	**201,053**	**0.25**
Leadership, Coordination and Partnerships	Coordination and partnerships strengthened	216,997	0.26	185,283	0.23
Rights Group Total:		**216,997**	**0.26**	**185,283**	**0.23**
Logistics and Operations Support	Logistics and supply optimized to serve operational needs	8,142,633	9.80	7,088,861	8.91
	Operations management, coordination and support strengthened and optimized	3,425,181	4.12	2,846,160	3.58
	Instalments to Implementing Partners (still to be reconciled)	0	-	4,992,492	6.28
Rights Group Total:		**11,567,813**	**13.92**	**14,927,513**	**18.76**
GRAND TOTAL ETHIOPIA		**83,104,524**	**100.00**	**79,549,902**	**100.00**

Source: MSRP accessed on 01/09/2015

Annex 4: Refugee Coordination Mechanisms in Ethiopia





Annex 5: Interviewees

The list below may have omitted a few interviewees as some names were not retained.

HQs GENEVA and Regional Support Hub Nairobi

1. Betsy Greve, Principal Emergency Service Officer, DESS
2. Preeta Law, Deputy Director a.i. DIP; Greg Garras, Senior Coordinator, DIP;Rick Sollom, Senior Monitoring Specialist, Safe from the Start, DIP
3. Ann Encontre, Deputy Director and RRC, Africa Bureau
4. Oscar Mundia, Operations Manager and HSO Gambella
5. Valentin Tapsoba, Director, Africa Bureau
6. Beatrice Ngendandumwe, former Snr. Desk Officer Ethiopia
7. Murray Burt, Snr. WASH Coordinator HQs
8. John Wain, Shelter & Settlement
9. Sharon Cooper, Head, RSH Nairobi
10. Caroline Wilkinson, Nutrition, DPSM
11. Heiko Herring, Snr. Public Health Officer, DPSM
12. Axel Bischopp (Chief of Section, Humanitarian Financing),
13. Monika Brulhart (Chief, Partnership Section), Anna Buskens (Associate Donors Relations Officer), DRRM
14. Pablo Mateu, Head of Inspection Service, IGO;
15. Nagette Belgacem, IGO and former Regional Legal Advisor, Bureau for Africa
16. Benoit De Schoutheete De Tervarent, Senior Auditor, IGO
17. Paul Spiegel, Deputy Director, DPSM
18. Jeddy Namafua, Snr. Desk Officer, Uganda
19. Olusegun Olubowale, former Head of Sub-Office Gambella
20. Alessandro Telo, Registration Officer, FICCS
21. Philip Sacher, Legal Officer, LAS, emergency deployee to Uganda
22. Joanina Karugaba, Snr. Protection Project Officer, DIP, former Regional Advisor Women and Children, Nairobi
23. Ita Sheehy, Senior Education Advisor, HQ
24. Janis Ridsdel, former Child Protection Advisor
25. Allen Kahindo Maina, Snr. Public Health Officer, DPSM
26. Allison Oman, former Snr. Regional Food Security and Nutrition Officer, RSH
27. Blessing Mureverwi, Nutrition, formerly RSH

UGANDA

UNHCR

1. Neimah Warsame, Representative, Kampala
2. Sakura Atsumi, Deputy Representative, Kampala
3. Mohammed Qureshi, Snr. Admin. Finance Officer Philippe N. Soum, Administrative Officer (HR)
4. Esther Kiragu, Ass. Rep. Protection, UNHCR Kampala
5. Lynn Ngugi, Multi-Sectoral Coordinator, UNHCR Kampala
6. Noëmi Fivat, Child Protection Officer, UNHCR Kampala
7. Mekonnen Tesfaye, Snr. Programme Officer Abdou Mahman Dango, Programme Officer, Kampala; Ida Marenge, Programme Associate, Kampala.
8. Umar Yakhyaev, Protection Officer, Kampala
9. Halimo Hussein Obsiye, Head SO Adjumani
10. Fatuma Kaba, Assist. Progr. Officer, Adjumani
11. Micaela Malena, Assist. Field Officer, Adjumani
12. Juliet O. Mwebesa, Uganda WASH Coordinator, Mbarara
13. James Karanja, Community Services Officer, Adjumani
14. Tako Ganai, Snr. Physical Site Planner, Adjumani
15. Michael Njeru, WASH Officer, Kiryandongo
16. Julius Kasozi, Public Health Officer
17. Constanze Qhosh, Senior Protection Officer (SGBV), Adjumani
18. Akiko Tsujisawa, Associate Protection Officer, Adjumani
19. Claude Buelongo, Education Officer, Adjumani
20. James Onyango, Community Services Officer, Kiryandongo
21. Micaela Maena, Associate Field Officer, Adjumani
22. Lucas Machibya, Nutrition Programme Officer, Adjumani

