Evaluation Report on the

MSF Response to Displacement in Open Settings

"Leaving the camp paradigm…"

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Acknowledgements

The Vienna Evaluation Unit

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Table of contents

List of abbreviations

ACAPS	Assessment Capacities
ADGM	Age, Gender and Diversity Mainstreaming
ALNAP	Active Learning Network for Accountability and Performance
CAR	Central African Republic
CMR	Crude Mortality Rate
EMA	Emergency medical assistance
FARDC	Military of the Democratic Republic of Congo
GAM	Global Acute Malnutrition
HNTS	Health and Nutrition Tracking Service
HPN	Humanitarian Practice Network
IASC	Inter Agency Standing Committee
IDMC	Internal Displacement Monitoring Centre
IDMC	Internal Displacement Monitoring Centre
IDP	Internally displaced person
IFRC	International Federation of Red Cross and Red Crescent Societies
IOM	International Organization for Migration
LSHTM	London School of Hygiene and Tropical Medicine
LRA	Lord's Resistance Army
LRA	Lord's Resistance Army
MoH	Ministry of Health
MR	Mortality rate
MSF	Médecins Sans Frontières
MUAC	Mid-upper arm circumference
NASC	Needs Assessment Task Force
NFI	Non food items
NRC	Norwegian Refugee Council
OAU	Organisation of African Unity
OCA	Operational Centre Amsterdam
OCB	Operational Centre Brussels
OCBA	Operational Centre Barcelona-Athens
OCP	Operational Centre Paris
OCHA	Office for the coordination of humanitarian affairs
ODI	Overseas Development Institute
ORW	Outreach worker
PHC	Primary healthcare
SAM	Severe Acute Malnutrition
SGBV	Sexual and Gender Based Violence
TFC	Therapeutic feeding centre
U5MR	Under five mortality rate
UNHCR	United Nations High Commissioner for Refugees
WatSan	Water and sanitation
WFP	World Food Program

1   EXECUTIVE SUMMARY

Current conflict and displacement trends - showing an increase in out-of-camp displacement - pose a challenge to humanitarian actors such as Médecins Sans Frontières (MSF) because assessment tools and intervention strategies are mainly based on experiences in camp settings.

The purpose of this evaluation was to review the experience in needs assessment and response to displacement in open settings. For the evaluation process, six interventions were reviewed: MSF Operational Centre Geneva (OCG) interventions in the Democratic Republic of Congo (DRC) (Haut-Uélé), Djibouti, Cameroon and Iraq; Operational Centre Brussels (OCB) interventions in South Africa and Pakistan; and partial review of Operational Centre Paris (OCP) experience in Pakistan.

Challenges identified include invisibility, geographical spread, multiple displacements, security constraints and the constantly changing environment. Displacements happen in an environment with fluctuating availability of resources and an infrastructure, which functions to variable extents.

Main findings on assessment show that **critical information was lacking**, and **decision-making often based on poor qualitative data** because reliable quantitative data had not been available. Views of internally displaced persons (IDPs) were sorely lacking in assessments and external sources of information were underused. There is a **lack of frameworks for understanding the concept of vulnerability** and the related notion of risk. The identification of needs is more complex in open settings and much more attention needs to be paid to conducting sound assessments. The assessment of imminent risks is essential, especially in absence of acute needs. Changes in the situation have to be expected and there is a need for "continual assessment". Existing assessment tools are applicable (although none are specific to open settings), but assessments need to be tailored to the specific context and the level of emergency. **The health system**, **access barriers** and **health seeking behaviour** must be better explored. Systematic use of qualitative assessment methods is required to understand the diverse vulnerabilities, capacities and coping strategies. The complexity of open settings requires more attention and resources for assessment.

In situations of population displacement, crude and under-five mortalities (CMR, U5MR) are considered the key indicators to evaluate the magnitude of a crisis and the effectiveness of the humanitarian response. This evaluation points out the **difficulties to using mortality rates (MR)** as a prime indicator in open settings. Quantitative methods (sample surveys, counting population, etc.) have important limitations where access is limited and population is scattered or invisible. Overcoming some of these would require significantly more resources and competencies than are allocated today. **One-off mortality surveys provided varying results** due to rapidly changing character of the crises. Such results are of little value in absence of prospective mortality surveillance to able to detect trends of mortality over time. Alternative indicators and innovative methods to measure mortality are needed; proxy indicators such as food security and access to health care and other basic needs could be an example.

MSFs key reference book, the *Refugee Health* bases its logic on a linear progression from emergency to post-emergency phase. In open settings, a clear delineation between these two phases often does not exist, and peaks of acute need may regularly emerge during protracted crises. The *Top Ten Priorities* (from *Refugee Health*) aim at reducing high

mortality during the emergency phase by targeting risk factors typical of camp-like settings.[1] However, the risks factors vary greatly in many open setting situations.

Intervention strategies reviewed were often decided on an ad hoc basis and changed frequently, partially due to uncertainty about the appropriateness of choices. This is well understood in the absence of evidence-based tools that could provide guidance on intervention choices, objectives and indicators adapted to such complex settings. Unlike in camp situations where timely assistance would in most cases be demonstrated by decreased mortality rates, the **impact of interventions in most open settings can hardly be** measured.

Classical short-term 'emergency relief' was rarely seen in the reviewed interventions and the medical strategy in most intervention aimed at support or facilitation of access to existing health structures.

Engagement with the existing health system is much more demanded in open settings, but remains a main challenge. In open settings, it is hardly feasible to duplicate the 'four-level health care model' (from community health workers to the referral hospital) developed for camps, simply because of the immense resources needed. Evaluators argue that the engagement at hospital level must be made more consciously in terms of the potential investment and the expected output. In the absence of a functioning referral system, few patients effectively have access to supported hospital services. There are positive examples from the field that illustrate how "**light support" enabled primary health facilities** to cater to the excess burden caused by displacement.

Effectiveness of mobile clinics greatly depended on the phase of the emergency; outreach workers proofed invaluable, however the practical set-up requires improvement. Non-medical assistance was marginal in the reviewed interventions, objectives for non food item (NFI) distributions were unclear, and the minimum standards for water and sanitation (WatSan) and shelter are often not applicable to open settings.

The widespread needs in non camp situations present differently in rural or urban setting and must be addressed with flexible and innovative strategies. In rural setting they need to **aim at better coverage**, and **opt for community-based approaches**. Only with strong involvement of the affected communities can activities be continued even where (external) staff presence is restricted. One workable choice may be to **simplify the intervention strategies** by targeting the main cause of morbidity and mortality rather than aiming at globally improved healthcare provision. In urban areas the "light support" or facilitation of access to existing heath structures seems an appropriate choice. A strong partnership with local NGOs and existing networks of civil society organisations is essential and their capacity and experience should be exploited not only to deliver humanitarian assistance, but also to advocate to local governments for better coverage of the needs.

Generally, a **better balance between prevention and early diagnosis and treatment** is needed. The current work on innovative strategies within MSF/OCG may serve as a real opportunity for a sustained change in that direction.

MSF needs a **new concept for working in open settings**. Evaluators recommend developing new intervention frames based on existing models and they provide specific considerations for those. New approaches and strategies will have to be tested and their outcomes measured and compared. Operational research is needed to prove results and develop innovations further.

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1 Typical risk factors of camp-like settings: overcrowding, inadequate shelter, poor water, sanitation and hygiene conditions, lacking treatment facilities and insufficient nutrient intake.

2 INTRODUCTION

Displacement of refugees and IDPs in open settings is not a new phenomenon - both groups have traditionally settled outside of camps. However, over the past three decades refugee issues have been looked at from a camp paradigm, resulting in policies and practice that equate to refugees in camps. Humanitarian agencies have primarily targeted refugees settled in camps, neglecting the needs of self-settled refugees and IDPs (Chambers, 1979) based on the assumption that the latter are the exception rather than the rule. Today, the camp-based approach is increasingly criticized and encampment discouraged whenever alternative solutions are viable and political will exists. Displacement in open settings – both urban and rural – is now acknowledged as a growing trend and recognition of the needs of displaced persons outside camps has lead to the development of new policies (UNHCR, 2009a).

The current trend poses a challenge to humanitarian actors such as MSF because assessment tools and intervention strategies developed for displacement situations are mainly based on experiences in closed settings, particularly camps.

This evaluation aimed to assess current challenges and shortcomings in needs assessments and response to displacement in open settings, and to adapt assessment techniques and intervention strategies accordingly. The outcomes will feed into an ongoing OCG working group on displacement in open settings and provide the basis for a future training module.

The objectives of the evaluation were to review available external competencies and internal MSF experience in order to: i) assess the appropriateness of assessment techniques and tools currently used by MSF, in order to improve them for future interventions; and ii) analyse the appropriateness of intervention strategies.

The following projects were selected for evaluation from OCG and OCB:

MSF section	Project location	Project start date	Project end date
OCG	DRC (Haut-Uélé)	2008	Ongoing
OCG	Cameroon	July 2007	March 2009
OCG	Djibouti	October 2008	Ongoing
OCG	Iraq (Kurdistan)	November 2007	June 2008
OCB	South Africa	December 2007	Ongoing
OCB	Pakistan	May 2009	End 2009

All reference literature used for this evaluation is cited at the end of the document. The detailed Terms of Reference and evaluation questions are available in Annex 1.

The report starts with an introduction to evaluation processes and methods as well as definitions and concepts used. History and current trends of displacement are briefly described, with a particular focus on displacement in open settings and an elaboration of the case study settings. A chapter on operational challenges follows. The two main chapters on assessment and intervention strategies look into existing internal and external tools and policies, describe findings from the reviewed projects and end with a discussion on these findings. Recommendations are provided in the final chapter. A series of annexes is provided and references made in the respective chapters. Details of reviewed interventions are described in a separate part of the report (part II).

This evaluation covers a wide range of issues; it has not been possible to explore all of them in the depth they deserve. Further investigations into many of these subjects would be certainly needed, and some recommendations will require more detailed elaboration.

2.1 Evaluation process and methods

Alena Koscalova (MD) and Elena Lucchi (MSc) formed the evaluation team; Giuseppe Scollo had joined the team in the initial phase. The evaluation team members represented different positions on the key issues under assessment: on the one hand, arguing in favour of the 'old-school thinking' of MSF, with a focus on established and proven operational experience and practice; on the other, emphasising the need for rigour and sound methodology in assessment as well as flexibility and innovation in intervention strategies. The team recognises that this tension reflects the current reality in MSF.

The projects chosen for review are managed by two different MSF Operational Centres (OCG and OCB). The choice of project countries was driven by the need to analyse a variety of open displacement settings, both rural and urban, and to provide a balanced perspective of experiences in low income and middle to high income countries.

The evaluation team gathered the relevant documents from all the projects under review, including assessment reports, surveys, project reports, mission reports and advocacy documents.

Assessment tools and manuals currently in use within the MSF Movement were reviewed as well as existing tools and literature from other humanitarian organisations.

The team interviewed key informants at MSF headquarters both in Geneva and Brussels, including managers of regular and emergency desks, health advisors, epidemiologists, advocacy specialists and others. During field trips, key informants in the field and beneficiaries were also interviewed; see Annex 2 for list of interviewees.

The team visited three MSF interventions: in Djibouti, in DRC (Haut-Uélé), and in South Africa. The purpose was to have a closer look at key projects, discuss with the team on the ground and directly observe the conditions and needs of vulnerable communities.

In order to standardize the information collected through interviews with key stakeholders and beneficiaries, interview checklists were used.

On the basis of all the information collected through the above-mentioned methods, the evaluators compiled a 'country file' for each country including key issues on assessments and implementation strategies, challenges, strengths and weaknesses. Detailed information on the country case studies, and the 'country file', are available in part II of the report.

Limitations

Limited access or poor availability of relevant information made it difficult to review a number of projects. Retrospective information on assessments was often hard to find. Some documents for desk review were obtained late or not at all. For some countries the evaluation team was presented with a large number of documents to review without a pre-selection of the key papers – this slowed down the evaluation process further.

The team did not always succeed in interviewing the key persons from the desk, because of field visits, holiday and staff being called away to respond to the Haiti earthquake emergency. In addition, the involvement of more than one desk at different stages of the projects made the understanding of some interventions very challenging.

Members of the evaluation team had varying availabilities, which slowed down the work of the team considerably.

2.2 Definitions and concepts

For the purposes of this evaluation, and for the sake of simplicity, the team decided to use the term **'displaced'** indiscriminately in the report. The evaluators refer to 'displaced' regardless of the individual's refugee, IDP or socio-economic migrant status in the general parts. In practical examples the evaluators try to be more specific about displacement status and related vulnerabilities.

The evaluators fully appreciate the importance to know the legal status of our target population, as it will guide the teams on deciding who to mobilize (in terms of authorities and other agencies), and which arguments to use in advocacy activities if felt appropriate and necessary. Therefore definitions of key terms are provided below.

'**Open settings**' means any non-camp displacement. By definition, an open setting is a site with no clear boundaries. Different definitions of '**camp**' have been used in the literature. Edith Bowles in her article about the Thai-Burma border uses the word 'camp' to describe both small, open settlements where the refugee community has been able to maintain a village atmosphere and larger, more crowded camps where they are more dependent on assistance (Black, 1998). In the evaluation, it is the latter definition for camps that the evaluators use. Additionally, the evaluators use the term '**camp-like setting**' to describe situations without a formal camp management, but similar to camps with respect to size, density and dependence on external aid. The main differences between camp and non–camp settings are illustrated in Annex 3.

Box 1: Commonly used terms

> ▪ **Asylum Seeker:** An asylum seeker is a person who has left their country of origin, has applied for recognition as a refugee in another country, and is awaiting a decision on their application.
>
> ▪ **Internally Displaced Person (IDP):** Internally displaced persons are *"persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalised violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognised State border."* (UNOCHA, 2007)
>
> ▪ **Migrant:** There is no comprehensive and universally accepted definition of a migrant. One definition says that a migrant is *"any person who lives temporarily or permanently in a country where he or she was not born, and has acquired some significant social ties to this country."* (UNESCO, 1995-2010) Generally speaking, a migrant is a person who moves from one place to another (either within a country or crossing an international border) to live and usually to work, either temporarily or permanently (Amnesty International, 2006). Migrants are people who make choices about when to leave and where to go, even though these choices are sometimes extremely constrained.
>
> ▪ **Mixed Migration:** *"Complex population movements including refugees, asylum seekers, economic migrants and other migrants"* (IOM, 2004). Forced and voluntary migrants increasingly move alongside each other, using the same routes and means of transport. Lacking safe and legal alternatives, they are forced to use the services of smugglers and often face violations of their human rights in transit and/or in countries of destination (MSF OCBA, 2009).
>
> ▪ **Refugee:** According to the 1951 Convention Relating to the Status of Refugees, a refugee is a person who *"owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country…"* (UNHCR, 1951).
>
> The 1969 Organisation of African Unity (OAU) Convention Governing the Specific Aspects of Refugee Problems in Africa uses the 1951 Convention definition and extends it to cover those compelled to leave their country of origin on account of *"external aggression, occupation, foreign domination, or events seriously disturbing public order in either part or the whole of his country of origin or nationality"* (African Union, 1969).
>
> ▪ **Returnees:** Refugees or IDPs who have voluntarily returned to their own countries or villages of origin. (UNHCR, 2002-2010).

Other key concepts.

- The notion of **acute versus protracted** nature of a crisis. Refugee crises have traditionally equalled emergency situations; therefore the typical response has been an emergency intervention. From a medical point of view, open settings are not automatically emergency situations in the classical sense. They may be as severe in terms of overall mortality, but often these protracted, intermittent crises show a complex dynamic of increasing vulnerabilities, multiple coping strategies and a steady exhaustion of the latter. In many cases they could be considered pre-emergencies, with the risk that the humanitarian situation turns into an emergency if no assistance is provided.

- The concepts of **primary health care (PHC)** as part of overall development, and of **emergency medical assistance (EMA),** or emergency relief. Van Damme (1998) has developed a reference framework on these two concepts and how they need to be seen in relation to the stability or instability of a given situation. He points to the act of balancing between 'assisting refugees' and 'developing and safeguarding the existing health system.'

2.3 History of displacement

Camps for displaced persons were first observed in post-war Europe. There have been refugee camps in the Middle East since 1948 and in Uganda since 1959. However, during this period most people settled outside of the camps (Freund/Kalumba, 1986) and camps were the exception rather than the rule (Pitterman, 1984). A systematic approach to medical care in refugee camps was first reported in 1971 when some 10 million refugees fleeing former East Pakistan (now Bangladesh) to Bengal, India were installed in more than 1,000 camps along the border. (Seaman, 1972; Van Damme, 1995) The successful experience of Bangladesh led to the implicit assumption by UNHCR and other humanitarian actors that refugees can be best cared for in camps and before the Goma crisis few challenged this assumption.[2]

One of the strongest critics of camps, Barbara Harell-Bond pointed to their negative impact on physical, mental and social wellbeing by encouraging passivity and dependence on external assistance. She argued that if the goal of assisting refugees is to maintain their ability to be self-sufficient, then aid should follow refugees rather than forcing refugees to follow the aid (Harell-Bond, 1998 and 1994).

Van Damme argued that the refugee camp approach was successful during the Bangladesh crisis because refugees were spread over a large number of small camps and because the problem was temporary. Unlike Bangladesh (and Pakistan in 2009), many displacement crises are protracted and the negative aspects of camps outweigh their potential benefits once the initial emergency has passed. In his extensive work on the subject, Van Damme presents an alternative to camps based on the example of refugees from Liberia, Sierra Leone and Guinea where assistance to self-settled refugees was integrated into the existing health system benefiting both refugees and the host population (Van Damme, 1995).

The negative effects of protracted encampment were emphasised recently (Loescher, 2008). Earlier, it was highlighted that the general argument against camps might be better put to governments, who have ultimate responsibility for settlement policy, rather than to international organisations (Black, 1998).

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2 About 500 000 to 800 000 of Rwandan Hutu refugees flew into the North Kivu region of Zaire in July 1994and were confined into large, massively overcrowded camps with poor sanitary conditionsr. About 10% died within one month, mainly because of a cholera epidemic, Health care was vastly insufficient, GAM up to 18-23% were recorded

2.4 Current trends of displacement

The past two decades have seen an increasing trend towards internal displacement rather than refugee situations (see Graph 1 below), reflecting the rise in internal conflicts, increasing urbanisation and perhaps the hardening attitudes of host countries towards acceptance of large numbers of refugees (Salama et al, 2004). Trends in internal displacement show that the majority of IDPs do not seek shelter in camps, but with relatives, friends or members of their community or ethnic group in urban or rural areas.

