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

were in a down-scaling mode even if the 2013 was foreseeing an increase in new arrivals 2760 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 2770 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South Sudanese refugee arrivals in Gambella Region was prepared by UNHCR’s Gambella Sub Office in March 2013104 but was out of date and grossly underestimated the scale of the influx and impact on land/site allocation.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 2780 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 2014106, in the midst of 2790 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”. 70

Figure 5: New South Sudanese Arrivals in Ethiopia 2014 Post December 2013 South Sudanese Refugee Population in Ethiopia 200,000 180,000 160,000 140,000 120,000 100,000 80,000 60,000 40,000 20,000 0 New Arrivals Cumulative New Arrivals Source: UNHCR Gambella 2800 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 2810 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 2820 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 2830 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 71

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 2840 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 2850 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”. 2860 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 2870 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. 2880 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. 72

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 2890 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 survey109 90% of respondents criticised UNHCR’s coordination role. The following is a sample of comments on this topic, made by International NGOs: 2900 (cid:120) “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”, (cid:120) “The coordination has been weak especially in the WASH sector. The management of the matrix is non transparent and results in delays in assistance”, (cid:120) “There are visible gaps and duplications in Gambella. NGO partners have noted that UNHCR has left them to coordinate themselves…”, (cid:120) “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 2910 to be reviewed”, (cid:120) “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, 2920 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 camp110, which made monitoring 2930 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) 73

to be informed on the rationale of specific decisions on selection or retention111, let alone to have a partner co-leading some technical sectors112. 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 2940 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 2950 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 2960 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 2970 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 WASH114 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 2980 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 74

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 2990 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 3000 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 3010 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. 3020 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 permanent115 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 3030 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. 75

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 3040 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 3050 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, 3060 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. 3070 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. 3080 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. 76

3090 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. 3100 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 3110 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 % Against 2014 Actual % Against Expenditure Total Expenditures Total Level A.E.L. Actual Exp. Favourable Protection 235,397 0.28 319,259 0.40 Environment Fair Protection Processes and 8,650,760 10.38 5,467,277 6.86 Documentation Security from Violence 3,243,619 3.89 3,317,817 4.16 and Exploitation Basic Needs and 57,143,056 68.58 53,744,126 67.40 Essential Services Community Empowerment and 2,046,502 2.47 1,572,857 1.98 Self-Reliance Durable Solutions 217,397 0.26 201,053 0.25 Leadership, Coordination and 216,977 0.26 185,283 0.23 Partnerships Logistics and 11,567,813 13.88 14,927,513 18.72 Operations Support 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 3120 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 77

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 3130 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 3140 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 3150 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 3160 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 3170 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. 78

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 3180 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- 3190 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 3200 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 3210 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. 3220 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. 3230 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 79

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 3240 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 3250 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 3260 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 3270 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, 3280 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 80

neighbouring countries, ‘prima facie117’ refugee status was granted to people fleeing South 3290 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 3300 (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 3310 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 3. Unwilling to move from border entry locations - refugees with large livestock herds as well as traders and other categories Cat.3 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 3320 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 81

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 3330 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 3340 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 Days of Entry point(s) Start End Date of suspension 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 3350 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 3360 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. 82

3370 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 60,000 50,000 40,000 30,000 20,000 10,000 0 Source: UNHCR Gambella 3380 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. 3390 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 3400 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. 83 seegufeR fo rebmuN 41-naJ 41-beF 41-raM 41-rpA 41-yaM 41-nuJ 41-luJ 41-guA 41-peS 41-tcO 41-voN 41-ceD Akobo entry point Burbiey entry point Pagak entry point Matar transit Center (refugees from Burbiey and Akobo)

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. 3410 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. 3420 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 3430 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. 3440 UNHCR’s SGBV response was partly shaped by the Safe from the Start121 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 3450 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. 84

3460 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 points. Documentation for children remained limited in 2014– children were included in 3470 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 3480 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 3490 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. 3500 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 3510 were reportedly very low122. 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 85

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 3520 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. 3530 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 3540 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 3550 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 3560 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 3570 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. 86