Government

23. David A. Kazungu, Commissioner Refugees, OPM, Government of Uganda
24. Titus Jogo, OPM Adjumani
25. Nixon Owole, Adjumani District
26. Richard Kolema, Assistant Administration Officer, Adjumani District
27. John Bosco, Head of UNHCR Programmes for Adjumani District
28. Acting Health Officer, Adjumani District
29. David Okello, Production Officer, Adjumani District
30. Charles Giyaya, Senior Environmental Officer
31. Mark Ambayo, District Education Officer, Adjumani District

32. Francis Otema, Head of Works Department, Adjumani District
33. Collins Latigo, District WASH Officer, Adjumani District
34. Head of Administration, Adjumani Hospital
35. Kiryandongo Settlement Commandant
36. Frida Nabiye, District Chief Administration Officer, Kiryandondo
37. Snr. Inspector of Schools, Kiryandongo
38. District Health Officer, Kiryandongo

4900 NGOs

39. Jesse Kamstra, Country Rep. Uganda Burundi, LWT
40. Medical Teams International: Felix Omodi, Country Director; West Nile Coodinator
41. Lilu Thapa, Country Director DRC
42. Kasukaali Methuselah, Programme Development Manager, Windle Trust, Uganda
43. Interaid Uganda: Ms. Scholastica Nasinyama, Executive Director; Lilia A. Alenyo, Associate Project Coordinator; Dr. Herbert, Health Coordinator.
44. Justus Muhwezi, Accord (Adjumani);
45. Sirak Mehari, DRC (Adjumani);
46. Giremew Wadessa, LWF (Adjumani)

4910

47. Simon Nyeko, WASH Officer, DRC Adjumani
48. Tina Goret, WASH Officer, DRC
49. Denis Abiko, Engineering Assistant, DRC
50. WASH Team Leader Oxfam
51. Paul Ongona, Livelihood and Shelter Officer, Uganda Red Cross, Adjumani
52. James Drizi, WASH Officer, LWF
53. Francis Atine, WASH Officer, LWF
54. Ismael, Programme Coordinator, NRC
55. Michael Kolwe, Deputy Programme Manager, WHH
56. War Child, Adjumani

4920

57. Tutapona, Adjumani
58. InterAid, Kiryandongo
59. MSF, Adjumani
60. Benedict Nsana, Operation Manager, Concern Worldwide

UN, IOs and Donors.

61. Gerry Dyer, Snr. Emergency Coordinator, UNICEF
62. Mariela Guajardo, Programme Coordinator, IOM
63. Erlend Linklater, Regional Humanitarian Advisor, DFID

64. Mr. Tatsuya Nakai, 2nd Secretary (in charge of Development Cooperation), Emb. Japan
65. Joshua Fischel, Regional Refugees Coordinator, BPRM, USA
66. Camilla Matteucci, Protection Coordinator, ICRC
67. Siddartha Krishnaswamy, Head M & E, WFP Uganda
68. Prakash Raj Lamsal, WASH Specialist, UNICEF
69. Emmy Bakkab, Education Specialist, UNICEF
70. Victoria Dancy, Child Protection Specialist, UNICEF
71. Matseketse David Chrispus, Health officer, UNICEF
72. UNWOMEN, Adjumani
73. UNFPA, Adjumani
74. Primo Madra, National Programme Officer, UNFPA

Refugees Focus Groups Discussions

1. Community Watch group, Adjumani ,
2. Youth group, Adjumani
3. Child Protection Committee, Adjumani
4. PSN representatives, Adjumani
5. Psycho-social group, Adjumani
6. Women's committee, Nyumanzi
7. Refugee Welfare Committee, Nyumanzi
8. Mothers, Nyumanzi
9. Water User Committee, Ayilo
10. Women / mothers Ayilo
11. Male members of Refugee Welfare Committee, Kiryandongo
12. Female members of Refugee Welfare Committee, Kiryandongo
13. Urban refugees, Kampala

Please note that in the Uganda debriefing we mention 15 FGDs

ETHIOPIA

UNHCR

1. Bornwell Kantande, former Deputy Representative, Addis Ababa
2. Milagros Leynes, Assistant Representative Protection
3. Cathrine Evans, Protection Officer, Addis Ababa
4. Laura Giammarinaro, Registration Officer, Addis Ababa