Precise information on the profile of displaced populations (forcibly displaced or not), including their location and their number disaggregated by age and sex, was still limited in 2008 and essential data is lacking. Available figures on general trends are summarised in Box 2 below.

Box 2: General trends in displacement

- There were some **42 million forcibly displaced people** worldwide at the end of 2008. This includes 15.2 million refugees, 827,000 asylum-seekers (pending cases) and 26 million IDPs (UNHCR, 2009b).

- The most affected continent is **Africa with 11.6 million IDPs in 19 countries** (Internal Displacement Monitoring Centre (IDMC)/NRC, 2009).

- In addition, approximately **36 million people were displaced as a result of sudden-onset natural disasters** (IDMC, 2009).

- More than **839,000 people** submitted an individual **application for asylum or refugee status** in 2008. More than 16,300 asylum applications were lodged by unaccompanied and separated children in 68 countries.

- With one quarter of applications globally, South Africa is the largest recipient of individual applications in the world.

- **Women and girls constitute 47 per cent** of refugees and asylum-seekers, and half of all IDPs and returnees (refugees). Forty-four per cent of refugees and asylum-seekers are children below 18 years of age.

- **Developing countries are host to four-fifths of the world's refugees**. Based on the data available for 8.8 million refugees, UNHCR estimates that half of the world's refugees reside in urban areas and one third in camps. However, seven out of ten refugees in sub-Saharan Africa reside in camps.

Some new trends are starting to emerge in terms of displacement patterns. These trends deserve particular attention and reflect the changing nature and focus of humanitarian emergencies, from short-term emergencies in refugee camps to prolonged emergencies over large geographical areas (Salama et al, 2004).
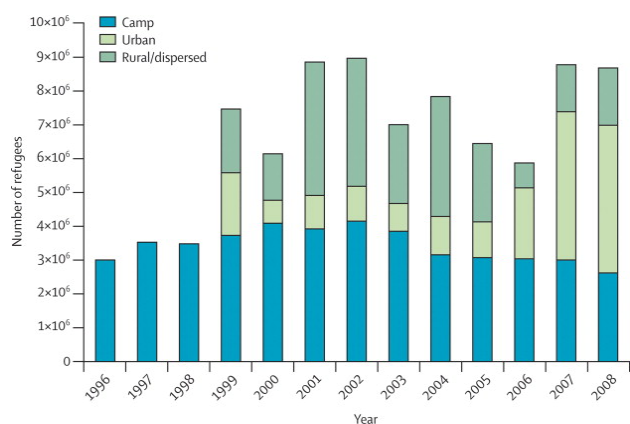
Graph 1

Number of refugees living in camp-like, urban, or rural and dispersed settings, 1996–2008*(Spiegel et al, 2010).
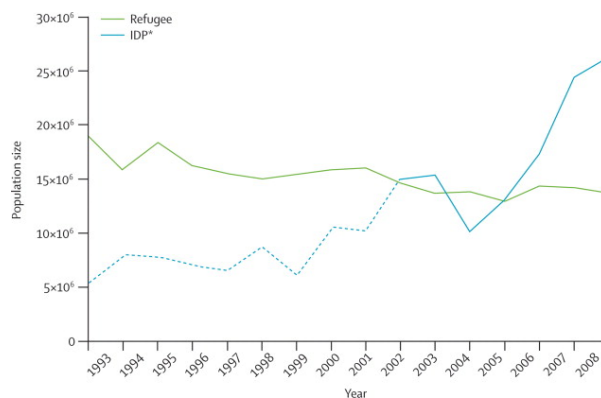
Graph 2

Estimated populations of refugees and internally displaced people, 1993 to 2008 (Spiegel et al, 2010).**

Only major refugee populations recorded by UNHCR (generally >50,000 people) are included; thus, numbers do not represent the total refugee population worldwide. Definitions of major populations used by UNHCR varied by year (≥10,000 in 1993 and 1994, not stated in 1995, ≥100 in 1996 and 1997, ≥1,000 in 1998, ≥100 in 1999 and 2000, ≥5,000 in 2001–05, no limit stated in 2006–08). Before 1999, refugees were mainly registered in camps, and data for those in urban or rural and dispersed localities were mostly not recorded, and are only shown for years since 1999.

**Dashed line from 1993 to 2001 shows that population data for IDPs were inconsistently recorded. Data are combined IDMC and UNHCR estimates. IDMC figures were used when two numbers for the same country were reported for both sources, because UNHCR reports for only IDPs for whom they have responsibility. The midpoint was used if IDMC figures provided a range for population size.*

2.5 Displacement in open settings

In more than half of the displacement situations monitored in 2008, displaced or refugee populations were dispersed, having in many cases found refuge with host communities outside organized camps either in rural or urban areas. This pattern of displacement is also called displacement in open settings. (NRC/ IDMC/ OCHA 2008) Displaced populations are found in a wide range of locations, including but not limited to the following:

- With host families, friends and relatives (urban or rural).

- In urban settings – often in slum areas – in and around major towns and cities where they intermingle with local communities.

- In rural settings, where displaced populations are often scattered across large rural areas living in proximity or hosted by local families.

- Occupying public or private buildings.

- In transit between locations, in search of grazing for their livestock, or as 'night commuters' seeking safety from armed attack.

- Hiding in forests or other rural settings where they fled before or following an attack, or in fear of an attack.

12

In some situations people prefer to remain anonymous and inconspicuous, not wishing to draw attention to themselves for fear of arrest, eviction or other perceived threat. Displaced populations often shift between these various situations or divide their families or become separated so that different family members may find themselves in different situations simultaneously.

Increasingly, urban areas are becoming the destination of choice for many refugees, IDPs and migrant workers displaced in open settings. According to UNHCR, one out of two legally recognized refugees currently lives in urban areas (UNHCR, 2009b).

This is in part due to the global trend of urbanization and the fact that people are on the look-out for new opportunities in cities (employment, anonymity, support from relatives). Many of the displaced in urban areas – especially those that are not recognized as refugees – lack the protection and assistance which is provided to refugees in camps, and are thus very vulnerable (UNHCR, 2008).

Mixed migration patterns are one of the current challenges. While refugees and asylum seekers account for a relatively small proportion of the global movement of people, they increasingly move from one country or continent to another alongside other people whose reasons for moving are different and not necessarily protection-related (e.g. extreme poverty or hunger, environmental disasters, etc.).

Selected case studies for the evaluation

The case studies evaluated were chosen in order to reflect the existing diversity in displacement patterns. Box 3 below shows the multiple features of displacement case studies.

Case studies from Cameroon, DRC, Pakistan and Iraq represent rural displacement, where people are scattered in many places over a large geographical area, and therefore difficult to reach.

In **Cameroon,** refugees fleeing violence from Central African Republic (CAR) were scattered in 74 settlements along the border, co-existing with the host community. The arrival of refugees was progressive and the humanitarian situation steadily worsened over time with diminishing coping mechanisms due to scarce food resources and late humanitarian intervention resulting in a high level of acute malnutrition and mortality peaking above the emergency threshold.

In **DRC,** the violence committed by the Lord's Resistance Army (LRA) continues to force people to move from rural areas to other rural areas or small towns in search of security. IDPs traditionally stay with host families, returning intermittently to their homes where they feel physically, emotionally and spiritually more secure, rather than fleeing to refugee-like camps. An estimated 70 per cent of IDPs stay with host families. A new trend was observed recently, with more people joining formal or informal camps. The main reason for this phenomenon is thought to be the increasing 'saturation' of overburdened communities hosting IDPs and insufficient humanitarian assistance provided to the host communities (Haver, 2008). The character of the DRC crisis is also intermittent, with several waves of displacement following peaks of violence.

Iraq and Pakistan are two middle-income countries where people have been forcibly displaced because of conflict. In both countries displacement was on a large scale and people found accommodation in a variety of places. More than half of the displaced population shared houses with other families. In Pakistan, in Takht Bhai, Mardan district, most IDPs were living in public buildings and with host families. The displacement crisis was rather sudden and of short duration in Pakistan; in Iraq it was protracted and occurred in several waves.

Djibouti and South Africa are both examples of mixed patterns of migration towards urban settings. Refugees, asylum seekers and migrants live in the poor neighbourhoods and slums of big cities such as Djibouti town or Johannesburg. The onset of the displacement and migration crisis is of a progressive and protracted nature.

In terms of the health system, this was relatively well functioning in Iraq, Pakistan, and South Africa. In Djibouti and Cameroon, the health system is functioning, but important gaps are present and the cost-recovery system is a major barrier to access to healthcare. In DRC, the health system is poorly functioning and collapses easily when faced with minimal disturbances.

The profile of countries affected by conflict is gradually shifting towards higher baseline incomes and life expectancies (South Africa, Iraq, Pakistan) which change the burden of disease. While infectious diseases and neonatal disorders remain important causes of excess mortality in low income countries, chronic non-infectious diseases are dominant in middle to high income countries.

Clearly, the context in the selected case studies differs in many ways: setting (rural versus urban, low income versus middle to high income); type of accommodation upon arrival (squats in South Africa, host families in DRC, in proximity with host community in Cameroon, etc.); scale of displacement (large scale in Pakistan and Iraq); onset (sudden onset in Pakistan, progressive in others); duration of displacement (very short in Pakistan, protracted in others).

Such diversity explains the complexity of displacement situations in open settings and renders the analysis and identification of common issues even more challenging.

Box 3: Displacement patterns and settings of selected case studies

	Low income and life expectancy	Medium to high income and life expectancy
Rural settings Living dispersed with or in proximity to host families, relatives or friends, hiding in forest or other rural areas	• **Cameroon*** • **DRC** • Djibouti	• **Pakistan** • Iraq (Kurdistan) • South Africa
Urban settings Often in slum areas, scattered in and around major cities where they intermingle with local communities	• **Djibouti**	• **South Africa** • **Iraq (Kurdistan)** • Pakistan
Camp-like setting (rural or urban) Formal camps, but also informal settlements such as schools, public or private buildings, churches or new displaced villages	• DRC • Djibouti	• South Africa • Pakistan • Iraq (Kurdistan)

* Bold font indicates the predominant displacement pattern in a particular country.

3   OPERATIONAL CHALLENGES IN OPEN SETTINGS

This chapter provides a synthesis of the main operational challenges experienced in projects in open settings. It also gives an overview of the relationship between specific challenges and certain types of displacement. The focus is on operational challenges experienced in the projects reviewed within this evaluation; however, some challenges from other sources are also included. Although common issues are reported in many similar contexts, it is important to note that a wide variety of factors influence the nature of operational challenges, including:

- security
- rapidity of onset (sudden, slow)
- duration of displacement (short, prolonged)
- character of emergency (acute, chronic, intermittent)
- causes of displacement
- humanitarian space
- level of trauma experienced
- accessibility, affordability and quality of existing health services
- cultural communalities / differences with host population

A number of these identified challenges which are closely linked to assessment methodology (e.g. population counting, use of surveys, standard indicators and intervention criteria), or to types of intervention (dealing with mental health and chronic diseases), are discussed in detail later in this report.

Defining and identifying "the most vulnerable"

Although there is broad consensus that MSF should always be aiming for the most vulnerable, there is little agreement on how to define them. Directly linking vulnerability with the displacement is questioned when in fact the host populations is in need as well (Djibouti, Cameroun, DRC, South Africa). Definitions of vulnerability in reviewed interventions seemed mainly linked to operational priorities (malnourished children, victims of sexual violence, etc.).

A common operational practice was to target sites with larger number of displaced (Cameroun, DRC, Pakistan). However the most vulnerable might not necessarily be found there.

The challenge to identify the most vulnerable presents itself differently depending on urban or rural setting. In rural areas IDPs often live scattered in vast areas or are hiding for fear of attacks. In urban settings the humanitarian situation can be more critical at the beginning of the displacement, before people establish themselves and identify networks and coping strategies. In rural setting, where the local population is hosting the displaced, the situation may be less severe in the beginning when support capacity of local population is present, but it often worsens with decreasing resources and coping strategies.

Invisibility in urban areas

In urban areas potential beneficiaries are often highly mobile, sometimes inaccessible and frequently integrated into existing slums and settlements scattered across the city. Refugees and IDPs who have been displaced in or to urban areas often have particular reasons for remaining hidden, such as fear of harassment, detention or eviction.
In South Africa, the majority of Zimbabwean migrants remained 'invisible' due to fear of deportation until asylum permits were made readily available to all Zimbabweans entering South Africa with a valid passport and deportation was stopped. However, police harassment

and threats of xenophobic attacks continue.[3] The problem of invisibility remains for migrants entering South Africa without documents or for those who overstay the legal permit (and are forced back to 'invisibility'). The essential question remains: how can we identify and assist this vulnerable population? The use of small, less visible support teams, mainly from the same community, has proved to be a workable strategy in South Africa. In Djibouti, due to more benevolent authorities, the invisibility of illegal migrants is less an issue.

Geographical spread in rural areas

Huge efforts and resources are required to reach a population when it is spread over a large geographical area. Needs are not easily visible and difficult physical access hinders needs assessments.

In Cameroon, refugees were living in 74 settlements, with 100 to 2,500 refugees per site, spread along the 650km border with CAR. New pockets of refugees and a high proportion of non-registered refugees posed additional problems in terms of assessing needs. One consequence was that it was extremely difficult to follow up patients on the nutrition programme, which was a key reason for the high defaulter rate.[4]

In DRC, the displaced are dispersed as a result of the high mobility of the LRA with multiple attacks spread over a large area. Thus the situation in Haut Uélé is constantly changing (new pockets of displacements, multiple displacements, populations cut off from assistance, etc).

In Pakistan, many IDPs were seeking refuge in hard-to-reach mountainous areas, far from the reach of humanitarian actors.

Constantly changing humanitarian situation and needs

In open settings, the humanitarian situation can change considerably over time. In DRC/Dungu, the displaced population was initially accommodated by host families, but later became autonomous and constructed their own huts in an area assigned by the local authorities. Paradoxically, this increased their vulnerability, since they left most of the received assets[5] to the host families and settled in an area with limited possibilities to cultivate due to security constraints. In the absence of regular re-evaluation, these new needs were overlooked by the MSF team.

In Cameroon, a first assessment carried out in April 2006 did not reveal emergency needs. More than one year later, a new MSF assessment detected a critical humanitarian situation with mortality rates above the emergency threshold and a high level of acute malnutrition.

Mobility of displaced populations

In many settings, displaced populations move from one location to another. This happens for a variety of reasons: for protection, to seek livelihood opportunities or, more often, to find a better life. Migrants can be very mobile, particularly in big cities. Upon arrival, they generally find accommodation with family members, and/or members of their community of origin. People then tend to move on to more appropriate, or stable, accommodation as soon as possible. Those who end up occupying public spaces illegally are often forced to move from one area to another, usually towards the periphery of the town. This is common in Johannesburg, Djibouti and in other urban migration settings.

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3 http://msf.org.za/viewnews.php?n=622
4 Other factors were: i) nomadic life style of the population, and ii) different cultural understanding of the nutrition problem.
5 Non food item kits distributed in the beginning of the intervention by Solidarité, OXFAM and CARITAS.

Multiple displacements in rural areas

Displaced populations in rural areas often move from one village to the next, e.g. in DRC/Haut Uélé. There, even in Dungu town, people move from one neighbourhood to another in order to seek safety from LRA attacks. In Cameroon, new pockets of displacement often appeared very quickly. Such mobility represents a challenge in terms of response to the medical, humanitarian and protection needs of these people. On the medical side, it has implications for identifying locations for the provision of services (fixed or mobile clinics), as well as for the follow up of patients for nutritional care, response to sexual violence, treatment of chronic diseases, or overall outreach.

Responding to violence in insecure urban areas

Violence is often an additional problem in urban areas, making entire neighbourhoods insecure and causing extra medical and protection consequences for entire communities trapped by violent outbreaks - migrants, as well as the local population.

The South African case study highlighted the challenge of responding to xenophobic violence, which is a constant threat in the country. MSF struggled to respond to recent episodes of violence in the townships. With the exception of Khayelitsha, where MSF has worked for many years on an HIV-AIDS programme, MSF is not known in the townships and has little network in those places. Without activities it is very difficult to establish and maintain an efficient network. Given the restricted access to such very insecure neighbourhoods, it is difficult to prepare for, and to respond to, violent events.

Administrative constraints

In Djibouti, the authorities were formally opposed to particular targeting of the migrant population and against offering free healthcare that contradicted the cost recovery system introduced in Djibouti in 2006. MSF's registration in the country took longer than expected and the authorities refused MSF movements out of Djibouti city. This meant that the assessments and activities for refugees and migrants proposed in the initial activity plan that was validated in September 2008 were still not implemented in 2009.

Security constraints

The security risks in DRC make it impossible for MSF teams to stay overnight, except in the few secured towns which have a permanent presence of MONUC and FARC. Therefore MSF intervention was restricted to these secured areas, with rare short trips to other locations (so far mainly for assessment), although humanitarian needs outside of these towns are enormous.

In Pakistan, the security situation triggered a non-classical set up of the MSF programme. The international staff was forced to keep a low profile, and the national team were at the forefront of all activities. Accordingly, MSF made major efforts to recruit national staff and adopted a strategy of using small teams from local communities.

Similarly in Northern Iraq, security constraints prevented survey and distribution in some locations. In some 'hot spots', the team needed members of the Defence Forces of Kurdistan Region (Peshmerga) to maintain order during distributions.

In Iraq and Pakistan, the high level of insecurity restricts humanitarian work, largely as a result of the political polarisation of aid. This poses an additional challenge to the perception of MSF as an independent, impartial and neutral organisation.

Box 4: Summary of operational challenges in open settings

	Low income	Medium to high income
Urban		
Examples	Djibouti,	Iraq, South Africa,
Main operational challenges observed	- Relative invisibility - Mobility of migrant population in the city - Urban poor are as vulnerable as migrants - Cost recovery system makes health care unaffordable to vulnerable patients	- Identifying the most vulnerable - Displaced population as vulnerable as poor host population - Access to areas affected by criminal/gang violence - Adapting MSF response to standards of a middle-income country - Dealing with chronic illnesses
Rural		
Examples	DRC, Cameroun	Pakistan
Main operational challenges observed	- Geographical spread of the affected population – difficult to identify and reach - Rapidly changing humanitarian situation and population needs –multiple displacements - Coping mechanisms diminish over time - Engagement with existing health system - Supply difficulties – inaccessible roads due to insecurity, lack of airstrip, bad road conditions	- Targeting the most vulnerable in a massive displacement – geographical spread and huge needs - Access to quality care for all IDPs. Different actors claiming to provide healthcare but quality not assured. - Supply difficulties - managing an enormous emergency with local supplies
Challenges, general	- Indicators to benchmark the crisis - Counting and mapping the affected population - Quantifying the needs - Criteria and indicators for engagement with the health system - Criteria for exit in protracted crises	

4   ASSESSMENTS

> *Assessment is a vital element of the program-planning process. Assessment provides the information on which decision should be made. Whilst good information does not guarantee a good program, poor information almost certainly guarantees a bad one. Curiosity and rigour are the essential elements of an emergency assessment.*
>
> *(IFRC, 2008)*

This chapter starts with a review of internal and external assessment tools; it describes the main findings and draws conclusions on those. Immediate comments to findings are written in *italic.* The appropriateness of assessment was looked at in terms of i) quality and completeness of information obtained, ii) the analysis and use of the obtained information for intervention design, iii) the application of quantitative and qualitative assessment methods and tools. The chapter closes with conclusions and recommendations on assessment.