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 0 0 0 0 123 0 refoulement % of persons of concern 100% 100% registered Civilian character of asylum Yes Yes Yes Yes Yes, maintained Extent reception conditions Low Medium Low Medium High meet minimum standards Security from violence, abuse and neglect # of police in camps n/a n/a n/a 12 per n/a camp # of UASC n/a n/a n/a 18 000 n/a # of Child protection social 179 138 n/a workers # of children attending child 0 n/a 6,752 15,424 n/a friendly spaces % of children with specific n/a n/a n/a 50% n/a needs identified receiving appropriate services # of PoC trained on SGBV n/a n/a 34 468 n/a prevention and response # of community-based n/a n/a 8 8 n/a committees/ groups working on SGBV prevention and response # of awareness raising n/a n/a 15 47 n/a campaigns on SGBV prevention and response conducted 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. 87

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 3600 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 3610 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 3620 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). 3630 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 2014127, 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, 3640 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. 88

UNHCR organized a training in October 2014 to improve the quality of reporting129 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. 3650 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 3660 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 3670 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 3680 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. 89

Table 16: Selected health indicators\* for the Gambella refugee response, 2014 Indicators March 2014 June 2014 December Emergency 2014 Standard Outpatient Utilization Rate 3.2 1.9 1.9 1.0 - 4.0 (new visits/ refugee/year) Coverage of complete 0% 20% 17% 100% antenatal care % Births Attended by 81% 46% Greater or Skilled Health Worker equal to 90% Anaemia Prevalence Not 21.7%\*\* 16%-37%\*\*\* n/a Women 15-49yrs Available (Combined) (Kule, Tierkidi) Measles Vaccination Not 77.6% \*\* 77%-93%\*\*\* Greater or Coverage Available (Combined) (Kule, Tierkidi) equal to 95% CMR 0.20 4.68 \*\* 0.20 Less than (deaths/1,000/month) (Leitchuor) 0.75/1,000/mo nth 4.96 \*\* (Tierkidi) U5MR 0.00 12.37 \*\* 0.41 Less than (Leitchuor) (deaths/1,000/month) 1.5/1,000/mont 17.15 \*\* h (Tierkidi) Measles Morbidity (Crude) 48% 37% 32% n/a ARI Morbidity URTI 45% 32% 32% n/a (Crude) 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 3690 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 90

3700 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. 134UNICF/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 3710 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. 3720 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 3730 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 outbreak141 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 3740 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 91

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. 3750 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 3760 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 3770 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 3780 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 3790 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 92

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 others146’ 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 3800 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 3810 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 3820 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 3830 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 3840 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 93

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 3850 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 3860 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 centres150 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 3870 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 3880 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 3890 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. 94

Based on that assessment an interagency response plan153 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 3900 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 3910 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 3920 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 3930 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 3940 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 95

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 3950 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 3960 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 reported156. 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 respondents157 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. 96

Table 17: Nutrition indicators\* for the Gambella refugee response, 2014 Indicators February June/July December 2014 Standard 2014 2014 GAM 28.1%\*\* 21.3%-28.3%\*\*\* Less than 10% Not Available 37.1% \*\*\*\* 13.4%\*\* 8.5%-10.4%\*\*\* MUAC MUAC MUAC SAM Not 7.9%\*\* 5.2%-8.6%\*\*\* Less than 2% Available 11.1% \*\*\*\* 4.6%\*\* 2%-3.8%\*\*\* MUAC MUAC MUAC Recovery Rates for Not 60% 97% Greater than SAM Available 75% Death Rates for SAM Not 0% 2% Less than 10% Available Coverage of OTP Not 300% 29% HIS or Greater than Available 90% 22.2-36.7%\*\*\* Coverage of SFP Not 58% 45% HIS or Greater than Available 90% 14.3-14.7%\*\*\* Vitamin A Not 69.4%\*\* 80%-91.5%\*\*\* Greater or equal supplementation Available to 95% \*Data is from HIS unless otherwise specified. \*\* Nutrition and Mortality Survey, Gambella, June 2014 3970 \*\*\* 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 3980 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 distribution160 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 97

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 3990 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 4000 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 4010 Correction of Malnutrition The nutrition services and activities in the camps were appropriate and included: (cid:120) Routine MUAC screening conducted by community outreach agents (cid:120) 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 (cid:120) Outpatient and inpatient therapeutic feeding programmes for severely malnourished children and infants (cid:120) Blanket supplementary feeding programme (bSFP) for all children 6-59 months and pregnant and lactating women 4020 (cid:120) 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 4030 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. 98

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 4040 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 45 40 35 30 25 20 15 10 05 00 4050 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 2014165, which gives the emergency response phase as March to August, 4060 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 4070 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 99 etar MAG CAUM yxorP MUAC <12.5 cm screening Data New Arrivals Gambella Pagak Kule 1 Leitchuor Emergency Threshold Weeks 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. 4080 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 2014166. 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 4090 environment they would soon move out of167. 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 4100 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. 100