5. Girma Yadeta, Associate Education Officer, Addis Ababa
6. David G. Njoroge, WASH Offier, Addis Ababa
7. Charles Saleh, Programme Officer, Gambella
8. Angele Djohossou, Head SO Adjumani
9. Marti Romero, Snr Protection Officer, SO Gambella
10. Peter Waita, Registration Officer, SO Gambella
11. Parveen Mann, IM Officer, SO Gambella
12. Kristina Johnson, Associate Protection Officer, Gambella
13. Selina Nguti, Protection Officer, SO Gambella
14. Millicent Kavosa, Nutrition and Food Security Officer, SO Gambella
15. Christopher Okumu, WASH Officer, SO Gambella
16. Giovanni Pellegrini, Health Officer, SO Gambella
17. David Dak, Health Officer, SO Gambella
18. Karina Klevian, former Education deployee, SO Gambella
19. Nasir Khan, Snr. Programme Officer, SO Gambella
20. Pamella Nyaidho, Administration and Finance Officer, SO Gambella
21. Stella Murongi, Associate HR Officer, SO Gambella
22. Alexander Kishara, Senior Field Coordinator, SO Gambella
23. Siba Koivogui, Physical Site Planner, SO Gambella
24. Patrick Mutahi, Shelter Officer, SO Gambella
25. Andrea Cippa, former WASH Officer, Gambella (Skype interview)
26. Berhanu Geneti, Programme Associate
27. Alfatih Suliman, Health Officer, UNHCR Addis
28. Dejene Kebede, Public Health Officer, UNHCR Addis

Government

29. Ayalew Aweke, Deputy Director, ARRA Addis Ababa
30. ARRA Gambella

NGOs

31. Hiwote Simachew, Country Director, Plan International, Gambella
32. Charles Manson, Humanitarian Director, Save the Children, Addis Ababa
33. Dr. Hajir Z. Elyas, Medical Coordinator, MSF-France, Addis Ababa
34. Isabelle Robin, Country Director, ACF Addis Ababa
35. Hana Yemane, Nutrition Programme Manager, Seid Yusuf Abdu, Deputy Coordinator, International Medical Corps Addis Ababa
36. Tekele Hunder, Public Health Officer, Oxfam, Addis Ababa

37. Solomon Kebede, Finance Director, ADRA Addis Ababa

38. Joshua E. Friedman, Deputy Country Director/Regional Mixed Migration Manager, DRC Addis Ababa

39. Asbjørn Lodeor, Programme Director, NRC, Addis Ababa

40. David Dominic Maliro, Shelter Manager, NRC, Addis Ababa.

41. Corien Janssen, Emergency Manager ZOA, Gambella

42. Assad A. Ali, Environmental Health Coordinator Refugee Programs, IRC, Addis Ababa

43. Mulugeta Dadi, Education and WASH Officer, WVI, Gambella

44. Stanley Njau, Emergency WASH Technical Manager, DRC, Gambella

45. Sammy Chagali, Regional Programme Manager WASH, Horn of Africa, Southg Sudan, Yemen and Uganda, NRC

46. Yuko Maeno, Program Officer, ADRA, Gambella

47. Gulima Mesfin, Field Coordinator, IRC, Gambella

48. Kedenecha Hawas, Environmental Health Manager, IRC, Gambella

49. Gamechissa Abdiyo WASH Program Officer, LWF, Addis Ababa

50. Mamushet Tulu Project Coordinator, LWF, Gambella

51. Abraham Tesso, Shelter Manager, NRC, Gambella

52. Hajir Elyas, Medical Coordinator, MSF- F Addis

53. Medical Coordinator, MSF- F Gambella

54. Medical Officer, MSF-Holland, Tierkidi

55. Mr. Kassar, Regional Programme Manager, GOAL

56. Mr. Cheru, Area Coordinator, Concern

57. Abdul Wass, Regional Mental Health Officer, IMC Gambella

58. Iasu Makunan, Deputy Country Director IMC Addis

59. Mr. Seid, Head of Sub-Office IMC

60. Faisal Nagasah, Senrior Reproduective Health Officer, GOAL

61. Lance Anh, Nutrition Expert ACF

62. Mutasim, Field Coordinator ACF

<u>UN, IOs, Donors</u>

63. Ousmane Mahmane Badamassi, Head, WFP Gambella

64. IOM in Kule camp

65. David Del Conte, Deputy Head, OCHA Addis Ababa

66. Narineh Aslanyan, Emergency Specialist, Mini Bhaskar, Social Welfare Specialist, UNICEF Addis Ababa

67. Juliet Prohdam (Team Leader, Humanitarian Team) DFID (UK) Addis Ababa

68. Lin'an Bartlett, Refugee Coordinator, BPRM, USA, Addis Ababa
69. Johan Heffinck, Head, ECHO, Addis Ababa
70. Delphine Dechaux, Refugee Coordinator, WFP, Addis Ababa
71. Samir Wanmali Deputy Country Director, WFP, Addis Ababa
72. Mini Bhaskar, Social Welfare Specialist, Child Protection Section, UNICEF, Addis Ababa
73. Elizabeth Girma, Water and Environmental Sanitation Officer (Emergency), UNICEF, Addis Ababa
74. Kidist Negash, Nutrition Specialist, UNICEF, Addis Ababa
75. Narineh Aslanyan, Emergency Specialist, UNICEF
76. Robert Kizito, WASH Officer, UNICEF (seconded to UNHCR SO Gambella)
77. Abdirahman Isaac, WASH Officer, UNICEF (seconded to UNHCR SO Gambella)