The rapid health assessment of refugee or displaced populations and Refugee health were used as internal references for the analysis. Additionally, IFRC guideline for assessment in emergencies was used as external reference.

Box 5: Glossary on assessment:

Tools refers to existing assessment guidelines, practical checklists and technical frameworks, An overview of assessment tools is provided below, the summary of reviewed assessment tools can be found in Annex 4.

Methods refers to any systematic quantitative or qualitative ways to collect and analyse data. An overview of assessment methods is provided in Annex 5.

Assessment is a process of gaining an understanding of a situation in order to identify the problems, their sources and consequences (IFRC, 2008)

Monitoring is continuous observation of the project/programme's progress (IFRC, 2008)

Initial assessment is considered the first of the top ten priorities in the response to the acute phase of an emergency involving population displacement (MSF, 1997). It should cover, as objectively as possible, the qualitative and quantitative aspects of the situation. Because the collection of reliable data requires time, particularly quantified data that has to be compiled by surveys, the initial assessment may be undertaken in two steps, a first rapid assessment for immediate action (initial exploratory mission) and in-depth assessment. **Rapid health assessment** is usually carried out in the second phase of the assessment. The time needed to complete both phases of the initial assessment will depend on many factors, but in most situations necessary information may be gathered within 7 to 10 days. (MSF, 1997)

Initial exploratory mission (first rapid assessment) should result in a rapid decision on whether or not to intervene and the type and the size of intervention needed. The information collected should indicate the severity of the situation, as well as the need and feasibility of relief intervention. These data are obtained by fast, simple methods: direct observation, interviews with refugees, agencies present in the area, the Ministry of Health (MoH) and local authorities, health data from medical facilities, and, if required, a rapid estimation of the population size by mapping. This phase can be completed in less than three days. (MSF, 1997)

Rapid health assessment (RHA) refers to collection and analysis of information concerning the demography, mortality, morbidity, nutritional status and immunisation of the concerned population, as well as food, water and basic living conditions. RHA are generally carried out at the start of an intervention, together with the first operational activities. They rapidly provide data on the size of the population, health priorities and vital needs. This information may be obtained from a sample survey,

from data collected at distribution points or from other methods, notably for demographic related information. The information collected is used to calculate indicators, which are compared to internationally accepted standards. The immediate implementation of a basic surveillance system provides a mechanism to further monitor the ongoing situation as well as the impact of the interventions. (MSF/Epicentre, 2006).

Continual assessment involves regularly updating information on the situation and seeking relevant feedback from beneficiaries in order to facilitate decision-making on long-term activities (IFRC, 2008)

Assessment fatigue may occur when an area has been assessed many times by different agencies. The people are frustrated because they are expected to answer the same questions repeatedly, often with no obvious result. Under such circumstances, an assessment is unlikely to produce useful information (IFRC, 2008).

Vulnerability is defined as the conditions determined by physical, social, social, economic, environmental and political factors or processes which increase the susceptibility of a community to the impact of shocks/hazards. (IFRC, 2008)

Capacity is defined as "The resources of individuals, households, communities, institutions and nations to resist the impact of a hazard." (IFRC, 2008)

Coping strategies are those chosen by people as a way of living through difficult times.

4.1 MSF assessment tools

The evaluation team reviewed the following MSF tools available for assessments in situations involving population displacement:
   I. Rapid Health Assessment of Refugee or Displaced Populations, MSF/Epicentre, 3rd version, 2006
   II. Refugee Health: An Approach to Emergency Situations, MSF,1997
   III. Manual for the Assessment of Health and Humanitarian Emergencies, MSF Holland, 2002
   IV. The Priorities (Checklists, Indicators, Standards): Situations with Population Displacements OCB, 2009
   V. Assessment Grids, MSF Switzerland, 2001
   VI. Guide to using qualitative methods, MSF UK, 2002[6]

For the purpose of this evaluation, the content of the tools was reviewed, their use in the reviewed projects started and the main limitations of their use in open settings described. This chapter briefly presents the content of each tool; summary tables on the most important assessment methods and on the reviewed tools can be found in Annex 4 and 5.

- *Rapid Health Assessment* was designed for people wishing to carry out an emergency assessment of the health status of displaced populations. It is composed of the framework for rapid health assessments, presentation of objectives and methods, areas of assessment with corresponding indicators and recommendations for carrying out these assessments. It also provides practical guidance on various quantitative methods (sample survey, counting of habitats, mapping, etc.). This practical guide remains of great value for camps or camp like setting. However, its use by non-epidemiologists in

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6 This is a good reference guide on how to systematically use qualitative methods, a subject which is not covered in the other references reviewed.

rural dispersed and urban settings is challenging. The main method presented to collect the data during RHA is community sample survey. It is widely argued that community surveys in such complex settings clearly require epidemiological expertise and the use of "cookbook" methodologies has been discouraged by experts (Spiegel, 2007). At the other hand, description of more simple ("quick and dirty") methods could serve the field teams to obtain some quantitative data in situations where the organization of the community survey is impractical.

- *Refugee Health* considers initial assessment as one of the top ten priorities of intervention in a displaced population. It foresees the assessment in two phases: i) a first rapid assessment for immediate action, and ii) a second assessment to provide more comprehensive information. It emphasises the need to collect both quantitative and qualitative information during assessment and briefly presents different methods used in an assessment. Its descriptive character limits its practical use.

- *Manual for the Assessment of Health and Humanitarian Emergencies* is a comprehensive manual on assessment in an emergency situation, but is not specific to displacement. It considers seven steps: i) planning the assessment; ii) initial assessment (data collection); iii) first conclusions and identification of areas for in-depth assessment; iv) surveillance; v) in-depth assessment; vi) analysis; vii) report and recommendations. It contains checklists, a sample report format and provides the support for data analysis (both quantitative and qualitative). Because of its modular structure, it appears to be the best suited tool for displacement in open settings, however prior training on assessment steps and methods may be needed for appropriate use.

- *The Priorities* is not a true guide, but rather a practical reminder with checklists of data to be collected during an initial assessment. The book is based on the top priorities and illustrates simple data collection frames. This guideline enjoys high popularity among the assessment teams for its user friendly character. However, for assessment design and different methods, other tools need to be consulted.

- The MSF UK *Guide to using qualitative research methodology* is designed to help people to become familiar with and use qualitative methods, and to ensure that those methods produce a credible result. It is divided into four parts, starting with the definition of qualitative methods and practical applications. It covers the necessary approach, sampling methods, data collection and analysis. It is a very valuable tool with great potential for use in open settings.

4.2 External assessment tools

A number of agencies have developed their own assessment tools, yet there is hardly any specific tool for displacement in open settings. Out of ten selected assessment tools (see Annex 4), most of them are emergency assessment tools, but not specifically for displaced populations (except the Rapid Response Mechanism used by Solidarité). In terms of health assessment, most of the organisations interviewed said that they use MSF guidelines.

- In March 2009, humanitarian stakeholders met in Geneva to discuss how to improve cross-sector needs assessment in a collaborative, consultative and coordinated manner. Based on these discussions, the IASC Working Group decided to establish a Needs Assessment Task Force (NATF). A new initiative, ACAPS (Assessment Capacities) will support the NATF in the identification, design and adaptation of existing tools for assessments.[7] The NATF has compiled a list of all assessment tools (116)

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7 ACAPS is being set up under the auspices of the Inter-Agency Standing Committee (IASC) Needs Assessment Task Force (NATF). The project is a joint initiative of the NATF (represented by OCHA) and a

they have gathered so far. One outstanding tool is the *Guidance on IDP Profiling by IDMC*. It has been developed to collect data on IDPs, their condition and vulnerability. An IDP profile is an overview of an IDP population that shows, at a minimum: i) number of displaced persons, disaggregated by age and sex (even if only estimates); ii) location/s; and in addition (optional and not limited to these); ii) causes of displacement; iv) patterns of displacement; v) protection concerns; v) humanitarian needs; and vi) potential solutions for the group / individual, if available. The tool proposes different methodologies (both quantitative and qualitative) and provides advice on where to use which methodology. It also examines how to obtain a better picture of who and where the IDPs are, the difficulties of distinguishing them from surrounding communities and how to compile workable estimates for programming, protection and advocacy purposes.

- *The Good Enough Guide: Impact Measurement and Accountability in Emergencies* provides another useful tool for profiling beneficiaries and identifying vulnerabilities. It contains a basic tool with suggested questions for assessment of vulnerabilities (p 36).

- The IFRC *Guidelines for Assessment in Emergencies* are based on the principle of identification of vulnerabilities and capacities. The guidelines addresses continual assessment in addition to rapid and detailed assessments. They contain an interesting flowchart on vulnerability that can be found in annex 6.

- The HPG and ODI report *According to needs?* published in 2003, presents the results of one year-long study on the link between needs assessment and decision-making in the humanitarian sector. The study recommends that instead of an analysis based on ambiguous concept of need, one should be based on acute risk, understood as product of actual or imminent threats and vulnerabilities. The reports also deals with practice of needs assessment, identification of vulnerable groups targeting, prioritisation and decision-making, including general criteria for good practice.

- *Analysing Disrupted Health Sectors* is a modular manual published recently by WHO providing guidance for analysis of health sector in crisis. It presents patterns recurring in disrupted health sectors and provides instruments for data collection and analysis with common pitfalls and the ways to overcome them.

- Practical information on epidemiological tools used in rapid assessments, surveys and surveillance can be also consulted on LSHTM website: *conflict.lshtm.ac.uk/page_02.htm.*

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consortium of NGOs – HelpAge International, Merlin and NRC. Key partners will include the Overseas Development Institute, Tufts University, the Karolinska Institute, Columbia University and, relating specifically to building in-country capacities, the Emergency Capacity Building Project (ECB).

4.3 Findings on assessments

Initial assessments were reviewed for all interventions evaluated; in addition other assessments carried out before or during the intervention were looked at. Initial assessment was carried out prior to intervention in all cases. The Pakistan assessment was excluded as it was only documented for the assessments in and not outside the camps. Many findings are not specific to displacement in open settings; however where considered relevant for the analysis, they are presented briefly. The specific details for each assessment / country can be found in part II of this report.

Critical aspects of information missing in assessments

Initial assessments varied considerably in the type of information they provided. While the geopolitical context was well described in all the reports, specific findings on health and food were sometimes insufficiently elaborated; water, shelter and NFI were the least developed findings. Mortality rates were initially only estimated in Cameroon (based on grave counting), and in later stages also in Djibouti and DRC (based on a cross-sectional two-stage cluster sample survey). Estimates of population size and population movements were rather rough in all assessments, except for Cameroon. Mapping of displaced people was incomplete, and specific vulnerable groups were not identified. The presence and activities of international actors were generally well described. Except for South Africa, there was no information on local organisations. Socio-cultural aspects were underreported.

Evaluators believe that the information gap in reviewed assessments was linked to the complexity of the situations evaluated and the fact that assessment techniques are not adapted to these realities. Providing population estimates and mapping of displaced people seems particularly challenging for the assessment teams, and reflects the difficulty of using quantitative methods in these settings. The information gaps on water, shelter and NFI might be related to the difficulty of quantifying these needs, but also to the lack of internationally standardised indicators to which the findings can be compared. Regarding the identification of specific vulnerabilities, it is suggested that currently used assessment methods are not appropriate to reach this objective. These particular issues are discussed further at a later stage in this chapter.

Assessments in open settings take longer

All the assessments were rather long when compared to the reference (MSF, 1997) which suggests 3 days for initial exploratory mission, and 7 to 10 days for the in-depth assessment. In reality assessments took between 6 days and one month. Nevertheless due to the complexity of the situation, longer assessments seem to be needed in open settings.

Decision making informed by poor qualitative data

Qualitative methods were used in all the initial assessments, sometimes unknowingly, and often as the only alternative when quantitative data could not be obtained. Therefore, operational decision making was mainly based on (poor) qualitative data provided by the initial exploratory teams.

Unlike with surveys, the exact qualitative methodology was never described. Assessment teams seem to experience difficulties in analysing qualitative data and interpreting findings. Data were also not scrutinised in terms of reliability, accuracy, completeness and consistency. There was no information on how the results were validated by different methods. Potential bias and errors are not mentioned.

Certain qualitative methods such as group interviewees and focus group discussions were under-used or under-reported in final reports.

In DRC, a good balance of both qualitative and quantitative methods was used during the initial assessment. However, the findings obtained by interviews were under-represented in the report.

In Djibouti an 'Interview dossier' brought valuable information about specific problems facing the displaced. However, the information collected in interviews was not reflected in the final report, and therefore 'lost' as most of the readers (HQ, coordination, and field) overlooked the annexes.

> *Whilst a different level of rigour is required for the application of qualitative methods in day to day activities from that required for research, a more thorough approach to the application of qualitative methods on a day to day basis will result in less biased results – meaning we can have more confidence in both them and our response.*
>
> *(MSF UK, 2007)*

Confusion around the concept of rapid health assessment (RHA)

RHA as a part of initial assessment was only carried out in Iraq. RHA was also conducted in Doruma (DRC), 6 months after the start of the intervention. Both RHA were carried out by EPICENTRE and a community sample survey was the main method of data collection.

Evaluators observed that field teams were not comfortable performing rapid health assessments. On one hand this might be due to the complexity of conducting a sample surveys in open setting, while it still remains the first method suggested in the MSF Rapid Health Assessment. On the other hand teams seemed not familiar with more simple methods that could be used during the RHA.

Concerns on the use of community sample surveys

With various objectives and at different stages of the interventions, community sample surveys were carried out in 4 out of 6 reviewed projects. EPICENTRE was involved in Cameroon, and DRC; an MSF epidemiologist carried out the survey in Djibouti and MSF team continued the survey based on initial RHA in Iraq. All surveys provided good quality information; however some concerns appeared regarding the representativity, justification and utility of these rather costly exercises. The details can be found in Annex 7.

In Iraq, one of the objectives of the RHA was to identify the target population for the NFI distribution. As this was not achieved after the first exercise, the team continued an exhaustive survey through the intervention to identify the beneficiaries for the distribution. Despite the focus of the intervention on NFI distribution, an initial questionnaire including health related data was administrated. This approach is questionable as most of the information collected was not used neither for operational nor for advocacy purposes.

The objectives of DRC survey were comprehensive and adapted to the context, investigating access to health care, main health seeking behaviours, people's livelihoods, their disruption and existing coping mechanisms. The consideration of both displaced and host community can be considered good practice. Additionally, a focus group discussion was carried out, providing an insight into the problem of access to health care. However, due to compromised access to the affected population with less than 20% included in the sampling frame and lack of homogeneity among the displacement sites, the results of the survey cannot be generalized beyond the sampled population (see Box for more details). Moreover, prospective mortality surveillance, even though recommended by survey team, was not set up after the survey, thus the trend of mortality and therefore the evolution of the crisis, could not be observed.

Retrospective mortality was estimated in all surveys, except in Iraq. Prospective mortality surveillance was only set up in Cameroon, but even there, probably due to inadequate supervision, it showed implausible low mortality rates[8].

Nutritional surveys were conducted in Djibouti and Cameroon; but in both countries UNICEF already described a critical nutritional situation prior to the MSF survey (using similar methodology with better coverage). On the other hand, no nutritional survey was carried out in DRC, even though the problem of food insecurity was detected and no data on malnutrition was available[9].

In addition, all surveys (except Iraq) were conducted after the operational strategy was designed and it is not clear how much the results served to fine tune the already defined strategy. Additionally, it appears that the limited involvement of MSF teams in these surveys results in weak appropriation of the results and limited follow up of the recommendations.

Box 6: Example of DRC (Haut Uele)

Six months after the onset of the crisis in Haut Uélé District in DRC, a two-stage cluster sample survey was carried out in Dungu town (Muller, 2009) and partially (rapid evaluation only) in the town of Doruma. Initially, several rural places hosting large numbers of IDPs were included, but due to security constraints, the survey took place only in Dungu and Doruma towns.

The survey highlighted the widespread violence in the region. In Dungu, between Christmas 2008 and the survey day, the crude mortality rate was 1.9 (95 per cent CI 0.9-2.9). Sixty-five per cent of the deaths were caused by violence. In Doruma, a peak of crude mortality rate of 5.4 persons per 10,000 per day was registered in the period after Christmas. Of all reported deaths, 92 per cent were due to violence.

The survey showed that both host and displaced populations were living in precarious conditions because of violence, theft of cattle and other belongings, destruction of houses, and restricted access to their land. Supplies and assistance from NGOs were insufficient, mainly due to the constraints of working in the area, and water and sanitation conditions were below humanitarian standards. Access to healthcare in Doruma was considered to be relatively good; however fees for consultation and treatment in Dungu represented an important barrier.[10]

Thus the survey provided relevant information but it also demonstrated significant weaknesses. As it was only able to assess the conditions of the population living in the most accessible areas with the highest presence of international actors, it was only representative of a very small proportion of the affected population. It could only provide a snapshot of the rapidly changing environment, and very likely did not capture any "pockets of vulnerability", nor patterns of mortality over time.[11] Moreover, in the absence of additional mortality estimates coming from other surveys or prospective surveillance, these figures are difficult to interpret and provide little information about the magnitude of the crisis, its dynamic and the adequacy of the assistance.

8CMR of 0.14/10 000/day and U5MR of 0.25/10 000/day were reported in the MSF 2nd Quarterly report 2008, Cameroon.

9 Nutritional screening was suggested by Epicentre, but the recommendations were not followed.

10 It appears that the influx of IDPs in Dungu produced stock ruptures to which health centres responded by buying drugs at private pharmacies and by charging patients for their cost.

11 The prospective (real-time) mortality surveillance was not set up in the affected area due to problems of training and supervision of staff because of geographical spread and security constraints.

Quality of assessment determines quality of response

Inappropriate assessments in open settings are more likely to result in wrong decisions being taken on whether to start or not to start an intervention. They might also lead to an inappropriate intervention strategy. The example of Cameroon showed that even an experienced team 'understanding the emergency situation correctly' did not succeed in arguing for an intervention without the presentation of rigorous findings.