Table 18: Key WASH Indicators170 in Gambella, Ethiopia tracked by UNHCR Entry Points Camps Overall End Month (2014) 101 noitalupoP retaW d/p/l noitpmusnoc enirtal rep nosreP eneigyh / nosreP retomorp noitalupoP retaW d/p/l noitpmusnoc enirtal rep nosreP eneigyh / nosreP retomorp noitalupoP retaW d/p/l noitpmusnoc enirtal rep nosreP eneigyh / nosreP retomorp 23,24 26 26 January 7 4 9 23,247 4 9 51,47 37 29 February 3 3.1 7 18,691 9 81 70,164 4.7 8 81,65 23 13 100,34 21 March 0 8 1 18,691 9 8 1 8.2 4 17,40 16. 101,07 10. 15 118,48 11. 13 April 6 6 50 8 4 2 4 3 7 25,98 11. 23 109,60 10. 135,58 10. 11 May 4 5 4 1 2 83 5 4 2 18,91 154,00 172,91 June 0 9.1 94 2 9.7 60 2 9.6 64 13,37 39. 10 154,38 10. 50 167,75 12. 46 July 2 5 62 0 2 2 60 0 4 5 60 8 18,26 52 154,53 11. 48 172,79 11. 48 August 3 9.4 95 3 1 7 71 4 4 5 74 8 Septemb 19,83 31 150,35 12. 47 170,18 12. 45 er 1 18 71 0 4 1 56 9 5 8 58 9 21,11 30 150,70 13. 48 171,82 13. 45 October 8 16 76 9 5 3 52 0 3 6 55 9 Novembe 18,41 29 152,70 48 171,11 12. 46 r 3 12 90 7 4 13 53 0 7 9 57 0 Decembe 13,59 29 159,62 14. 48 173,21 46 r 3 31 43 7 4 7 37 0 7 16 37 6 4110 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 4120 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 4130 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. 4140 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 access171. Sanitation scouts were hired to patrol open defecation areas to monitor and discourage open defecation. In the August KAP survey172, 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 4150 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 4160 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 latrines173. 4170 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 2014174. 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. 102

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 4180 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 4190 Integration of community outreach activities in hygiene, health and nutrition placed constraints on hygiene promotion. This strategy, rolled out in April 2014175, 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 4200 audience of mothers (as carers of young children). WASH actors raised concerns about the effectiveness of HCOAs176 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 4210 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 4220 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. 103

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 4230 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, 4240 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 4250 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 4260 Leitchuor camp was at high risk of flooding and evidence was presented to UNHCR and ARRA177 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 4270 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 refugees179. 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 104

were in place in Leitchuor180. 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, 4280 community structures were disrupted as the refugees became more dispersed upon self- settling on higher ground181. 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 April182 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 4290 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 4300 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 Strategy183 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 4310 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 4320 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 105

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. 4330 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 3.5m2 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 4340 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 4350 flooring. Communal infrastructure in temporary and transit facilities should be of higher construction quality than that of refugee camps184, 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 4360 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. 4370 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 4380 shelter construction but in the end daily labourers did most of the work. The capacities of the 184 UNHCR Emergency Handbook (2007) 106

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. 4390 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 4400 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 two185, one of which was for the old South Sudanese caseload. UNICEF and one operational partner supported education programming for the host communities. 4410 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 4420 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). 107

4430 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 2014186 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 4440 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 4450 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 provided187 and education services were not offered at entry points and transit 4460 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. 4470 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. 108

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 4480 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 4490 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. 4500 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 4510 high: Monitoring data show a considerable increase of enrolment in primary education and an increase in pre-primary education after the emergency188, 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 ratio189. 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 4520 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. 109

the education curriculum, language of instruction, refugee teacher recruitment and cooperation with the Ministry of Education. 4530 Table 20: Education indicators March June August December Standard Pre-primary: Enrolment pre-primary 0 11% 34% 100% Pupil/classroom ratio 0 n/a 206190 107 Pupil/facilitator ratio 0 n/a 106 (2 101 40:1 camps) Primary: Enrolment primary school 0 28.6% 84% 100% (GER) 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 4540 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 4550 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, 4560 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. 110

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 4570 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. 4580 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 4590 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 4600 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 4610 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. 4620 The nutrition response was consistent with UNHCR corporate strategies as well as in line with 111

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 4630 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 screening191 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 4640 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 4650 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 4660 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. 112