Refugees Focus Groups Discussions

1. ARRA, NGO Representatives, Kule
2. ARRA, NGO Representatives, Tierkidi
3. Men, Kule
4. Youth, Kule
5. Men, Tierkidi
6. Women, Kule
7. Women, Tierkidi

Annex 6: Terms of Reference

I. Introduction

1. The Evaluation of UNHCR's response to the refugee emergency in Ethiopia and Uganda follows from the declaration of the L3 emergency for South Sudan on 3 February 2014.[195] It will be undertaken in line with UNHCR's revised Policy on Emergency Response, Activation, Leadership and Activities approved by the High Commissioner on 21st January 2015.[196] These Terms of Reference (ToR) have been prepared by the Policy Development and Evaluation Service (PDES) and provide the evaluation with its overall purpose, focus and deliverables. They also set out the key evaluation questions to be answered and the methodology to be followed. The final ToR will be based on comments on this draft document and during the inception phase which will involve the desk/literature review and interviews with key stakeholders at HQs. The evaluation is scheduled to start in May 2015.

II. Background

2. South Sudan is the 193rd and youngest member of the United Nations, having gained its independence from Sudan on 9 July 2011 after protracted conflicts and negotiations, following the results of a self-determination referendum held in January 2011 in which the overwhelming majority of its citizens voted for independence. A few months later South Sudan started receiving tens of thousands of refugees from the southern areas of Sudan proper who numbered almost 170,000 by the end of 2012.

3. In spite of the hopes that the newly gained independence brought about, on 15 December 2013, clashes broke out in Juba between competing factions within the Sudan People's Liberation Movement/Army (SPLM/A) which constituted the backbone of the Government, and the situation quickly degenerated into a full-scale, ethnically based conflict. As argued by the International Crisis Group "although the dispute within the SPLM that led to the conflict was primarily political, ethnic targeting, communal mobilization and spiraling violence quickly led to appalling levels of brutality against civilians, including deliberate killings inside churches and hospitals".[197]

4. According to some estimates the death toll including both civilians and armed elements exceeded 50,000 by November 2014[198]. At the same time hundreds of thousands of Southern Sudanese were displaced internally, often in the bases belonging to UNMISS (the UN Peacekeeping Mission in South Sudan) or externally as refugees mainly in Ethiopia, Uganda, Sudan and Kenya.

5. As a result of these events UNHCR declared its internal L3 corporate emergency on 3 February 2014 while on 11 February the IASC Principals declared an L3 system-wide emergency in accordance with the criteria of the Transformative Agenda to ensure a coordinated response to the internal and external dimensions of the displacement.

6. By the beginning of 2015 there were approximately 1.5 million IDPs registered in South Sudan and over 500,000 South Sudanese refugees in the neighbouring countries in

195 UNHCR Emergency Policies and procedures – A summary of the Guidance Notes 1 October 2012, https://intranet.unhcr.org/content/intranet/unhcr/en/home/support_services/emergency/emergency_policy/Current/_jcr_content/mainpar/multidownload_0/multidownloadItems/multidownloadfile/file/file.res/UNHCR%20Emergency%20Policies%20&%20Procedures%20all%20in%20one_1.pdf

196 Policy on Emergency response, activation, leadership and accountabilities (UNHCRHCP/2015/1) Section 10, Accountabilities, Paragraph 10.5

197 International Crisis Group "South Sudan, a Civil War by Any Other Name", Africa Report No. 217, 10 April 2014

198 http://reliefweb.int/report/south-sudan/50000-and-not-counting-south-sudans-war-dead

addition to the 130,000 who had fled before the December 2013 violence, for a total of over 630,000 refugees:

South Sudanese refugees in neighbouring countries as at 1 February 2015

Country	Refugees pre-December 2013	Refugees post-December 2013	Total
Ethiopia	63,341	195,453	258,794
Uganda	22,264	140,462	162,726
Kenya	45,239	44,953	90,192
Sudan	-	120,401	120,401
Grand Total	**130,030**	**501,269**	**632,113**

Source: UNHCR Operational data portal, South Sudan Situation

7. This influx stretched the local absorption capacities considering that these countries were already hosting hundreds of thousands of refugees such as Somalis in Ethiopia and Kenya, Congolese in Uganda and Eritreans in Sudan. Moreover the new refuges from South Sudan were arriving with no belongings, "exhausted, nutritionally weak and in poor health" with a "disproportionate number of women and children" requiring not only immediate assistance in life-saving sectors such as health, water, sanitation and emergency shelter, but also attention to the vulnerable groups, for example through prevention and response mechanisms for SGBV and protection activities for the high number of unaccompanied minors[199]. Borders have remained open and no substantiated reports of *refoulement* have been confirmed to date.