DRC / Haut Uélé is a striking example of a mission where a series of assessments has been conducted without finding a clear intervention strategy. Although several factors contributed to the poor response, the evaluation team is convinced that the quality of assessments is an important one. A comprehensive and sound assessment of needs, capacities and vulnerabilities is indispensable for a targeted and effective intervention.

Views of IDPs are gravely omitted

Few of the assessments reviewed (South Africa, and partially Djibouti and Cameroon) systematically included the views and perspectives of displaced or ensured their active participation during the assessment. This was commonly justified by lack of time during the assessment, the priority being put on interviews with key informants, such as community leaders and health personnel. It was also argued that information provided by the displaced tends to be inaccurate, because the problems and needs are often exaggerated in expectation of assistance.

> *Humanitarian organisations see people as victims; assessments are needs focused, capacity analysis is forgotten. We need to understand who are the most vulnerable and what makes them so. A more active role needs to be attributed to the affected population. They should be seen more as active actors, 'primary stake holders' rather than passive beneficiaries.*
>
> *(IFRC, 2008)*

External sources of information are under-used

During the assessments, MSF tends to underestimate the information that can be obtained from other sources. Information already existing in the field (authorities, other actors, etc) is often under-used which leads to duplication of efforts and loss of time during the assessments. As is well known, repetitive assessments lead to assessment fatigue and in some cases might delay the intervention.

Sound assessment provides solid findings

In Cameroon, recommendations of the first assessment proposing a small scale intervention were not followed, probably because of a failure to demonstrate clear emergency needs in the area. This might be due to numerous factors - complexity of the situation with the spread of refugees over a large geographical area, no recognition of the problems of refugees by the authorities, but also because of poor diversity of methods leading to incomplete findings and an assessment focus on security and context analysis. Despite a comparable timeframe, the second assessment provided much more solid results. This is considered to be due to comprehensive methodology mixing quantitative and qualitative methods and involving the refugee population, but also because of better knowledge of the area related to the presence of other actors, recognition of the problems of refugees by the authorities, and better realisation of the needs due to the increased number of refugees.

Poor follow-up leads to critical delays on intervention

More than a year passed between the first and second assessment in Cameroon (see above). A major conclusion drawn from the second assessment was that it was conducted too late and an earlier re-assessment and intervention could have prevented the deterioration of the humanitarian situation (nutritional status and mortality rate).

Strong but very subjective conclusions and recommendations

In many of the initial exploratory missions, the teams seemed to be lead by their common sense and personal experience, while there was an apparent lack of sound methodology.

Consequently, experienced teams present strong conclusions even in the absence of solid findings in written reports.[12] On the other hand, less experienced teams tend to present timid recommendations despite well elaborated findings.[13]

Specific expertise in the assessment team can be a necessity

Most of the assessment can be carried out by 'generalists', who are experienced and skilled in assessment, but with no specific technical background; in some situations the support of other specialists appears necessary. Including an anthropologist in the assessment team in Djibouti or psychologist in DRC would have been beneficial. The involvement of a lawyer in the assessment in South Africa and participation of a psychologist in Djibouti are positive examples.

Lack of frameworks for defining the most vulnerable

Although there is broad consensus that MSF should be aiming to assist the most vulnerable, there is little knowhow and practice of actually defining these groups. A number of lessons can be drawn from the reviewed interventions.

Geographical targeting was considered a good choice in Djibouti. By targeting the poorest areas of the city, MSF today finds that 50% of beneficiaries are migrants. However, little was done to describe the specific vulnerabilities of both populations.

In Iraq, identifying the most vulnerable by a door-to-door survey was time (and resources) consuming. As an alternative, MSF team tried to use an official list of vulnerable families provided by national authorities, however, the team realised that the list did not include the most vulnerable IDPs as it was out-of-date and that some IDPs preferred not to be registered. Accordingly, the team re-started a door-to-door survey. Through the intervention, MSF team discovered specific factors of vulnerability: a) recent IDPs were considerably more vulnerable than 'old' IDPs; b) poor IDPs concentrated in rural areas rather than in big towns (cheaper rent); c) a high number of females living in a household made the household vulnerable because of limited working opportunities for women; and d) female-headed households were particularly vulnerable.

In Pakistan, teams relied on information provided by community leaders. National staff formed small teams to explore the region and identify communities with a large number of displaced and/or the most economically vulnerable.

In South Africa, MSF still reaches only the most visible among the three million Zimbabwean migrants in the country. The teams made major efforts to access the most vulnerable through mobile clinics in typical illegal work places (rural areas) or poor urban neighbourhoods. Still, there is no certainty that the most vulnerable really live in the places identified today.

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12 Example of first assessment in Cameroon, April 2006

13 Example of Bangadi assessment, November 2009

4.4 Discussion/ Conclusions

Use of existing tools possible, assessment frame to be tailored to specific context

Even though none of the internal assessment tools reviewed is specifically designed for displacement in open setting, all of them - with some limitations - can be applicable in open settings. The best suited assessment tool appears *MSF-H Manual for the assessment of Health and Humanitarian Emergencies*. This comprehensive and self explanatory guideline presents a wide range of qualitative and quantitative methods and gives space for adaptation to various contexts.

Assessment in open setting needs to remain flexible for the many different situations. Appropriate methodology needs to be selected according to the context, giving maximum consideration to:

- Type of displacement, urgency of the situation and existing constraints (time, access, security)
- Good diversification and complementary use of quantitative and qualitative methods, allowing cross-checking (triangulation) of information from different sources
- Systematic use of qualitative methods, which are more suitable for identifying particular vulnerability
- Alternative methods to sample surveys in order to collect quantitative data
- Population perceived needs to be represented
- More rigor in the methodology and better/standardised reporting to allow the comparison with previous assessments
- Continual assessment to detect the changes quickly and adapt intervention accordingly

Continual assessment is a necessity

Currently used MSF guidelines, are focusing on initial assessment, which is assumed to be followed by prospective surveillance and monitoring. However, as observed in reviewed case studies, - with the humanitarian situation considerably changing over time - multiple assessments are carried out and actual intervention is often delaying.

In order to quickly adapt intervention to changes, and also rationalise the information collected, it is suggested to adopt the concept of *continual assessment*. Within an intervention area, prospective surveillance (community based and through health structures) should be systematically implemented and be seen as integral of such assessment. Additionally, continual assessment will cover the new sites of displacement as they appear. Existing local networks should be used or – if not possible - new ones established to feed information into the continual assessment. This has partially been done in some of the projects, but clearer objectives and better feed-back into project planning is needed. These networks must be representative of the entire population they serve[14].

Teams specifically devoted to assessment might be needed in constantly changing environments. In order to optimize resources and maximize impact, based on example of PUC and PUB in DRC[15], such assessment & rapid response teams could play a key role in continual assessment.

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14 In DRC and Djibouti, CHW were only from non displaced population.

15 PUC: Emergency pool Congo (OCB), PUB: emergency pool Bunia (OCG) with a key objective of rapid assessment and short term intervention during various emergency situations

Health system, barriers of access and health seeking behaviour must be explored

In emergencies presenting as acute and/or camp-like situations in which standard sets of internationally accepted indicators (MSF/Epicentre, 2006) may be applied, the process between the assessment and intervention is quite straightforward, as tools and strategies are available and can be implemented immediately, even with a minimum of information available. In these situations even poor findings of initial exploratory mission will have little effect on the quality of the intervention. It can be rapidly informed/corrected by a rapid health assessment (which remains of key importance in these situations) or by operational updates provided by the teams present in the field.

In none of the reviewed cases such a straightforward assessment to intervention process appeared either feasible or appropriate. In all these situations, displaced settled in environment with some existing resources and to different extent functioning health system. In these circumstances, in addition to needs assessment, it is essential to evaluate the performance of such system and explore the patterns of health seeking behaviour and main barriers of access in order to decide the best suited medical strategy. While such assessment efforts are important to define intervention strategies, they must not delay response to apparent emergency needs.

Need for better understanding of vulnerability, capacity and coping

Today, MSF is paying little attention in to the concepts of vulnerability, capacity and coping. The evaluators argue that a thorough assessment including these concepts is of crucial importance. Particularly where situations of displacement in open setting present as prolonged crises with blurred distinction between emergency and post-emergency phase. It is essential to understand the extent to which adopted coping strategies cover the needs. Such will allow to decide on meaningful intervention strategies (present and future), taking into consideration that the coping strategies tend to diminish in prolonged crises.

More systematic use of qualitative assessment methods is required to understand the diverse vulnerabilities and needs. A participative approach including both displaced and host population should be privileged. MSF needs to actively consult the people affected, talk to the communities and actively seek out marginalized groups to ensure that their interests are taken into account. Concepts of vulnerability, capacity and coping go beyond the current MSF expertise. It is suggested to consult external sources familiar with these subjects, such as IFRC or IDMC.

> *The nature of hosting transmits vulnerability from displaced to host.*
>
> *(McDowell,2008)*

Use of rapid health assessments and surveys in open setting calls for revision

Although both qualitative and quantitative methods are recommended and used for initial assessments, quantitative information still has a much higher credibility in MSF. There was an almost systematic use of community sample surveys and little attention/credibility paid to qualitative information. The availability of reliable quantitative data is often poor in open setting, especially in the beginning of the crisis. Assessment teams experienced difficulties in obtaining simple quantitative data – e.g. on population size and structure, on mortality or quantification of vital needs.

In absence of reliable quantitative data, community sample surveys were carried out at later stage of the projects. Even though technical expertise was provided by EPICENTRE or experienced epidemiologist, some limitations were observed while using surveys in open settings (see the following chapter on mortality).

Evaluators argue that the use of RHA and surveys in open setting calls for revision. In reviewed interventions, an initial RHA was rarely performed and the surveys were done at

later stages, following general assessments, when the intervention strategy had already been defined. The results of the surveys were used for lobbying purposes (Cameroon), convincing MSF teams about the needs (Djibouti, DRC) or identification of target population for NFI distribution (Iraq).

Assessment teams need to be trained to perform RHA using simpler methods in situations when epidemiological expertise is not available and/or sample surveys do not seem appropriate. Such training needs to address the estimation of population figures and mapping using methods adapted to dispersed populations and urban settings, such as remote sensing.

Difficult use of mortality as prime indicator in open settings

In the situations with displacement of population, crude and under-5 mortalities (CMR, U5MR) are considered the key indicators to evaluate the magnitude of a crisis[16]and the effectiveness of the humanitarian response. From the six interventions reviewed only in Cameroun mortality was assessed retrospectively and prospective surveillance implemented. This may be partly explained by insufficient resources allocated, but also by the general difficulties to measure and interpret mortality rates (MR) in open settings.

There are two principal methods for measuring mortality in a population: a) retrospective surveys which provide baseline information and b) prospective surveillance which monitors trends. Even though surveys can be carried out in any situation, conducting them in extremely difficult/dangerous situations has limitations (and consequently leads to biases and imprecision) (WHO, 2009). In general, surveys are prone to sampling biases (population sampled smaller than target population due inaccessibility, outdated or imprecise population figures, bad sampling design, high non respondent rates), and to sample imprecision (inadequate sample size, design effect due to cluster sampling) (Checchi/ Roberts, 2005). Additionally, retrospective mortality surveys are prone to important response biases due to inaccurate date recall, poor questionnaire design and intentional misreporting of deaths due to fear, stigma or expectation of assistance. In reviewed surveys, the main limitations observed were the sampling shortcomings related to insecurity and inaccessibility.

Due to rapidly changing character of observed interventions, a one-off mortality survey might provide varying results depending on the timing it is performed. Such results are of little value in absence of prospective mortality surveillance to able to detect trends of mortality over time. As has been argued elsewhere, the prospective mortality surveillance is appropriate mostly for camp-dwelling or regimented populations as it needs a regular epidemiological supervision and its quality may not be sustainable over many months (Checchi/ Roberts, 2005).

In chronic crises (as open settings often represent), mortality rates of near-normal levels can gradually rise overtime or display peaks due to epidemics, exhausted livelihoods, collapsed health system, new waves of displacement and isolation from relief providers. Consequently, as the impact of an elevated CMR depends not only on its magnitude, but also on its duration and on the size of the population experiencing, such often-neglected crises can become as deadly as acute emergencies (Checchi/ Roberts, 2005). However, this was not demonstrated in reviewed interventions as the excess death toll was impossible to estimate in absence of baseline mortality data and of information on mortality trend.

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16 Doubling of non-crisis (baseline) mortality is taken to define an emergency situation. Baseline, non-crisis CMRs in most of Sub-Sub-Saharan Africa are in the range 0.3-0.6 per 10 000 per day, with a probable current average of 0.44. Based on this, in 1990 Tool and Waldman suggested an approximate doubling of CMR (to 1 per 10 000 per day) as a useful threshold for formally declaring an emergency, at least from a health standpoint.

Interpretation of MR might be problematic when they are close to emergency threshold, which is commonly seen in open setting, as higher precision is needed[17] compared to situation displaying high MR where achieving a very good precision is not essential.

It is argued that in prolonged situations using an emergency threshold to benchmark the crisis might not be appropriate as these shows often only moderate elevation of mortality, but protracted and over a large population. Here, the excess death tolls might better reflect the magnitude of the crisis while evolution of mortality rates might reflect the trend (Salama/ Spiegel/ Talley/ Waldman, 2004)
.
Based on reviewed case studies and arguments from the literature, the evaluators conclude that using mortality as prime indicator to evaluate magnitude of the crisis and adequacy of assistance in situations with displacement in open setting is difficult. It will be essential to search for alternative ways to measure and monitor mortality, and to identify and use alternative indicators (e.g. food security, access to health care and other basic needs, etc) in order to best judge the magnitude and evolution of crises when measurement of mortality is unpractical.

A community-based network could play a key role in a mortality surveillance system, in order to monitor the evolution of a crisis, however considerable simplification of indicators to be collected and continuous effort of supervision would be needed

When conducting the mortality surveys, an expertise should be guaranteed to overcome methodological challenges. Epicentre or other agencies experienced with the subject could be approached to discuss the recommended best practices and potential area of research.

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17 For example, assuming a recall period of six months and cluster sampling with design effect of 2.0, classifying a CMR of 1.1. per 10 000 per day as being unequivocally above the emergency threshold would require a precision of +/-0.1 per 10 000 per day (that is, a lower 95%CI bound not bellow 1.0), namely a sample of 46 953 households.

5 INTERVENTION STRATEGIES

> *Present priorities and practices for healthcare provision in conflict settings are still broadly based on a model of humanitarian relief that was developed during the last two decades of the Cold War, when conflict was synonymous with overcrowded refugee camps sheltering young populations from developing countries.*
>
> *(Spiegel et al, 2010)*

MSF's ambition in an emergency intervention is to make a solid impact in terms of decreased mortality. As health services (if they exist) are often overwhelmed or have deteriorated because of the crisis, it is common to run a parallel healthcare system. Priority is usually given to curative care of acute conditions and to prevention, detection and rapid response to disease outbreaks.

In comparison to camp-like situations, the need to engage with the existing healthcare system is much greater in open settings. The establishment of parallel health systems has the potential to raise equity issues between host and displaced populations, and to undermine quality and sustainability of healthcare provision (Rowley/ Burnham/ Drabe, 2006).

This chapter starts with an overview on MSF internal intervention tools as well as external guidelines and policies. Findings on interventions from the reviewed case studies are described and conclusions on those follow.

5.1 MSF intervention tools

The intervention guides listed below were reviewed during the evaluation process:

  I.   Refugee Health: An Approach to Emergency Situations, MSF,1997
  II. Organisation and Supervision of Outreach Programmes, MSF-Holland, 2009
  III. The Priorities (Checklists, Indicators, Standards): Displacement situations, OCB, 2009
  IV. Nutrition: Displacement situations , OCB, 2007
  V.   Shelter: Displacement situations , OCB, 2006
  VI. Measles vaccination: Displacement situations, OCB, 2006
  VII. Care for Victims of Sexual Violence: Displacement situations, OCB, 2007
 VIII. Non Food Items Distribution, Emergencies IDPs/Refugees and Natural Disasters, OCB, 2009

The review focused on the intervention strategies presented, and their use and applicability in the case studies on displacement in open settings included in this evaluation. Internally, *Refugee Health* remains the key reference for displacement situations. OCB has published a more updated version in the form of the 'pocket guidelines (IV-VIII)'..

- Refugee Health is based on MSF's experience in refugee programmes. It deals with healthcare during the emergency phase of a refugee crisis, when priority is given to action that aims to prevent or reduce excess mortality. These intervention priorities have been labelled 'The Top Ten Priorities.' One separate chapter briefly addresses the post-emergency phase. It focuses on policies rather than on practical aspects, and is meant as a guide for decision-makers.

- The medical intervention strategy presented in Refugee Health is based on the objective to reduce excess mortality and morbidity in the refugee population by ensuring appropriate medical care for all refugees and responding to epidemics.

- The 'four levels healthcare model'18 (from community health workers to the referral hospital) is suggested as the most suitable to fulfil the above mentioned objective. The main focus is on curative services (early diagnosis and treatment of the main killers such as malaria, acute respiratory infections, diarrhoea and measles with malnutrition often acting as an aggravating factor). The referral flow of patients between the services is essential (see chart 1 below).

Chart 1: Camp services and the referral flow of patients (MSF, 1997)

HC:	health centre
OPD:	Out- patient Dpt.
IPD:	In-patient Dpt.
HP:	Health post
HV:	Home visitor
FC:	Feeding centre
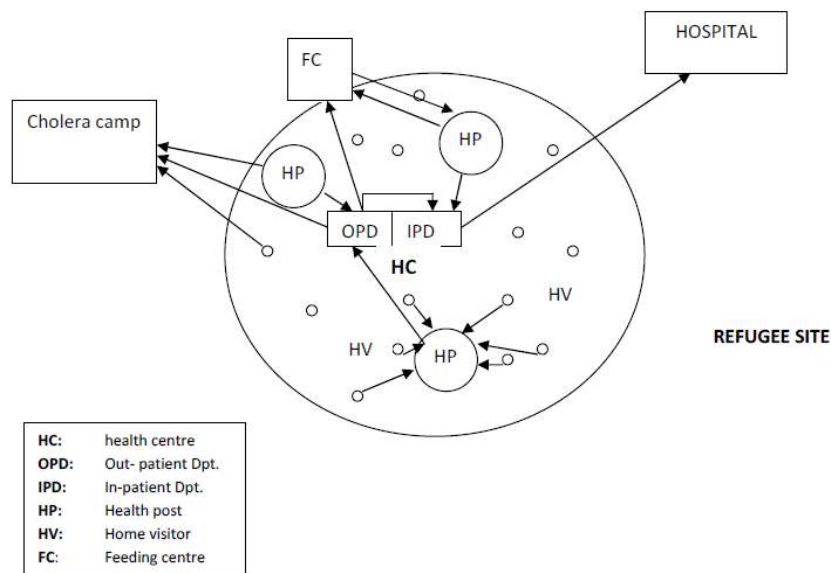
A brief synopsis of the MSF guidelines reviewed is provided here; several tools have already been described in the Assessments chapter (see page 20).