III Operational Context

8. Though UNHCR had a long-standing presence in all areas affected by the refugee influx, it had to launch a Supplementary Appeal in January 2014 to secure additional financial resources in order to boost its response capacity for a refugee population that was fast approaching twice the planning figures. The Appeal targeted 400,000 IDPs within South Sudan, and 125,000 refugees in Ethiopia, Kenya Uganda and Sudan for a total of 88 million USD, out of which 5.3 million for Ethiopia and 27 million for Uganda for the period January – March 2014. The April 2014 Revision targeted 750,000 IDPs, 340,000 refugees in the four countries for a total of 426.5 million USD, out of which 43.6 million USD for Ethiopia and 98.7 million USD for Uganda. Finally, the August 2014 Revision targeted 750,000 IDPs, 715,000 refugees in the four countries for a total of 566.2 million USD, out of which 90.7 million for Ethiopia and 123.2 for Uganda.

9. In March 2014 UNHCR also launched an Interagency Appeal for the South Sudanese Refugee Emergency (i.e. excluding the South Sudan IDPs component), incorporating also the financial requirements of twenty-four other agencies and NGOs for a total of 370 million USD (including 102 million for Ethiopia, out of which 43 million for UNHCR, and 182 million for Uganda, out of which 98 million for UNHCR) targeting 340,000 refugees for the period January-December 2014.

10. In July 2014 this Appeal (now called "South Sudan Refugee Emergency Revised Regional Response Plan") was revised upwards to 657 million USD (including 210 million for

199 UNHCR, South Sudan Refugee Emergency Revised Regional Response Plan, January – December 2014

Ethiopia, out of which 90 million for UNHCR) and 224 million for Uganda, out of which 123 million for UNHCR), targeting 715,000 refugees. The number of partners covered by this appeal rose to thirty-three. As at 31 December 2014 the financial situation for Ethiopia and Uganda is summarized in the following table:

Country	2014 OL (committed funds)	2014 OP (requested funds)	2014 Expenditures*	2015 OL (committed funds)	2015 OP (requested funds)
Ethiopia	72,362,619	90,707,303	63,874,319	38,519,973	153,235,556
Uganda	48,519,404	123,167,155	42,344,515	24,120,923	99,447,418

Source: Expenditure figures are extracted from MSRP on 13 February and as per the approved amount of the Budget Committee.
*Expenditures are provisional figures as the 2014 year account is yet to be closed. Note, the expenditure figures do not include staff costs due to ongoing cost adjustment.

11. Regarding coordination, at the central level on 13 March 2014 the High Commissioner appointed, for six months, a Regional Refugee Coordinator (RRC) working closely with the concerned Governments, UNHCR Representatives and implementing and operational partners. The initial six-month mandate of the RRC was extended in October 2014 for an indefinite period owing to the continuing crisis in South Sudan and an RRC office was established in Nairobi to ensure coordination with key stakeholders in sectors such as Protection, External Relations, Public Information and Information Management. The RRC office coordinated the launch of the 2015 Interagency Regional Refugee Response Plan in December 2014.

12. Regional coordination in Nairobi, consists of regular coordination meetings for the South Sudan Situation, which are co-chaired by the RRC and OCHA, and with the active involvement of UN agencies, NGOs and donors. Additionally, regional Sector Coordination Working Groups on key issues, such as protection and child protection specifically, education, and food security and nutrition are held on a regular basis in Nairobi. In the countries of asylum affected by the South Sudanese emergency, similar coordination structures are operating, to ensure adequate information exchanges, common analysis of priorities and gaps, and harmonized and coherent approaches to the interventions.

13. The refugee outflow is projected to exceed 800,000 by the end of 2015. Children and women bear the brunt of the conflict: 70% of the refugees are children, and almost 80% of the refugee households are headed by women. It is estimated that some 35,000 South Sudanese children are unaccompanied or separated from their families. The majority of refugees have settled in border areas with some of the highest levels of chronic vulnerability in the world, further straining the already scarce resources of hosting communities. The 2015 South Sudan Refugee Response Plan urgently requires USD810 million in 2015 to address the needs of the South Sudanese refugees and the communities hosting them.

Ethiopia

14. In Ethiopia UNHCR coordinates with the governmental institution in charge of refugees affairs, ARRA, and with other government authorities, UN agencies and NGOs through the standing Refugee Task Force. An implementation matrix specifying sectoral responsibilities, drafted in the early stages of the emergency, contributed to the rapid delivery of key activities, including health, transport and registration. A total of 5 UN agencies (including UNHCR) and 11 NGOs are included in the Ethiopia section of the revised Refugee Regional Response Plan.

15. Refugees arrive from South Sudan in poor physical and mental condition to very remote locations in western Ethiopia, particularly in the Gambella region and, to a lesser extent, to the Benishangul-Gumuz region. Access to the border points of the Gambella region, the least developed in Ethiopia, is possible only by boat, which poses a major logistical challenge. Nutrition surveys carried out June/July, soon after the refugees' arrival, showed Global and Severe Acute Malnutrition (GAM and SAM) rates above emergency thresholds,

but crude under 5 mortality within acceptable limits[200]. Refugees were originally hosted in 3 camps: Tierkidi, Kule and Leitchuor.

16. On 25 August 2014 heavy rains caused severe flooding in the Leitchuor camp and the newly opened NipNip refugee camp near the Gambella entry points prompting calls for an urgent relocation of the refugees, even though options were limited owing to the lack of available high ground. Furthermore, the ethnic composition of the host communities living in possible relocation areas made the refugees reluctant to move on security grounds.[201] Eventually it was agreed that the existing Pugnido camp, further inland and on higher ground, could be expanded to accommodate relocating refugees. As at 18 December 2014, 7,196 refugees have been relocated to Pugnido[202] and approximately 2,000 to the Okugo camp (also pre-existing).

17. The following are the highlights of the UNHCR key planned activities under the revised 2014 Refugee Emergency Regional Response Plan:

- Protection: border monitoring, physical security, registration (Level 2), documentation, child protection, SGBV prevention and response;
- Food: nutritionally balanced food rations to all refugees, school feeding and supplementary feeding for malnourished children.
- Health and nutrition: primary health care, control of communicable diseases, community-based mental health services, referral mechanisms, nutritional screening for all children and pregnant/lactating women, High Energy Biscuits for all new arrivals, blanket supplementary feeding for all 6-59 months children and pregnant/lactating women.
- Shelter/infrastructure: provision of materials for the construction of transitional shelter, provision of emergency shelter, including family tents and communal shelter, construction of 100 km of access roads, in-camp roads and security perimeter roads
- Water, sanitation and hygiene (WASH): Provision of potable water through emergency water trucking and construction of temporary distribution and pumping pipeline, construction of permanent water system, including drilling of boreholes, constructions of communal showers and laundry desk, distribution of water kits (NFI), hygiene-promotion activities, construction of family latrines.
- Education: early childhood care and education for 24,000 children, primary education for 45,000 children, construction of temporary and permanent schools (4 per camps for a total of 352 classrooms);
- Environment and livelihoods: 100 ha of degraded land protected, 120 ha planted with tree seedlings, 50 ha for multi-purpose forest (including wood for fuel and construction), provision of renewable energy for households, solar lanterns and grinding mills.
- Logistics/transport: Transportation of new arrivals from entry points to the camps, including medical evacuation by helicopter from areas not accessible by road, transportation of about 60,000 NFI kits.
- NFIs: provision of 60,000 NFI kits (blankets, jerry cans, plastic sheet, kitchen sets, sleeping mats, water buckets and mosquito nets), monthly provision of sanitary materials (sanitary pads, underwear, soap) to women of reproductive age, provision of 250 grammes of soap to each refugee per month.

Uganda

200 UNHCR Ethiopia: "Sector Indicators Matrix: Gambella Emergency Response (as of 01-December-2014)"
201 Interagency flooding assessment mission to Leitichor and NipNip camps, Gambella region, 26 August 2014.
202 Ethiopia UNHCR Operational Update 11-18 December 2014.

18. In Uganda UNHCR coordinates with the Office of the Prime Minister (OPM), UN agencies and NGOs. At the Kampala level, interagency coordination meetings take place on a fortnightly basis, supplemented by regular meetings at the field level.

19. A total of 8 UN agencies (including UNHCR) and as many as 40 NGOs are included in the Uganda section of the revised Refugee Regional Response Plan[203].

20. The majority of South Sudanese refugees arrive in the Adjumani district and, to a lesser extent, in the Koboko/Arua district, in the West Nile region. The priority is to move the refugees from congested transit centres to refugee settlements, such as the one in the Kiryandongo district. Others are settled in refugee villages which hosted the pre-December 2013 South Sudanese refugees. The OPM successfully negotiated with local communities the availability of additional land for the refugees. Contrary to the Adjumani district, there is no gazetted land for refugees in the West Nile and the refugee settlements are established in on host community-owned land with refugees living in and around local villages. In Kampala refugees have freedom of movement and can decide to reside wherever they wish.