- *Organisation and Supervision of Outreach Programmes* is a revised guideline designed for project coordinators, medical coordinators and outreach work supervisors to be used as practical reference for decision making and implementation of outreach programmes in different settings. It offers guidance, suggestions and examples related to the most important *aspects* of outreach programmes and aims to cover the principles of organisation and supervision of outreach programmes depending on the context setting and priorities of the project.

- *The priorities* presents checklists and indicators related to the Top Ten priorities and introduces five additional priorities: 11. Security, 12. Mental Health, 13. Protection, 14. Temoignage, 15. Proximity.

- *Nutrition, Shelter, Measles Vaccination, Care for Victims of Sexual Violence and Non Food Items Distributions in Displacement Situations* are the pockets guides developed by OCB, based on the model of a 'quick start manual'. They are part of a series covering activities to be implemented in the first phase of an emergency (zero to three months).

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[18] 4 Level health care system: 1. Home visitors 2. Health post 3. Health centre 4. Hospital.

5.2 External intervention guidelines and policies

In terms of policies and guidelines, a wealth of literature has recently been developed on the issue of urban contexts, and urban IDPs and refugees, with UNHCR taking the lead on this. Of particular interest is the review of UNHCR interventions for the Iraqi refugees in urban areas of Jordan, Lebanon and Syria. Linked to this review are the new UNHCR guidelines: *Designing Appropriate Interventions in Urban Settings*.

- UNHCR's general position is that camps should be a last resort where there is no other choice, that aid should be provided in ways that take into account the living standards of surrounding communities, and that responses to host families should be improved. UNHCR's ambition is to distribute aid more according to the criterion of vulnerability than simply the status of being displaced per se. UNHCR has recently set up a unit called AGDM – Age, Gender and Diversity Mainstreaming – to better deal with protection and assistance to vulnerable groups (Riera, 2010). UNICEF takes a similar position, aiming to strengthen traditional coping mechanisms.

- ALNAP developed some guidance on responding to urban disasters, although these do not specifically focus on IDPs, but on disaster relief in cities. It includes interesting sections on comprehensive needs and vulnerabilities assessment; effective coordination and partnership and communication; engagement and participation of local actors, shelter options.

- *Public Health Equity in Refugee and other Displaced Persons Settings* (UNHCR, 2010) explores key questions of cost and equity in the context of health services in those settings. It frames major operational questions that need to be addressed including the status of healthcare delivery, allocation of resources and strategies for transition and exit.

- *Public Health in Crisis-Affected Populations* is a practical guide for decision-makers commissioned and published by Humanitarian Practice Network (HPN) and the Overseas Development Institute (HPN, 2007) dealing with risks to health inherent in crises, and the potential impact of health interventions. Among five crisis conditions elaborated it deals with displacement into neighbouring host communities. Examples include Lebanese IDPs during the 2006 Israel-Hezbollah war, and Sri Lankans displaced by recent fighting.

- The Norwegian Refugee Council (NRC), together with others (including MSF), is in the process of finalizing guidelines entitled: Assistance in Urban Areas to Populations Affected by Humanitarian Crises. The particular focus of this is on shelter.

- The ICRC's humanitarian response is guided by the degree of vulnerability and the essential needs of all people affected by armed conflict and violence – including IDPs (International Review of Red Cross, 2009).

- Oxfam's policy considers expanded and more targeted responses to assist host families, including livelihoods interventions. At the programme level, a recent study suggests that livelihoods interventions, such as cash transfers, cash for work, vouchers, increasing market access and emergency micro-credit could play an important role in helping host families and IDPs to survive (Oxfam International Research Report, 2008).

- In a recent Lancet article (January 23, pp 341–345) Paul Spiegel and colleagues indicate changing trends on healthcare needs of people affected by conflict. To assist with orientation of future health strategies, policies, and interventions, the authors

propose a matrix of three types of settings (camp-like, urban, rural-dispersed) and two income and life-expectancies (low and medium to high, see Annex 8). Based on this framework, they provide recommendations for future policies and practice in four key areas: i) Delivery of health services to inaccessible conflict-affected people; ii) Address chronic diseases in conflicts; iii) Improve health services for conflict-affected people in urban areas; and iv) Changes *in surveillance, assessment, and monitoring or conflict-affected populations.*

Such proposals are very much in line with current discussions within MSF on implementation of innovative strategies through the massive delivery of preventive packages and also with the recommendations of this evaluation on possible intervention strategies.

5.3 Findings on intervention strategies

To assess the appropriateness of intervention strategies, the evaluation team reviewed interventions in terms of MSF guidelines and standards (in particular the *Top Ten Priorities* in emergency situations), as well as the specific programme objectives.

After revision of all case studies, the applied intervention strategies were categorised into four global approaches:

   i)   Emergency medical relief through MSF facilities (outreach, mobile or fixed), including measles vaccination, nutrition care and mental health.
   ii) Engagement with existing health system (light support or facilitation of access to existing health facilities).
   iii) Provision of non medical assistance (food, shelter, WatSan, NFI….).
   iv) Advocacy for better assistance (UN, NGOs, governments) and protection (from violence and abuse and concerning legal status).

The interventions reviewed are described in part II. The following chapter contains issues observed in regards to appropriateness of intervention strategies. The findings are structured as follows: i) Engagement with the existing health system; ii) Emergency medical relief; iii) Non-medical assistance; and iv) Others. The chapter ends with other examples of good practice in intervention strategies.

5.3.1   Findings related to engagement with the existing health system

Engagement with existing health system is a major challenge

 Compared to camp situations, where setting up (temporary) parallel structures is a more common choice, there is a stronger tendency to engage with the existing healthcare system in open settings. In all the reviewed interventions, MSF chose to work through the existing healthcare system. Such engagement – at the minimum – may mean facilitation of access to existing services and – at the maximum – autonomous management of some health facilities /departments. The evaluators refer to 'autonomous management' when the activities are run by MSF staff and under full MSF supervision. 'Light support' implies supply of drugs and materials, with limited or irregular presence of MSF staff (mainly for training and supervision). The facilitation of access to existing health facilities implies assistance with administrative constraints or subsidising user fees.

'Light support' was the choice of engagement in DRC, Cameroon and Djibouti. In DRC, MSF was reluctant to get involved again with the provision of health care in Dungu hospital as they had just withdrawn one year earlier after seven years of work in the same health facility. The problem of working with a system based on cost-sharing, without scope for removing fees where necessary, is a particular challenge in Djibouti.

Djibouti is the only intervention reviewed where MSF set up its own healthcare facility: a therapeutic feeding centre (TFC). This can be justified as a temporary solution, given the high level of acute malnutrition which is not sufficiently addressed in Ministry of Health (MoH) structures.

Cost recovery was a major obstacle for MSF in Djibouti. Even though exemption from healthcare costs theoretically exists, illegal migrants and urban poor often don't have the necessary papers to benefit from free of charge care. Generally, MSF is reluctant to pay for patients. However in this context there seems to be no alternative to paying, while lobbying for free care remains unsuccessful.

In Dungu (DRC, Haut Uélé) MSF decided to take responsibility for the surgical activities, while providing only light support to the paediatric ward. The provision of free of charge care for paediatrics and surgery fulfilled the objective to overcome the financial barrier to healthcare. However, the fact that MSF supports only half of the hospital has created confusion in the community and not many people (in particular not many IDPs) are aware that paediatrics and surgery healthcare is free of charge.

The focus on surgery seemed arbitrary as the costs of care in the maternity and internal medicine wards were unaffordable to a large part of the population and the surgical activity was dominated by elective surgery, with only a small proportion of conflict-related interventions.[19] While the support to surgery is not questioned as such, deployment of a full MSF surgical team seems disproportionate to the resources allocated to cover the needs in other services. It is also unclear on what arguments the decision to stop support to Dungu hospital was based, as the humanitarian situation has not changed and there is today an extra burden of 20,000 people.

In Cameroon, MSF attempted to improve the quality of management of acute malnutrition with one MSF medical doctor deployed to support the MoH hospital doctor during the rounds twice a week and to discuss follow-up of MSF's patient transfers to the hospital (mainly refugees but also local people who came to the mobile clinics). However, collaboration with the hospital staff was difficult, as there was no MSF presence on a daily basis. As the mortality of patients with acute malnutrition was above the acceptable level, it is believed that more effort could have been made to negotiate MSF involvement in the management of malnutrition at the hospital level, which is the main referral structure used by MSF's nutritional mobile clinics.

Entry and exit criteria were not identified in any of the reviewed cases – except Pakistan – which further complicates the issue.

→**Good practice:** Short term coverage of the extra burden put on the healthcare system

In Pakistan, temporary support was provided with clear objectives. MSF set up an additional emergency unit in Mardan public hospital, receiving all the patients requiring intensive medical care. The public capacity of the public hospital could be significantly strengthened with these essential services during the displacement crises. The unit ran for four months until the displaced people returned home.

In South Africa and Iraq, healthcare was ensured through referrals and facilitating access to existing health facilities. In both cases, advocacy was used successfully to guarantee free access to healthcare.

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[19] In Dungu hospital, out of 300 surgical interventions performed between June and September 2009, only 22 (7%) of interventions were related to violence.

In Iraq, MSF restricted its own role to thoroughly assessing the health needs and facilitating access to healthcare without much direct implementation of healthcare (except some mobile clinics providing mental health). This seems an appropriate choice in a context where health services exist.

'Light support' enables primary healthcare facilities to cope with 'excess' patient burden

In Cameroon, MSF's involvement in existing primary health facilities remained limited. Even though there were a series of quality concerns, it is suggested that after the emergency phase, more support to the existing health facilities (even if only through drug supply and training) could have been more effective than running a parallel system with mobile clinics. In DRC, the choice for primary healthcare facilities to be supported by MSF was appropriate in terms of the geography of the region (clinics were well situated in areas where there were large concentrations of people). However no attention was paid to the fact that services provided there were neither accepted nor used by IDPs for various reasons.[20]

The observed practice of involvement in existing primary health facilities (Cameroon, DRC and Pakistan), mainly through drug supply, training and limited supervision, seems an appropriate choice in order to allow uninterrupted functioning of existing services. It allows the existing system to cope with the excess burden of patients and the disruption caused by conflict and displacement.

5.3.2   Findings related to emergency medical relief

Classical 'emergency medical relief' is rarely seen in reviewed interventions

'Medical relief' refers to activities implemented in the emergency phase of a crisis, aiming at rapid decrease of morbidity and mortality rates. Such activities are based on the *Top Ten Priorities* and are often run in parallel with existing health systems.

In projects reviewed, various medical and non medical relief activities were carried out during peaks of acuteness, such as direct provision of medical care through mobile clinics, mass measles vaccination, WATSAN activities, limited support to shelter and NFI distributions. The effectiveness of these activities are impossible to evaluate as only in Cameroon, the objectives were formulated as to decrease mortality and morbidity rates (due to acute malnutrition). The other interventions presented the objectives only in terms of provision medical and non medical assistance without aiming to achieve measurable impact on morbidity and mortality rates. This might be due to lack of reliable baseline data in most of the projects and absence of prospective surveillance system to measure the trends.

Changing priorities of vaccination in open settings

Measles vaccination was carried out in two out of the six reviewed projects (Cameroon and DRC). Unlike in camp settings, where measles vaccination is a first priority and needs to be implemented in the first few days, in both projects vaccination was carried out after several weeks. In four interventions, no vaccination was performed at all; there was no measles outbreak in any of these situations. Although sufficient vaccination coverage remains highly relevant, the different living conditions in (most) open settings suggest that mass measles

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[20] As stated repeatedly in interviews, Namboli health centre has a very bad reputation among the IDPs. The perception is that the people do not get better after a visit to the health centre.

vaccination may no longer be systematically a first priority. If a campaign is deemed necessary, it may be used as an opportunity for implementing a more comprehensive preventive healthcare package (other vaccines, bed net distribution, etc.)

Nutrition programmes are well implemented, but defaulter rates are high

The decentralised approach to nutrition management currently in use allowed easy implementation of nutrition activities in all concerned projects. Nutrition was a strong component of the programmes and it provides an example of comprehensive management on all levels. Even in the complex context of DRC, nutrition is the best managed part of the programme. What remains a challenge is how to hand over MSF-designed nutrition programmes when there is no national programme for nutrition.

However, high defaulter rates remain a major problem, e.g. in Djibouti and Cameroon. In Cameroon, this was mainly due to long distances to treatment facilities and the nomadic lifestyle of the displaced population. In Djibouti, intra-urban mobility was a major challenge for follow–up care. So far, no strategies have been developed to deal with country-specific problems and bring down defaulter rates.

Mental health support: willingness, but lack of capacity

Despite an increasing awareness of mental health needs and a (rather) new MSF 'reflex' to implement related activities, MSF did not demonstrate the capacity to fully assume this activity in any of the evaluated programmes.

In Dungu (DRC), mental health was a priority from the beginning of the programme, but a proper set-up of psychological care failed to materialise mainly due to lack of specific capacities. The MSF expatriate psychologist was supposed to provide supervision and adequate response to more complicated cases. However, no psychologist was present for most of the project period. The volume of activity is rather small (three cases of rape per month and 20 cases of other type of violence per month). The collaboration with other actors, who provide psychological and medical support, is not very efficient. The added value of MSF provision of psychological care for victims of violence in Dungu town is questionable with other actors present and no medical care provided by MSF to sexual and gender based violence (SGBV) cases (usually a strong area of MSF care provision).

In Iraq, attempts to establish a mental health programme were made, but activities could not be supervised and progress has been limited. In Pakistan, OCP planned mental health activities, but never found the resources necessary to implement them.

Efficacy of mobile clinics depends on phase of emergency

The use of mobile clinics was a common medical strategy in all reviewed projects except Djibouti, where mobile clinics were not accepted by the authorities. The specific objectives behind using mobile clinics varied between the interventions and between different phases of intervention.

In the early stages of an intervention, mobile clinics were mainly used for monitoring purposes (DRC, Cameroon, Pakistan), aiming at providing an overview of the humanitarian situation, rather than at medical impact. In later stages, more regular but geographically restricted, semi-fixed mobile clinics were set up. In addition to general healthcare, the additional focus was on management of acute malnutrition (Cameroon), on voluntary counselling and testing (South Africa) and on mental health (Iraq).

In South Africa, the choice for a mobile strategy was based on the desire of migrants to stay invisible (hence locations and timing of mobile clinics was deliberately irregular). Later on, mobile clinics were still considered necessary, as the cost of frequent travel to existing centres for voluntary counselling and testing was unaffordable for many patients.[21]

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[21] It was assumed that once people who had tested positively were accepted into the public system, they would be able to afford occasional travel to the health clinic.

In Cameroon, mobile clinics specifically dedicated to acute malnutrition were appropriate to decrease high mortality rates rapidly. However, once the target was achieved (after a few weeks), integration of the nutrition services into existing health facilities would have been more appropriate.

In DRC, the choice of locations for regular mobile clinics seems logical considering the high concentration of IDPs in places with no existing health facilities. However, security constraints led to irregularity and eventually closing of the mobile clinics. The overall impact of the mobile clinics was therefore limited.

In Iraq, the mobile strategy allowed active case finding and follow-up of mental health patients that would probably not seek assistance in the MoH Mental Health unit.

→ **Good practice:** Gaining proximity to target population through mobile activities

In Cameroon, a high level of interaction and proximity with the target population was reached through extensive (mobile) monitoring activities, a network of community health workers and frequent interviews with diverse refugee groups. Information collected provided a good overview of the humanitarian situation in the area, and was mainly used for lobbying purposes. The proximity to the displaced population was rewarding for the team and contributed to a high motivation throughout the intervention (which was highly demanding).

Outreach worker invaluable, but set-up can be improved

Despite its potential – especially in open settings – it is obvious that there is little attention given to outreach programmes compared to the management of hospitals, for example. There also seems to be little awareness on proper set-up and a lack of knowledge about existing tools (e.g. OCA - Community Health Workers (CHW) guidelines).

In Djibouti, recruitment of community nutritional assistants was a very appropriate strategy to create links with the community, however as the assistants were only selected from among the local population, while 50 per cent of the beneficiaries are foreigners, representation of the target population is poor.

In DRC, MSF provides limited support to 30 MoH CHWs in Dungu town (5 USD/month, training, supervision). As well as their usual MoH activities, the main objective of the CHWs set by MSF is to inform the community about MSF activities, provide health education and nutritional screening. The use of CHWs seems a very good strategy for this type of situation; nevertheless, several problems were identified in Dungu.

It seems that the expectation for CHWs to carry out emergency relief was clearly overambitious. The OCA-CHW guidelines makes a clear distinction between emergency outreach and outreach connected to basic healthcare programmes. As proposed in the outreach guidelines, outreach workers should be paid for emergency work and managed separately from any existing system. Remuneration is considered best practice.

Box 7: Problems observed with community health workers in DRC/Dungu

- Lack of motivation of CHWs due to limited financial support by MSF.
- CHWs from local population only (not displaced population).
- The same CHWs work for MoH/MEDAIR and Mercy Corps, and have limited time for MSF.
- Poor exchange between CHWs and MSF staff; No planning of CHWs activities.
- Limited number of referrals (people refuse referrals as they need to pay for care in the hospital).
- No supervision of CHWs in the community; only one supervisor for 30 CHWs.
- Supervision of activities without clear directives and objectives.
- CHWs not visible in the IDP community (none of the IDPs interviewed knew the CHWs).
- Health education not adapted to resources available, e.g. promotion of use of bed nets, but no bed nets.
- No prospective mortality follow-up.

5.3.3 Findings on non-medical assistance

Non-medical assistance was marginal in reviewed projects, however the following observations could be made:

Objectives for NFI distribution unclear

For most of the projects it was impossible to evaluate the appropriateness of strategies regarding NFI, as neither objectives nor targets or outputs were clearly described in the proposal and project reports. As one MSF staff put it: 'We do NFI or shelter if we don't know what else to do.'

The exception was Iraq, where distribution of NFI was the main strategy to reduce the impact of the cold winter. This was based on the needs identified during the initial assessment, however unfortunately implementation was delayed and therefore the impact was reduced.

In Cameroon, Pakistan and DRC, some NFI distributions followed needs assessments. However, the criteria for these distributions were not clear to the evaluators. Cameroon provides a good example in the sense that MSF monitored the needs in the NFI sector and lobbied when important gaps were observed (this would have been relevant for DRC/Dungu as well).

In DRC, the evaluators observed that IDPs left plastic sheeting as well as NFI kits (water containers, cooking sets, blankets, bed nets, etc.) to their host families when they relocated, so new needs emerged with changes in the IDP situation. However, the MSF team was unaware of such changes and did not respond.

Minimum standards for water sanitation and shelter not applicable to open settings

The strategies observed did not follow the standards outlines by the *Top Ten Priorities*. However as many suggest, these standards are not applicable to open settings. Evaluators lack necessary expertise to elaborate further on this issue.

Regarding water sanitation (WatSan), the most extensive activities were carried out in Pakistan - external protection of some water sources, chlorine tablets/water purifier sachet distribution, construction of toilets/bathrooms for IDPs living in a newly constructed market, water trucking during acute shortages. These were appropriate actions considering the risk of cholera in an endemic area.

Other interventions only included fragmented activities: in Cameroon, MSF provided maintenance of boreholes, construction of protected wells and rehabilitation of water sources. In South Africa, MSF supported small shelters run by faith organisations through the provision of showers, toilets and setting up water distribution points.

In Iraq, the assessment revealed problems related to shelter and proposed to assist IDPs with roofing. However this was not followed up. Apart from distributing plastic sheeting together with other NFIs, MSF did not get involved with shelter in any of the interventions.

During the evaluators' visits to DRC and Djibouti, acute problems related to shelters were observed in both locations. In Dungu, after the separation of IDPs from host families, some IDPs lived in extremely 'sub-standard' huts lacking protection from rain and vectors.

Food: describing the situation and lobbying are a minimum requirement

MSF's policy states that describing a situation and lobbying are minimum requirements in any intervention.

In Cameroon, this ambition was fulfilled, and in addition a temporary blanket food distribution was carried out by MSF. The main purpose was to cover the gap before the World Food Program (WFP) set up a general food distribution. Covering emergency needs appeared to be a good strategy and it appeared to increase MSF's credibility for lobbying towards WFP to take responsibility for the food situation.

5.3.4 Other findings

Overambitious targets or under-response?

In Cameroon, DRC and Djibouti, initial coverage targets were not reached for various reasons. No numbered targets were set in South Africa and Pakistan.

In Cameroon, coverage of regular activities (nutrition mobile clinics) was quite limited (15% of target population); however the coverage of monitoring activities was considerably larger and the majority of refugees was accessed at least once for assessment and nutritional screening.

In Djibouti, a nutritional survey conducted by MSF in July 2009 showed that only a small proportion of malnourished children were included in the nutritional programme.[22] The target – to assist a population of 10,000 refugees and 100,000 migrants – has not been met so far.

In DRC, MSF provides assistance to one fifth of the target population of 100,000 IDPs in Dungu territory; the refugees receiving assistance are based in Dungu town.

MSF managed to survey 8,362 IDP households (44%) of an estimated 19,033 IDP households in Dohuk governorate in Iraq. Forty per cent of the 3,320 IDP households surveyed received NFI kits, indicating reasonable coverage of the beneficiary population.

The underestimation of complexity in open settings leads to overambitious targeting. As a result OCG, in DRC/Haut Uele region, considered for too long they could cover the needs without the OCB emergency teams, who had offered to come and assist.

Strategy adapted to the level of emergency

Cameroon is one example where the initial intervention strategy was appropriate for the emergency phase. Specific mobile clinics for treating acute malnutrition resulted in reduced excess mortality and emergency objectives were rapidly achieved within a few weeks.

Once mortality was reduced below emergency level (post-emergency), the mobile clinics lost their relevance. Here, the support to existing health facilities seems more appropriate than continuing to run a parallel (emergency) system, as happened for a total of 18 months (see Annex 9.)

More complex objectives (management of Konzo[23], WatSan) were added in later stages of the intervention. It is not clear how these were linked to the initial reasons for intervention. Committing to this longer term engagement should have been accompanied by a re-evaluation of needs, new targets and adaptation of the intervention strategy.

At the start of the interventions in DRC the level of emergency was basically unknown, despite the clear findings of the initial assessment. Given the constantly changing needs and the magnitude of the crisis (in addition to the fact that MSF has previous experience in the region), strategies were decided upon using the limited opportunities for access on the assumption that the crisis would be short-lived.

The intervention strategies changed many times, presenting real difficulties in finding a workable way to overcome the problem of access.

MSF tried to go everywhere with mobile clinics, and assess the area at the same time. Because of the inefficiency of such an approach it was decided to concentrate on a few places (well chosen locations for healthcare support and mobile clinics). This strategy would have been good if continuity could have been assured, but it had to be stopped due to the security situation.

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22 13 out of 101 (13%) acutely malnourished children identified during the survey were included in the nutritional programme.

23 Epidemic paralytic condition believed to be linked to consumption of unsufficiently processed bitter cassava

This example illustrates the dichotomy between the desire to provide quality care and the impossibility of doing so when needs are so widespread and access is compromised.

Recruitment of health workers from host but not displaced population

In Djibouti, as well as in DRC, MSF staff are from the host community only. This clearly limits MSF's understanding of the displaced (needs, changes in the situation, power structures, information flow). The fact that members of displaced communities are not systematically recruited and included in assessments is a missed opportunity and lowers the acceptance of MSF by the displaced population.

South Africa is a good example of migrants/refugees being actively recruited into the MSF team, which is of great benefit to the programme. In Cameroon, the team managed to get close to the displaced communities not least because of good interaction with CHWs coming from the refugee communities.

5.3.5 Good practice examples on intervention strategies

→**Good practice:** Accessing the invisible with innovation and flexibility

Invisibility of migrants is a major challenge in South Africa and the OCB team has adapted their approach accordingly by: i) using small teams, who are less visible, and including people from Zimbabwe; ii) using a strategy adapted to the changes in legal status of refugees, i.e. moving the focus from formerly 'invisible ' to 'newly arrived' migrants; iii) identifying 'areas of high migrant concentration' (eg. church, bus stations, derelict buildings; and iv) adapting the MSF clinic opening hours to the needs of the people, such as evenings hours for those working during the day.

→**Good practice:** Dealing with chronic diseases

The prevalence of HIV and TB in Zimbabwe(and South Africa) is high. The challenge was how to design services for a highly mobile and partly invisible population. OCB made major efforts and used innovative approaches to reach those populations. Despite the complex challenges, the project achieved significant progress towards free access to healthcare.

→**Good practice:** Assuring access to healthcare for refugees and displaced

Between 1990 and 1996, some 500,000 refugees from Liberia and Sierra Leone arrived in the Forest region of Guinea (Van Damme, 1995). Most settled among the host population, <20% in refugee camps (Van Damme, 1999). The basic reaction of the Forest region's health authorities after the influx of the refugees was to strengthen and expand the development of the network of health centres and health posts, and to set up a disease surveillance system. With the help of the refugee-assistance programme, the health system was well established within a year, assuring access to health care throughout the region for refugees and the local population alike (Van Damme et al, 1998).

→**Good practice:** Use of new technologies in refugee assistance

UNHCR intervened for Iraqi refugees in three cities in Jordan, Lebanon and Syria. The strategies included: the establishment of efficient registration and reception systems; the introduction of effective community outreach and communication mechanisms (outreach volunteers, community centres); the use of new technologies (SMS, hotlines, TV) for communication with refugees and in the distribution of assistance; forming creative external relations and public information opportunities; and introducing and supporting health insurance schemes for refugees to help them to access services in a dignified manner.

→**Good practice:** Follow-up of displaced patients on ARV during political unrest

During the political unrest in Kenya in 2008, innovative ways of patient follow-up – such as mobile phones and free telephone hotlines - were used. Patients throughout the country who had been displaced were able to call for guidance on how to get their medicines (MSF International, 2008).

5.4 The role of advocacy in operational strategies

In the current review, three missions (South Africa, DRC and Cameroon) stand out for having integrated advocacy objectives in their operational strategies. In all cases, they achieved important results to the benefit of their target population. Unfortunately the advocacy activities of the other interventions were less clear and/or less documented. Nevertheless the information that could be obtained is summarised briefly.

In **South Africa** the project benefited from a long history of advocacy. The advocacy strategy was completely integrated into the medical action early on because the legal status of Zimbabweans was a key problem, in particular for access to healthcare. MSF played a crucial role in getting the South African government to grant migrants free access to healthcare as stated in the Constitution. This was done through public positioning and social workers following up on individual cases. The South African government changed the visa regime for Zimbabweans so that they can now have legal status in the country and therefore have free access to healthcare.

> *"The project would not make sense without advocacy. The South African government has the obligation and capacity to provide health care".*
>
> *Interview: Liesbeth Schockaert,*
> *AAU/OCB*

Box 8: Advocacy activities in South Africa

- MSF published a press release to ask the South African government to stop the deportation of Zimbabweans (MSF, June 2008).
- MSF also used networks of activists very effectively. It channelled local activism to push for free access to healthcare by sharing information with legal groups which then mounted a legal challenge to the government.
- In addition, by providing healthcare, MSF showed the South African government that it can take responsibility. The South African constitution grants everybody free access to healthcare, regardless of their legal status in the country. Yet, this was not properly enforced. MSF's advocacy helped to make this a reality.
- On witnessing serious abuses against unaccompanied minors, MSF set up a special counselling service and deployed strong advocacy towards the authorities and UNICEF to ensure minors had protection, shelter, healthcare, legal documents and other basic rights.
- In June 2009, MSF published the report: *No Refuge: Access Denied - Medical and Humanitarian Needs of Zimbabweans in South Africa.*

In **Cameroon**, advocacy was pursued to achieve a better coverage of the humanitarian needs of the refugees. Information was shared with other humanitarian groups and they were pressed to supply food and medical assistance to refugee populations.

At the local level, coordination, advocacy and lobbying for better coverage of identified needs was the strong point of the intervention and it contributed to greater efforts by other actors present, such as WFP, CARE and UNHCR.

At the international level, however, the advocacy efforts seem to have failed due to the lack of common messages and the reactions at different levels of influence at MSF headquarters. (Several interviewees said that their efforts in the field failed to receive proper support).

Box 9: Advocacy activities in Cameroon (2007)

- Continuous lobbying at field and capital level at the very beginning of the project through regular meetings (the results of two surveys in East Province and Adamaoua were used for lobbying).
- Press release 30.07.07 Geneva/Yaoundé : "*Situation Nutritionnelle Critique pour les Réfugiés Centrafricains*"*
- Christian Captier's meeting with the (previous) Minister of Health 02.08.07
- Press conference, Garoua Boulaï 13.08.07 "*Intervention d'urgence auprès les réfugiés Centrafricains.*"*
- MSF also participated in the joint re-evaluation of humanitarian needs in collaboration with UNHCR, WFP, UNICEF and FAO (August 2007).

Achievements

- WFP started food distributions to the refugees and kept on doing so reasonably regularly (roughly every 5 weeks).
- UNHCR started carrying out registration rounds of refugees every six months.
- UNHCR started paying for fees for refugees in the health facilities, (although not always regularly).

In DRC, one of the project's objectives was to "document the situation of IDPs to develop a briefing and advocacy paper on humanitarian needs (protection issues)". Between September 2008 and March 2009, many testimonies were collected. This helped the field teams to have a better understanding of the context and the problems of extreme violence perpetrated by the LRA. The testimonies were also regularly posted on the MSF websites. This contributed to raising awareness and an increase in interest about the extent of the problem within the MSF Movement and the international community. For example, Human Rights Watch decided to investigate atrocities committed by LRA in the Haut-Uélé and Bas-Uélé region.

In February 2009, MSF made a public statement on the incapacity of MONUC to assure the protection of the civilian population despite its reinforced mandate on protection since the previous December.

In June 2009, OCG published a briefing paper: "*Trapped and Without Hope.*" It reported that the people of northeast DRC were paying a high price in an interminable conflict. At the same time, the DRC health ministry held a briefing at the UN in New York on the humanitarian situation in the Uélé region and the lack of an efficient humanitarian response and the absence of protection. The MSF office in New York reported a positive response to this, however here is no information on the outcomes of these actions, although it is believed that MSF advocacy contributed to the mobilisation of other actors to the Uélé region.[24]

Unfortunately, the strong advocacy at the beginning of the intervention faded over time. The consultants' visit to DRC flagged up a high level of needs among the displaced population and the impression during the visit was that MSF's opinion was highly-regarded by the many actors present in the area. In the light of this, MSF should have been continuously flagging the IDP needs, and could be pushing other actors to provide more and better aid for the affected populations.

In **Djibouti and Iraq,** no advocacy objectives were defined. However, the Djibouti mission lobbied for a change of national policy, in order to grant systematic treatment for acute malnutrition free of charge. As a result, free treatment of pathologies associated to malnutrition has been available since January 2010. **In Pakistan,** a series of press releases was issued on the plight of the displaced during the height of the crisis, but staff on the ground felt that MSF could have done more lobbying about the needs and the quality of care provided to the displaced.

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24 Conversation with Marc Poncin, RT desk 3.

5.5 Coordination

Coordination is one of the Top 10 Priorities *in a refugee situation, but it is probably also the most neglected or least implemented. Nevertheless, without proper coordination, any relief programme will rapidly become disastrous.*
(MSF, 1997)

Coordination was not handled in any of the projects reviewed as an "integrated organisation of relief activities under an accepted leadership" (MSF, 1997), but more as simple information-sharing among different actors, and, most often informally and at a bilateral level.

In DRC, despite a strong presence of multiple actors, coordination is very poor. Actors meet regularly essentially to exchange information on security issues, but an overall understanding of the humanitarian needs and coverage of these needs by different actors remains weak. MSF does not feel it is in a position to take a more active role in the coordination process because of its own difficulty in understanding the situation and consequently to plan properly.

It was observed that projects with a strong focus on advocacy and/or lobbying (Cameroon, South Africa) demonstrate better information-sharing and networking than others. However, this is mostly at the level of international actors. In urban areas such as in South Africa or Djibouti, it is evident that good networking and strong partnership are keys in identifying the most vulnerable and in getting access to 'invisible' populations, as well as providing opportunities for referral to relevant health, social and legal services. Similar arguments have been made in existing literature (see Box 10 below).

Interviewees emphasise the challenge that networking entails. It requires time to understand the environment and to create confidence with other organisations. For MSF, it is particularly important to identify trustworthy organisations to be able to refer patients for specialised medical services or for social, legal and protection services.

Regarding internal or intersectional MSF coordination, the most obvious challenge appears in the contexts of insecurity. DRC and Pakistan are examples where MSF capacities could have been used much more effectively with proper coordination rather than competition between MSF sections. This would have included a timely definition of what areas one section can cover or not. In the current, complicated set up, centralised decision-making on security[25] in particular significantly hampers reactivity and timely implementation of activities.

In addition to the complexity of the displacement in open settings, various elements have contributed to inefficient coordination in the projects reviewed: unclear role of UNHCR (DRC, Cameroon, South Africa), poor leadership of OCHA (DRC), the politicisation of aid (Pakistan) and an absence of adapted guidelines and policies for open settings including the standard indicators on health, shelter, WATSAN, food, etc.

Box 10: Coordination in urban settings - references to literature

Because of the urgency and scale of efforts, and the invisibility of vulnerable urban groups, response and recovery activities in urban environments are difficult to manage. An effective coordination mechanism can help to ensure that all relevant needs are considered across different sectors and diverse stakeholders interests. (ALNAP, 2009)

Local partnerships – or at least fairly elaborate networking with local authorities and other organisations (churches, NGOs, civil society groups, etc.) – are more commonplace in urban settings and provide ways of avoiding a completely substitutive role. Strong partnerships with civil society activist groups to further common advocacy objectives are key to the success and sustainability of these programmes. (Lucchi, 2009)

In urban areas, it is local leaders, decision makers and interlocutors who take, and must continue to take, the lead in mobilising and coordinating humanitarian action and also in managing urban risk reduction (FMR, 2010)**.**

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25 New movements need to be validated at headquarters level.

5.6 Discussion/ Conclusions

Beyond *top ten priorities*
Refugee Health, which has remained the key reference for MSF interventions for almost 20 years, bases its logic on a linear progression from emergency to post-emergency phase in refugee or displaced situations. However, as argued before, in open settings a clear delineation between such two phases often does not exist, and periods of acute need may regularly occur during protracted crises. Consequently, short-term objectives based on the *Top Ten Priorities*, aiming only to cover the initial emergency phase of the crisis, do not seem always adapted to open settings.

The *Top Ten Priorities* aims at reducing high mortality during the emergency phase by targeting risk factors typical of camp-like settings.[26] However, the risks factors vary greatly in many open setting situations. OCB's additionally defined priorities are important, nevertheless even those only focus on the first three months of an emergency.

It was observed that where the *Top Ten Priorities* are applicable (e.g. during the period of acute need in Cameroon), MSF is usually clear and comfortable about its role as an emergency actor, and what to do in a classical emergency is a natural reflex.

On the other hand, MSF often seems paralysed in protracted situations, hesitating to take on 'atypical' tasks. Teams commonly question the relevance of being present in the absence of visible and easily identifiable needs.

Need for new intervention frameworks
The diverse needs and challenges in the reviewed interventions were addressed with a wide range of sometimes innovative intervention strategies. On the one hand, this reflects the great flexibility of MSF and provides important good practice examples and evidence for development of new strategies. On the other hand, intervention strategies in the reviewed interventions were often decided on an ad hoc basic and changed frequently, partially due to uncertainty about the appropriateness of choices. This is well understood in the absence of evidence-based tools that could provide guidance on intervention choices in such complex settings. Moreover, unlike camps situations where timely assistance would in most cases be demonstrated by decreased mortality rates, the impact of most open setting interventions is difficult to measure.

MSF clearly needs concepts for working in open settings. Elaboration of new intervention frameworks for complex displacement situations is desirable to provide some advice on which strategies to opt for in which situations. Such frameworks, however, would need to take into consideration the various factors determining needs in open settings (see page 15):

Two existing models could provide a base for further work on such frameworks:

- Matrix of three types of settings (camp-like, urban, rural-dispersed) and two income and life-expectancies (low and medium to high) with corresponding challenges for future health policies and strategies (Spiegel et al; 2010); see table in Annex 8.
- A range of situations that lie between 'development' and 'disaster' and complex links between pre-existing health services (primary healthcare (PHC)) and newly created emergency medical assistance (EMA).

The first model is of particular interest for MSF as proposed interventions are in line with current internal discussions inside the MSF Movement.

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26 Typical risk factors of camp-like settings: overcrowding, inadequate shelter, poor water, sanitation and hygiene conditions, lacking treatment facilities and insufficient nutrient intake.