21. The demographic pattern of displacement is quite exceptional with 87% of the new arrivals being women and children. While at the beginning there were few concerns about the nutritional status of arriving refugees, later arrivals showed a deterioration of their condition.

22. The following are the highlights of the UNHCR key planned activities under the revised 2014 Refugee Emergency Regional Response Plan:

- Protection: improvement of reception conditions, registration and profiling, support to persons with specific needs, capacity-building for the police, child protection, SGBV prevention and response, protection monitoring and advocacy.
- Food security and livelihoods: provision of water, snacks and hot meals during convoy movement, hot meals in Transit Centres (TCs) and Reception Centres (RCs), general food distribution, agricultural inputs, cash-for-work and vcational training.
- Health and nutrition: provision of medical supplies and equipment to Health Centres, construction of new Health Centres and rehabilitation of existing ones, provision of sanitary material for girls and women, establishment of a nutritional screening system and supplementary and therapeutic feeding programme, systematic vaccination for under 5, reproductive health services, cholera kits, strengthening of medical referral system, HIV/AIDS services, mental health and psychosocial support.
- Environment protection: tree marking and tree planting, construction of energy saving devices at household level, promotion of alternative energy source, provision of energy saving device for communal lighting – schools, streets, health centres and staff accommodation, establishment of tree nurseries and demarcation of protected areas in/near the settlements.
- Logistics and transport: transport-hire (trucks and buses) for person and material transport, special transport facilities for persons with specific needs, warehouse establishment and management.
- Shelter and infrastructure: construction of communal shelters in TC/RCs, construction of additional way station, establishment of food distribution centres, procurement and distribution of standard shelter kits in settlements, rehabilitation of access roads, construction of base camp office/ staff accommodation, rehabilitation of base camps in existing settlements.

III. Objectives, purpose, and scope of the evaluation

203 But there is no breakdown between NGOs who are implementing partners vs. those who are operational partners, so not all 40 are envisaged to receive funds under the Plan, even if all contributed one way or the other to the planning process.

23. The broad objective of this evaluation is an interim assessment of UNHCR's response to the ongoing South Sudan refugee crisis in the neighbouring countries of Ethiopia and Uganda to where the majority of the South Sudanese refugees have fled. Owing to logistical reasons it would not be possible to include also Sudan, but this can be considered for a later phase.

24. The evaluation aims to assess the extent to which protection, including assistance needs of refugees, have been met and to gauge the degree to which timely operational adjustments have been made since the beginning of the crisis to meet the emerging needs of the refugee populations. It will also document good and best practices, as well as challenges, so as to assist in fine-tuning the response and to provide guidance for other emergency responses.

25. The purpose of the evaluation is to provide insights for the field operations, the Regional Bureau for Africa and other concerned Divisions/Services on the status of the emergency response to date and to agree upon recommendations for future action. The evaluation will be participatory and collaborative in approach with an emphasis on learning opportunities to inform future emergency programme design, management and implementation, as well as resilience.

26. The scope of the evaluation will focus on the response to the South Sudan refugee crisis in Ethiopia and Uganda. It will cover the one year-period from the declaration of the L3 emergency in December 2013 to December 2014 and include an assessment of preparedness measures, including contingency planning. It will cover emergency preparedness, coordination, operations management (all key technical sectors including nutrition, health, WASH, shelter), protection, information management, and capacity development.

27. The primary users of the evaluation will be the key UNHCR stakeholders, particularly managers, involved in the field response to this refugee emergency. Other internal users will be the Regional Bureau for Africa, the Division of Emergency, Security and Supply (DESS), Division of Programme Support and Management (DPSM), the Division of International Protection (DIP), Department of Information Systems and Telecoms (DIST), and the Division of Financial and Administration Management (DFAM). External stakeholders with an interest in the evaluation include the refugees, national and local authorities, UN and NGO partners, and donors.

IV. Evaluation Criteria and Questions

28. Recognizing the evolving status of the operation, the evaluation will seek to draw evidence based conclusions that will particularly emphasize the criteria of relevance, effectiveness, efficiency, coherence, impact, sustainability, coverage, coordination and connectedness.[204] Based on the objectives set out in the revised South Sudan Refugee Emergency Regional Response Plan[205], and on a range of internal reports and documents, the evaluation will examine the following key questions, including gender, age and diversity perspectives, in Ethiopia and Uganda:

Effectiveness:

- To what extent have the objectives of the Revised Regional Response plan been achieved in Ethiopia and Uganda?
- To what extent did the UNHCR-led protection and assistance activities meet the needs of refugees in a timely manner?
- Have satisfactory humanitarian standards (Sphere and/or UNHCR) been met?