The second model is based on experience from Guinea, described in the chapter on good practices. Here, two opposing logics come into play: EMA, also called medical relief, and PHC. While PHC is seen as part of development, medical relief is linked with emergency situations. Van Damme argues that while PHC and EMA are clear opposite poles, many field situations in the developing world are today somewhere in-between. In such 'non-development, non–emergency' situations, an adapted intervention strategy will have to combine characteristics of both (Van Damme/ Van Lerberghe/ Boelaert, 2002).

A joint effort (within MSF and with external actors) to develop such frameworks should be prioritised in order to share experiences and to build common knowledge on this complex issue.

Some operational dilemmas to be tackled within new frameworks and guidelines are presented below.

Engagement with the existing health system: which criteria?

Health system issues, previously not addressed in the context of parallel services in camps, are becoming of great importance in open settings. While defining its medical strategy in open settings, MSF often struggles to find a balance between highly effective parallel services and so called 'light support' to the existing health system. With high expectations on quality and accountability, MSF for a long time tried to avoid 'dropping drugs' without being able to control the outcomes. Furthermore, MSF's concern has been to not disrupt the existing healthcare system; but to find a balance between good quality care and minimal disturbance.

In the reviewed interventions, drug dropping is common at health centre level and seems an appropriate temporary solution to assure the continuity of healthcare during periods of acute disturbance, while lobbying with development-oriented actors and donors for the longer term support.

On the other hand, MSF remains reluctant to just drop drugs in hospitals and requires the presence of its teams to guarantee a quality of care. Nevertheless, this is done without the evaluation of the performance of the health structure and clear indicators about which quality of care should be achieved and how. Entry and exit criteria are also unclear when for this type of support.

The evaluators argue that engagement on the hospital level must be made consciously in terms of the potential investment and the expected output. Such a decision requires clear objectives on what is to be achieved and it also demands consideration as to whether resources could be used more efficiently with alternative strategies. Set up of benchmarks/minimum criteria for quality of care (e.g. mortality in paediatric ward less than 5 %) might be helpful to define clear objectives and to decide on the level of investment needed (light support versus more heavy investment).

Increasing access – rethinking set-ups

Providing high quality results in selected hospitals or health centres in open settings has led to frustrating results in terms of very low coverage of people most in need. In the absence of an effective referral system, few reach the supported services either as a result of poor access or by choice.

In open settings, it is arduous to duplicate the 'four-level health care model' developed for camp settings (MSF, 1997) including well-established referral links, simply because of the immense resources needed. In the absence of a functioning referral system, few patients effectively have access to the services.

The widespread needs in open settings clearly must be addressed with innovative strategies aiming at better coverage, and looking at more community-based approaches. Only with strong involvement of the affected communities can activities be continued even where

(external) staff presence is restricted. In a situation with only intermittent access, such as DRC, it is proposed to shift tasks to community-based outreach workers to provide both preventive and simple curative activities in order to prevent excess mortality. The latter can also be used for basic surveillance and should raise the alarm in case of an unusual event (epidemic, acute conflict, etc.)

MSF is currently piloting such approach, by systematically addressing different preventive options. These interventions can be implemented over a short period, i.e. using (security related) windows of opportunity, particularly in remote areas. They include vaccines preventing respiratory tract infections and diarrhoeal diseases, point-of-use water treatment, prevention of malaria and targeted food supplements.

MSFs recent experience in nutritional care demonstrates that it is possible to shift from a complicated and centralised approach to a more flexible and community-focused set-up. MSF may try to develop similar models in other areas of intervention such as mental health treatment, care for sexual violence etc.

Response to the need for surgical capacities – but how?

MSF faces a dilemma in unstable areas and prolonged crises where repetitive, but unpredictable waves of armed conflict cause war injuries and consequently a need for surgical intervention. As the care for victims of conflict remains an operational priority for OCG, this is an ongoing challenge.

Today, OCG is trying to reinforce surgical capacities in existing hospitals with very small output.[27] This might be partially explained by several factors: a) most risks in recent conflicts are due to its indirect consequences (such as infectious and non infectious diseases) and not to conflict related trauma; b) referral capacities are limited due to geographical spread and insecurity; c) services are often set up in small secondary health facilities with small catchment areas.

In order to improve outputs, the strategic option could be to run a central secondary heath level structure with surgical capacity in contexts prone to repeated conflicts (e.g. in Bunia for DRC, etc.)[28] This would allow to care for victims of conflict and other severe cases across a large geographical area. However, considerable means for referral should be put in place (e.g. MSF aeroplane in DRC).

Alternatively, the choice of OCP in Pakistan to set up a temporary emergency unit in the public hospital provides an option to consider where circumstances allow.

Tackle chronic diseases

It has been well described elsewhere how the burden of disease is changing in conflict affected countries due to various factors (Spiegel et al., 2010). Even though the management of chronic diseases (especially HIV and TB) has much improved within MSF projects during the last decade, it is still rare that these conditions are tackled during displacement crises. For the reviewed projects, South Africa was the notable exception (providing the management of HIV and TB to displaced populations). Non infectious chronic diseases such as hypertension or diabetes were not addressed.

Clearly, the continuity of treatment of infectious chronic diseases should be the priority in every setting in order to prevent drug resistance to current treatment.

Unfortunately this issue could not be addressed in detail in this evaluation, but it seems evident that MSF will be required to tackle this problem.

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27 In Dungu hospital, out of 300 surgical interventions performed between June and September 2009, only 22 (7%) of interventions were related to violence.

28 The ICRC has demonstrated this option with many pros (reliable, good quality care) and cons (problem of transport, postoperative care) over many years in South Sudan and Pakistan.

Role of advocacy

Given the proximity to the communities it works with, MSF can advocate for change as well as provide accounts of how people are suffering. Advocacy objectives can vary and may include:

- Introducing new protocols for care.
- Provision of health services in neglected areas.
- Access to existing health care.
- Exemption from user fees for particular or general health services.
- More and better aid to be provided by international donors and organizations in a particular setting.

Bearing witness and public communication on the suffering of populations affected by violence is equally important (Lucchi, 2009). Operational strategies would greatly benefit from an integrated advocacy approach.

6 RECOMMENDATIONS

6.1 Recommendations on assessment

⇒ **Explore innovative assessment approaches for areas with intermittent access**

    o Consider 'distance assessment', i.e. bring selected representatives of both communities (host and displaced) to location accessible for the MSF team in order to carry out 'assessment workshop'[29]

    o Include small pockets of displaced as these locations might present particular vulnerabilities

    o Based on secondary sources, elaborate and regularly update community mapping of affected area, informing on population demography, essential needs, vulnerable groups, etc.

    o Use security related windows of opportunity for rapid response based on secondary information and for updating assessment findings

⇒ **Actively consult and involve displaced and host communities**

    o Look at population's perceived needs, priorities, health seeking behaviour, vulnerabilities and capacities

    o Consult and assess the capacity and the willingness of local authorities to provide for the needs of the affected population

⇒ **Use existing information more effectively**

    o Use sources from authorities, NGOs, UN; limit the number of assessments and avoid assessment fatigue

⇒ **Adopt concept of continual assessment**

    o Monitor trends through community surveillance, running activities and regular consultation with the community and rapidly assess the new displacement sites

⇒ **Decide on one tool(box) to be used for assessments in OCG**

    o Possibly adopt OCA *Manual for the Assessment of Health and Humanitarian Emergencies* as a reference tool for assessments in open settings

⇒ **Provide better guidance on assessments**

    o At HQ level one person must be in charge of assessment in complex emergencies/open settings and provide technical guidance. S/he should be involved in planning, design and check validity of findings and data analysis. S/he

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29 The objective would be to get relevant information in order to identify priority locations for further assessment/intervention. Vulnerability mapping should also be done. During distance assessment, selected participants could be trained on specific data collection (food security, MUAC screening, mortality, main morbidities, etc.) in order to obtain more detailed information from each area.

should coach assessment teams on the use of different methods and provide them with appropriate tools and checklists.

o An assessment coordinator might be useful in contexts where many assessments are expected over a longer period of time (e.g. DRC, Cameroon). S/he should provide technical expertise for assessment design, appropriate methodology and tools depending on the context and objectives defined by the field coordinator or head of mission. S/he should also be responsible for training and supervision of national staff involved in assessments and/or surveys.

⇒ **Build assessment capacities**

o Organise training on assessment methods and skills for national and international staff

o Promote the role of national staff in assessment

⇒ **Facilitate the participation of specific experts when needed** (anthropologist, lawyer, psychologist, epidemiologist, etc.)

⇒ **Promote the use of qualitative methodologies**

o Use MSF-UK guide on qualitative methods as practical guide.

o Establish a training module on the use of qualitative methods (either integrated in existing courses: psychosocial support, field coordinator training) or possible new training on assessment, evaluation and monitoring

⇒ **Rethink the role of RHA and surveys for assessment in open settings**

o Revise objectives, timing, methodology, expertise needed.

o Participate in operational research on alternative ways of measuring mortality and explore new methods of population estimations

⇒ **Develop a frame to assess risks, vulnerability and capacity to cope**

o Build on external experience of **IFRC and IDMC to be used in assessment.**

⇒ **Provide guidance on assessing main barriers to access to health,** including health seeking behaviour and performance of health facilities

o Define criteria to benchmark the quality of healthcare

⇒ **Consult external expertise available to revise currently used indicators** (mortality, shelter, NFI, WatSan, etc.) to benchmark the severity and monitor the emergency in complex/open settings

o Use of alternative indicators such as food security, access to health care and other basic needs and when classical indicators, such as mortality rates are unpractical

6.2 Recommendations on intervention strategies

$\Rightarrow$ **Develop new intervention frameworks for complex emergencies/open settings** with strategies adapted to specific contexts (displacement setting, country's income, onset of crisis, character of emergency, duration, humanitarian space) based on:

- o Two models presented in this report (Annex 8 and 9) and best practices observed.

- o Consultations of external actors incl. international agencies and academics.

Some considerations for future frameworks:

- o **Distinguish between situations requiring immediate relief intervention** (ex. Pakistan), **and those requiring medium-term preventive interventions** (ex. South Africa), taking into considerations that in most situations, the combination of both will be required (Cameroon, DRC, Iraq, Djibouti, South Africa)

- o **Ensure that the medical strategy addresses exiting gap** accordingly to evaluated health status, capacity and performance of existing health system, barriers to access and it is adapted to local health seeking behaviour

- o **Keep a balance between medical relief and continuity of existing health system,** with varying strategies according to the level of emergency

- o **Define entry / exit criteria** and objectives for engagement at hospital level

    - o Assess excess burden on the hospital related to displacement and capacity to cope.

    - o Conduct quick assessment of the quality of care and identify main gaps.

    - o Set up benchmarks/minimum criteria for expected quality of care (e.g. mortality in paediatric ward less than five per cent).

    - o If minimum criteria of health facility performance are acceptable: Provide minimal support (drugs, material, incentives, few extra resources), Guarantee free access to healthcare (ensure ways to verify), Avoid whole MSF team getting involved in hospital management.

    - o If minimum criteria of health facility performance are not reached, MSF might decide to invest more heavily, if objectives are clear.

- o **Define context specific criteria and scope for so called 'light support' or facilitation of access**

    - o Based on the analysis of health status of affected population, main health threats, access to health care and performance of exiting health system

- o **Define non-medical assistance considering population vulnerabilities, capacity and** coping mechanisms

$\Rightarrow$ **Develop community based strategies**

- o Focus on prevention, early diagnosis and treatment of the main killers.

- o Prioritise outreach workers and allocate resources accordingly.

- o Develop the tool kit and the training program (based on OCG example in Myanmar) for rapid set up of CHW's network

- o Pilot mass delivery of preventive packages.

$\Rightarrow$ **Address chronic diseases,** at a minimum, assure continuity of TB and HIV treatment

$\Rightarrow$ **Use advocacy and lobbying as an operational tool** for better coverage of needs and protection issues

$\Rightarrow$ **Recruit health staff from affected populations** (considering all sub-groups of displaced and host populations)

$\Rightarrow$ **Carry out operational research to demonstrate outcomes of different/innovative intervention strategies**

6.3 Context specific considerations

Evaluators were requested to draw up recommendations for different types of displacement settings. This was a difficult exercise, however specific considerations related to the six different settings are described below. These are partly based on good practice examples, and partly on the analysis of the reviewed interventions.

1)   Iraq case study

Characteristics of the crisis:	Displacement in several waves, intermittent character, rural and urban setting,: middle income country, well functioning health structures
	Main risk factors: impact of cold winter season (bad living conditions), psychological trauma, financial barrier of access to secondary and tertiary health care
Target population:	Target the most vulnerable: - Recent IDPs - Geographical targeting (poorer IDPs living in rural areas) - Households with high number of females - Female headed households
Intervention strategy	$\Rightarrow$ distribution of NFI for winter season $\Rightarrow$ Mental health through mobile clinics linked with existing system for severe cases $\Rightarrow$ Facilitation of access to healthcare (subsidize user fees) for urgent cases
Specific considerations	$\Rightarrow$ Using new technologies (SMS) to organise the distributions $\Rightarrow$
Challenges	$\Rightarrow$ Criteria for facilitation of access (who should benefit?) $\Rightarrow$ Identify the target population for NFI distribution $\Rightarrow$ Timeliness of NFI distribution $\Rightarrow$ Link between MSF mobile clinics (psychological support) and existing structures

2) DRC case study

Characteristics of the crisis:	Acute onset, protracted character, periods of acute peaks of violence, rural/dispersed setting, low income country, displaced as vulnerable as host, collapsed health system, impended access (security, geography)
Target population:	All affected area; both displaced and host population
General considerations:	⇒ Target the main killers such as malaria, pneumonia, acute malnutrition and neonatal disorders ⇒ Simplify approach in order to increase coverage ⇒ Use security related windows of access for targeted assistance (distance assessment using secondary information and remote sensing) ⇒ Shift tasks to outreach workers (ORW) for basic prevention and curative activities ⇒ Continually assess to spot changes and adapt interventions accordingly - Distance assessment for inaccessible areas, MSF rapid response team to evaluate new displacement sites, simplified surveillance through ORW network and existing health structures, situation monitoring via mobile clinics

Peaks of acute violence	⇒ Directly provide medical relief through:
	   - Implementation of curative and preventive packages at community level through mass campaigns during security related windows
	   - Temporary mobile clinics for provision of basic medical care, emergency psychological assistance, management of acute malnutrition and SGBV
	- Provide the means for referrals of severe cases
	⇒ Assure the continuity and free access in exiting health structures (drugs, material, incentives)
	⇒ MSF run central referral structure for management of severe cases
	⇒ Non medical assistance through:
	   o Temporary provision of food, NFI, shelter
	   o Home based water treatment as part of preventive packages

"Chronic" period	⇒ Light support to existing health structures (drugs, material, incentives, trainings, supervision) ⇒ Provision of basic preventive and curative services through community networks in remote areas ⇒ Assure continuity of treatment of chronic diseases treatment (HIV, TB) ⇒ Lobbying for better coverage of non-medical needs ⇒ Targeted NFI distribution according to vulnerability assessment
Challenges:	❖ Identify and count population, quantify the needs, measure and interpret mortality data ❖ Specific indicators and criteria for shelter, water, NFI ❖ Entry and exit criteria for the engagement at hospital level ❖ Simplified assessment of health system performance ❖ Increase coverage in situations with intermittent access ❖ Means for referrals (MSF aeroplane, helicopter, etc.)

3) Cameroon case study

Characteristics of the crisis:	Slow onset, protracted character, intervention during acute periods, rural/dispersed setting, low income country, poorly functioning health system, free access for refugees
Target population:	Geographical targeting according to degree of need Assist both displaced and host population
Specific considerations:	⇒ Specialized mobile clinics appropriate for acute phase (acute malnutrition) ⇒ Integration of activities into existing health facilities (support for drugs and training) after emergency phase ⇒ Re-evaluation of situation after emergency phase with re-orientation of the programme ⇒ Mid-term strategy to address chronic diseases (TB, HIV) ⇒ More intensive engagement with hospitals (e.g. prevention of high mortality of hospitalized patients due to acute malnutrition)

4) Djibouti case study

Characteristics of the crisis:	Slow onset, protracted character, chronic crisis with temporary emergency situation due to acute problem of malnutrition, urban setting, low income country, poorly functioning health system, cost recovery, restriction from authorities to target migrants
Target population:	Geographical targeting of poor neighbourhoods (displaced and host)
Specific considerations:	⇒ Substitution appropriate as temporary solution for TFC (negotiation of hand-over in advance is a good practice) ⇒ Better briefed/trained expatriate staff (proximity) ⇒ ORW network for follow-up ⇒ Reduce financial barriers to access (e.g. pay for referrals) ⇒ Address chronic diseases (TB)

5) Pakistan case study

Characteristics of the crisis:	Rapid onset, short and acute character, rural setting, middle income country well functioning health structures, but over helmed by the crisis Main risk factors: cholera epidemic, access to health care
Target population:	Targeting of most vulnerable based on economic criteria, identified by local teams
Specific considerations:	⇒ Low profile intervention through well-established local networks ⇒ Cholera EPP ⇒ Facilitation of access to healthcare (e.g. free of charge consultation within existing healthcare system) ⇒ Short term support to existing hospitals (emergency unit)

6)   South Africa case study

Characteristics of the crisis:	Progressive onset, protracted crisis, mixed displacement setting urban and rural, high income country, functioning health system
	Main risk factors: access to secondary health care, high burden of chronic diseases (HIV, TB), xenophobic violence
Target population:	Illegal migrants in typical working places (farms in rural areas) and gathering places in urban areas
Intervention strategy:	⇒ Active facilitation of access to hospitals for migrants (referral letter, accompaniment by MSF social assistant, subsidized fees for urgent treatments) ⇒ Dealing with chronic diseases (TB, HIV) ⇒ Address problem of violence (SGBV management) ⇒ Targeted NFI distribution and support to shelter ⇒ Advocacy as a operational tool for change (legal status of migrants) and fully integrated into intervention strategy
Specific considerations	⇒ Intervention through small, less visible teams ⇒ Flexible approach through mobile clinics so as not to expose migrants (adapted opening hours, changing locations, etc.) ⇒ Networking with civil society (e.g. legal groups for litigation, activists, etc.) for better identification and assistance of migrants
Challenges	⇒ Reach the most vulnerable ⇒ Respond to urban violence

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8   ANNEXES

Annex 1: Terms of Reference

**TERMS OF REFERENCE FOR TRANSVERSAL EVALUATION ON
MSF'S RESPONSE TO DISPLACEMENTS IN OPEN SETTINGS**

Subject:...........................Transversal evaluation on displacement in open settings

Starting Date: ....October 2009

Length of the Mission: ...12-16 weeks

Responsible: ....Vienna Evaluation Unit

Ownership: ....The Evaluation was commissioned by Bruno Jochum, Operational director of OCG;

ToR elaborated by: ....Bruno Jochum, Mzia Turashvili, Sabine Kampmüller

CONTEXT

MSF faces increasing challenges in its response to displaced populations. The classical camp situations (with few exceptions such as Chad) are almost non-existent and displacement happens in open settings in both rural and urban areas. Besides, refugees fleeing conflict are decreasingly given legal recognition and are therefore forced into clandestine migration, seeking 'invisibility' inside big urban centres.