204 ALNAP guide for humanitarian agencies: Evaluating humanitarian action using the OECD/DAC criteria www.alnap.org/pool/files/eha_2006.pdf

205 Attached as Annex 1.

Relevance/Appropriateness:

- Has the design and delivery of the Regional Response Plan been based on sound assessments of the context and circumstances?
- Were the objectives and interventions appropriate and relevant to meet the needs of refugees?

Coverage:

- Did the protection and assistance interventions reach all the intended beneficiaries in need of such assistance or were there any gaps in terms of ethnicity, location, gender or age groups?

Coordination

- Did UNHCR's coordination role in this refugee emergency promote synergies with concerned actors avoiding gaps and duplications?
- To what extent have appropriate partners been identified and mobilized to assist the response effort?
- What measures were taken to involve national and local stakeholders and further strengthen their existing capacities?

Connectedness

- To what extent have longer-term objectives and solutions been given due consideration in the planning process and choice of interventions?

Impact

- What have been the outcomes, both intended and unintended, for refugee women, men, boys and girls?

V. Methodology

29. The evaluation team will be led by PDES. It will also require independent expertise in protection, health/nutrition, site planning/shelter, and water and sanitation. The independent consultants will be familiar with UNHCR's mandate, as well as its protection and programme role and functions. They will carry out their work in conformity with best practices and the UNEG code of conduct for evaluators.[206] Overall the team should be equipped with substantial evaluation experience of humanitarian policy, strategies and programmes and of complex emergency settings. PDES will manage the evaluation and be responsible for the recruitment of the team.

30. The evaluation will employ a mixed-method approach including qualitative (interviews and observation) and quantitative methods (document review and data analysis, including monitoring data if available). It will include interviews and focus group discussions with key stakeholders including relevant UNHCR staff at HQs and country level, UN partner agency staff in Ethiopia and Uganda, national authorities, NGOs, donors and affected populations. Consultations will ensure that diverse groups of refugees are included, including men, women, boys, girls, and persons with specific needs. Data from the different sources will be triangulated and cross validated so as to determine the robustness of the findings.

31. The evaluation will use the 2014 Revised Regional Response Plans and the above evaluation key questions as the analytical reference points against which to draw conclusions about the performance and achievements of the response plan to date. Prior to departure the evaluation team will further refine the methodology and evaluation questions following the desk review and preliminary interviews with key stakeholders. The evaluation will thereby assess and confirm the evaluability of the questions set out above. For each key evaluation

206 http://www.uneval.org/document/detail/100 UNEG Code of Conduct for Evaluation in the UN system

question, the information/data source, method and associated criteria will be clearly defined so as to constitute a solid evidence base for any findings.

32. The initial preparatory phase will include a desk review, finalization of the terms of reference, and recruitment of the evaluation team. The mission itinerary will include Ethiopia and Uganda with visits to the capitals and the main field sites lasting between 7 and 10 days in each country.

VI. Process and deliverables

33. PDES will take responsibility for steering the evaluation process and ensuring that good practices are observed and maintained throughout the conduct of the evaluation. The independent experts will draft relevant sections of the final report within 2 months of completion of the field mission and the evaluation task manager will oversee the completion of the report and ensure its conformity with required quality measures.

34. The main deliverable will be a concise report with clear recommendations linked to the key findings and conclusions. The report will preferably be no longer than 20 pages per country, excluding technical annexes. A summary of the main findings and recommendations will be available in French. In line with PDES policy on evaluations, the final report will be placed in the public domain on the PDES website. The following is the tentative time-frame for the evaluation:

- May 2015: beginning of the consultancies, desk/literature review, interviews at UNHCR HQs Geneva and refinement of the evaluation questions if necessary;
- June 2015: Fieldwork (10 days in Ethiopia + 10 days in Uganda);
- July 2015: report drafting and submission of first draft;
- August 2015: comments on draft report and finalization (allowances will be made for some delay for the summer holidays).

35. As the main focus of the evaluation is learning, the field mission will present preliminary findings, impressions and opportunities for improvement during exit debriefs in Addis Ababa and Kampala for principal stakeholders in order to share preliminary findings and to solicit early feedback from operation managers. There will also be de-briefings at HQs and to interested stakeholders, including other UN agencies, donors and NGOs.

VII. Follow up

36. The prioritized evaluation recommendations (5-10) in the mission report will require a formal management response from the concerned Branch Offices, the Bureau for Africa and other concerned Divisions and Services at HQs within 2 months of the receipt of the final report.