MSF, as a mainly emergency focused organisation, has over the years developed and adapted tools for assessment of the health status of displaced populations but all those are basically suitable for closed settings, such as IDP or refugee camps. The same is true for implementation strategies, which are adapted to closed settings, but seem less appropriate for open settings. The old, well established tools of assessment are not effective in detecting the specific vulnerability of displaced groups, or even marginalized sub-groups within the displaced population; today, they represent only a small fraction (10-15%) of the total displaced populations. We currently have few means and insufficient capitalization of experience to assess properly the vulnerability and needs of displaced people in open settings. The design of relevant programmes, which may imply 'discrimination' through precise targeting of beneficiaries, raises many questions.

Some countries, such as Somalia and Cameroon, provide good examples of displaced populations in open settings. In Cameroon, the fact that there are 70-80 dispersed sites with pockets of around 100 people makes access to them very difficult and minimizes the impact of the interventions. In many other settings, the displaced population is mixed with the local resident populations and identifying the most vulnerable is a tremendous challenge (current examples of Djibouti, DRC or Pakistan, experience of Iran with Afghan refugees).

States today frequently do not follow the conventions on refugees. Refugee populations have a choice between being illegal migrants or illegal refugees. While states are in favour of such displacement patterns that avoid camp settings and can lead to better social integration, major questions arise for MSF on how to practically organise meaningful humanitarian assistance and whether some situations require advocacy for legal recognition and better policies.

This challenge of changing displacement patterns is to be explored for MSF to identify appropriate response strategies.

OVERALL OBJECTIVE AND PURPOSE OF THE EVALUATION

The evaluation will fulfil the following objectives by reviewing available external competence, experience and recommended 'best practices' as well as recent MSF interventions:
- Assess the appropriateness of assessment techniques and tools currently used by MSF, in order to improve them for future interventions.
- Analyse the appropriateness of intervention strategies by reviewing relevance and effectiveness of MSF interventions.

The purpose of the evaluation is to assess current challenges and shortcomings in needs assessment and response to displacement in open settings, in order to adopt techniques and recommend strategies accordingly. The outcomes will feed into an ongoing working group in OCG on displacement in open settings and provide a basis for a future training module for coordinators.

KEY QUESTIONS

1. What are the 'best practices' (for needs analysis and intervention strategies) recommended by external actors with operational experience or knowledge of these situations?[30]
2. How does MSF approach the specificities of the different patterns of displacement in open settings?[31]
   a. Dispersion in small pockets across a large geographical area (Cameroon).
   b. Hosting by resident populations (DRC (Haut Uélé), Pakistan).
   c. Invisibility due to IDPs being scattered throughout big urban centres (Djibouti).
3. How appropriate were the assessments conducted in recent interventions?
   a. How were assessments carried out? How did existing techniques apply in practice (in this context)? What are the new demands on assessment techniques/tools/methods? *(Appropriateness of techniques – compared to existing tools/guides)*
   b. What was the outcome of assessments? What type of information was obtained? *(Quality of information obtained)*
   c. How were marginalised sub-groups and their particular vulnerabilities identified and considered in the assessments?
4. How appropriate are/were the different intervention strategies applied to displacements today (compare different settings) to address the prevailing needs?
   a. How was the information collected used to define objectives and strategies? *(Relevance of objectives)*
   b. What were the overall outputs and outcomes in terms of activities, coverage (of the specific target population) and timeliness? *(Effectiveness of current strategies)*

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[30] A description of 'best practices' is expected to provide a baseline against which the current MSF practice can be compared.

[31] A description of different patterns of displacement in open settings and their specific challenges is expected in order to consider the differences when addressing the subsequent evaluation questions.

EXPECTED OUTCOMES OF THE EVALUATION

- Final report of max. 40 pages, including an executive summary and table of recommendations.
- Intermediate presentations to the main stakeholders of the evaluation.
- Final presentation and discussion of findings.

PRACTICAL IMPLEMENTATION OF THE EVALUATION

The evaluation will focus on a variety of settings: rural and urban areas, areas where small groups of IDPs have gathered temporarily or IDP populations interspersed with resident populations.

For OCG, recent projects include:

- Iraqis displaced in Kurdistan (winter 2007/2008)
- CAR refugees in Eastern Cameroon (closed 2009) – displacement in small pockets
- DRC (Haut Uélé) and Irumu (opened 2008) – hosting by resident population
- Djibouti slums (opened 2009) – illegal arrivals, IDP populations interspersed with resident populations in urban centre

The evaluation will also include OCB projects in Pakistan (2009) and South Africa (Zimbabwean refugees) due to the specific challenges experienced in these settings.

The Vienna Evaluation unit will guide and supervise the evaluation process.

METHODOLOGY PROPOSED

- Internal and external literature review.
- Interviews and focus group discussions with MSF staff.
- Interviews with other emergency / international organisations.
- Desk study of assessment data, project documents, output/outcome data.
- Visiting selected projects for case studies, including interviews with displaced people.

EVALUATION TEAM

The evaluation team is composed of three people with complementary backgrounds including medical, operational and research experience. The process will be supported by a consultant from the London School of Hygiene and Tropical Medicine.

Annex 2: List of Interviews

Interviews were conducted between November 2009 and January 2010

OCG: Bouriachi, Oifa: deputy programme manager, E-desk Broillet, France: Innovative preventive strategies Ciglenecki, Iza: medical advisor, epidemiology Cristofani, Susanna: medical referent, Humphris, Phillip: programme manager, Kuge, Matthias: medical advisor, anaesthetist Lelevrier, Yann: logistics officer, Matte, Jean-Seb: programme manager, Mekaoui, Helmi: deputy programme manager, E-desk Poncin, Marc: programme manager, Queyras, Guillaume: operational logistics manager Quere, Michel: medical referent, Reaiche, Souheil: deputy programme manager, Rull, Monica: deputy programme manager, Rusch, Barbara: medical advisor, nutrition Souza, Renato De: medical advisor, mental health Urbaniak, Veronique: medical referent, Wolmark, Laure: project officer-violence **OCB:** Bauernfeind, Ariane: programme manager De le Vingne, Brice: programme manager Oberreit, Jerome: director of operations Schockaert, Liesbeth: Advocacy and Analysis Unit	**Interviews were conducted with representatives of institutions and organizations in the following countries/locations:** **Johannesburg:** MSF (head of mission, medical coordinator, logistics coordinator, field coordinator, medical responsible, medical doctor, outreach team, clinic responsible) **Pakistan:** MSF (former head of mission, MSF Pakistan) **Cameroon:** MSF (MSF field nurse) **DRC:** CARITAS, Comboni Brother, Namboli, Conscience, local NGO, COOPI, ICRC, local leaders and beneficiaries, MSF (emergency logistics coordinator, head of emergency mission, head of mission, field coordinator), MEDAIR, deputy administrator of Dungu territory, mental health counsellor), OCHA, Solidarites, UNHCR, WFP **Djibouti:** AMDA, beneficiaries, CARITAS, Catholic church (Bishop), FHI (Family Health International), ICRC, Imams, International Organization for Migration (IOM), Malteser, nutritional assistants, Protestant church, UNHCR, WFP

Annex 3: Main Differences between Camp and non-Camp Settings

	Camp setting	Non camp setting
Location	Well defined	Displacement sites often spread over a large geographical zone in rural setting or scattered across urban areas
Population affected	Population numbers easy to estimate (registration)	Difficult estimation of displaced population due to geographical spread and invisibility (eg. cities can absorb large number of people unnoticed and without formal registration)
Interaction between displaced population and local community	Limited	Important. Displaced population residing with host families or living in proximity to local population sharing the same resources
Type of emergency	Often acute emergencies, with sudden onset, large scale displacement	More common smaller scale, slowly evolving, chronic or intermittent emergencies. However, experience of sudden onset in Pakistan and large scale displacement in Iraq
Displacement dynamic	Easy to follow (registration of departures, new arrivals)	Difficult to follow due to informal character and multiple displacement patterns
Emergency indicators and minimum standards	Measurable and clearly defined in *Top Ten Priorities*: mortality rates (CMR, U5MR) as prime indicators (often largely increased over emergency threshold); minimum standards for water, shelter, food, etc.	More difficult to measure and interpret (sampling issues, selection bias, MR increase slowly from near-normal levels). Minimum standards for water, food, shelter not applicable as often not reached in host population, etc.)
Needs	Visible and easy to identify with available methods	Often invisible, difficult to identify and quantify (IDPs interspersed with local population, geographical spread, invisibility due to legal status, etc.)
Access	Good, camps are usually set up in secure and well accessible area	Geographical access and security are common constraints
Main vulnerabilities	Risk of epidemics due to overcrowding, access to basic commodities (food, water, NFI)	Depending on the situation (urban) violence, discrimination, exclusion, food insecurity, natural hazards, etc.
Survival coping strategies	Limited, high dependence on external aid especially in the beginning of the crisis	Generally better coping mechanisms due to more mobility and access to alternative food and existing facilities (water, health etc.) Strongly dependent on the level of integration, means of host population and the length of displacement. Tend to get exhausted over time without external assistance
Humanitarian assistance	Relatively easy to plan (based on *Top Ten Priorities*) and organize (distribution, mass vaccination, etc.)	More complex to plan and organise (identification of needs, knowledge of local situation, access, monitoring)

# Annex 4: Appraisal of Available Guides and Tools for their Use in Open Settings

	Rapid Health Assessment (RHA) of Displaced Populations	*Refugee Health*	*Priority Indicators + Assessment Grids (OCG)*	*Manual for the Assessment of Health and Humanitarian Emergencies*	*Guide to Using Qualitative Methods*
Description of the manual	Practical guidelines on how to perform RHA	Overview of information required and methods used in initial assessment	Checklists for data collection during initial assessment (based on *Top Ten Priorities*)	Comprehensive manual on assessment in emergency situations, including checklists	Comprehensive guide on use of qualitative methods including practical explanations of their use, application and data analysis
Methods presented	Quantitative (sample survey, mapping, etc.)	Quantitative and qualitative (survey, systematic observation, interviews, focus group discussions)	No methods described	Quantitative and qualitative	Qualitative
Explanation of the methods	YES	Partially	NO	YES	YES
Checklists/ Report formats	YES	Checklists	Checklists	YES	NO
Need for specific skills	YES (basic epidemiology)	Depending on the methods	NO	Depending on the methods	Prior training might be necessary
Consideration of vulnerabilities and coping strategies	NO	NO	NO	NO	Possible
Specific tool for displacement	YES	YES	YES	NO	NO
Strengths	Concise, sound methodology, reliable for baseline data	Comprehensive, consideration of vulnerable groups	Well structured, easy to use at field level	Very comprehensive, link between information to collect and methodology, good explanation of different methods	Very practical for day-to-day use of qualitative methods
Weaknesses	Time consuming and resource heavy, need for epidemiological support as more complex to carry out	Too descriptive, insufficient description of different methods, focus on camp settings	Not explanatory, can only be used in conjunction with other assessment tools	Might be too complex for emergency situation without proper training	Not used in assessments

Annex 5: Summary of Assessment Methods (Qualitative and Quantitative)

Method	Strengths	Weaknesses	Limitations of use in open settings
Review of secondary information Potential sources – HQ, MSF reports, census/vital statistics, Ministries, international organisations, local eye witnesses, health structures, internet sites for context, health statistics, maps, etc.	- Possible in every situation (even without direct access)	- Reliability of sources - Accuracy and objectivity of data	• Little information available for some contexts
Systematic observation For assessing many qualitative aspects by walking through displacement site and observing state of the population, food and water sources, available assets, etc.	- Wide range of information gathered quickly - Can detect unexpected information - Useful for cross-checking data from other sources - Direct/primary data without intermediaries	- Observer bias - Observer presence might affect people's behaviour	• Difficult when population spread across many sites • Security constraints • Invisible needs
Interviews with key persons People with specific knowledge of certain aspects of the community and who may represent the views of a population group - village chiefs, teachers, health staff, religious leaders, etc. Discussions with representatives of administrative and health authorities, local and international organisations	- Wide range of information (including technical) can be gathered quickly - More appropriate than group discussions for sensitive issues - Easy to organize	- Might not represent the views of most vulnerable and marginalized groups - Informant bias	• Difficulty of identifying key persons in urban setting (invisibility)
Focus group discussions (FGD) Group interview (8-12 people) to discuss specific issues, composition of the group depends on the type of information needed; general group interviews; groups of people from different backgrounds and with different perspectives to discuss a variety of subjects	- Possibility to target vulnerable groups (only applies to FGD) - Allows interaction between people - Possible to cross check information and probe issues - Allows to obtain perceptions, needs and priorities of the community - Relatively quick	- Hierarchy or differences (gender, ethnicity) within a group might inhibit open speech (applies to group interview) - Translation	• Security constraints
Survey of a representative sample Data collected in a standardized and structured way on a population sample (systematic or cluster sampling); retrospective mortality, nutritional status, essential needs (NFI, shelter, water) and its coverage, vaccination coverage, access to health, violent events, etc.	- Wide range of information can be collected - Widely accepted methodology - Reliable baseline data	- Time consuming and resource heavy - Often applied with insufficient rigour or insufficient knowledge on epidemiology	• Security constraints • Lack of homogeneity among the various sites (would falsely average out the sample) • Snap picture of changing situation • Limited use of data (no standards for open setting) • Need for knowledge of epidemiology and statistics
Estimations on population through mapping, counting habitats, census, satellite images Number of displaced persons, age and gender distribution	- Provides important data on target group		• Rural setting with large geographical spread • Displaced population mixed with host population
Participatory methods Mapping, time lines, piling, ranking, transect walks, etc.	- Helps to generate information, particularly from illiterate respondents - Eases the discussion	- Time consuming	

Annex 6: Vulnerability and Capacity Flowchart

Figure 1. Vulnerability and capacity flowchart
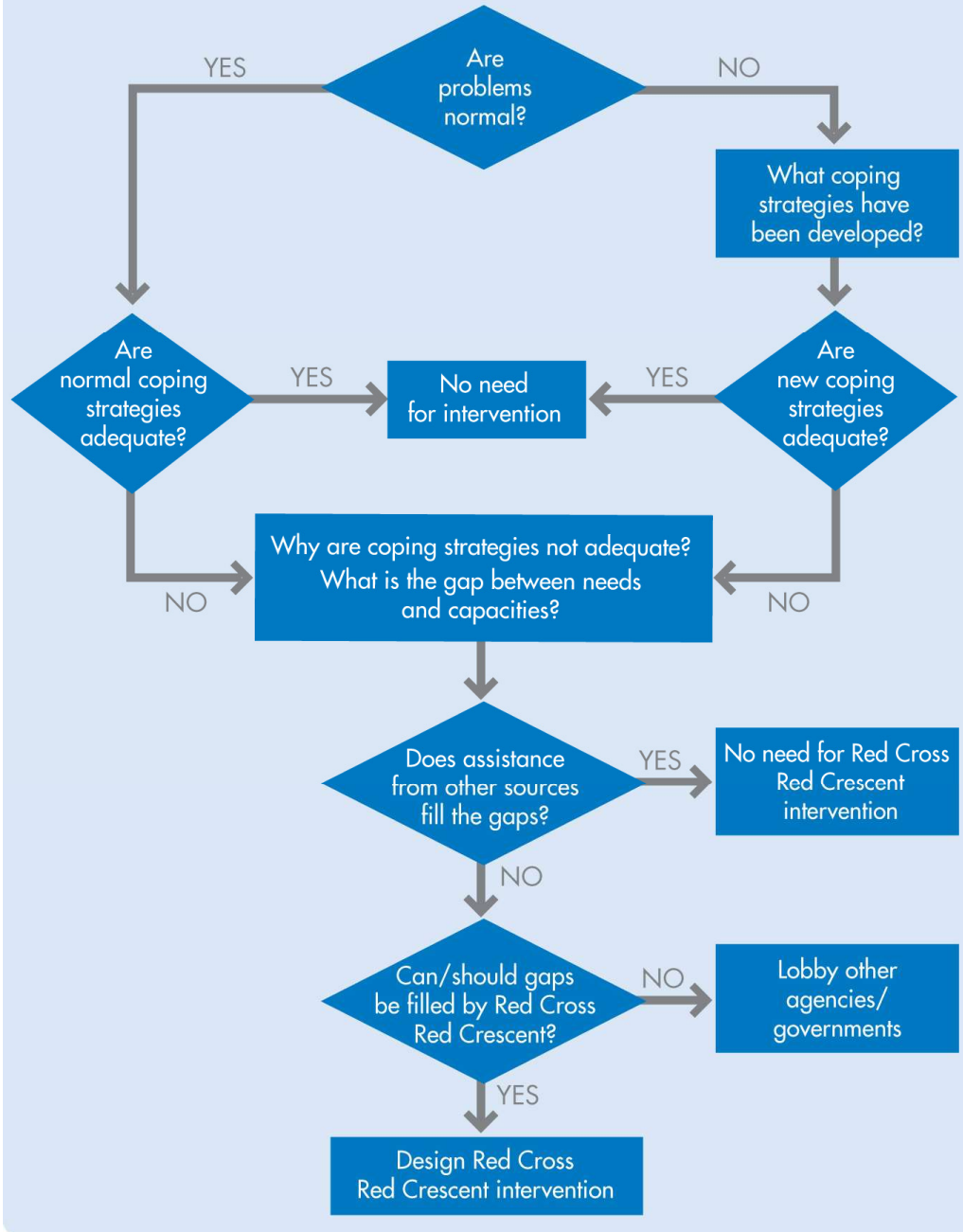
Source: IFRC (2008). Guidelines for Assessment in Emergencies.

Annex 7: Summary Table of Surveys Carried Out during the Reviewed Interventions

	Djibouti MSF survey	Iraq EPICENTRE survey	Cameroon EPICENTRE Survey[32]	DRC EPICENTRE survey
Timing	July 2009	August 2007	August 2007	March 2009
Location of the survey	Balbala slums	Semel town and four surrounding villages	4 villages – Ndokayo, Garoua, Gbiti, Nyabi	Dungu, Doruma
Rationale for chosen locations	Location of MSF nutritional programme (low number of beneficiaries with high malnutrition rates)	High density of IDPs, lower economic status than in Dohuk, easy access to IDPs, easy access to health facilities in Semel, absence of health facility and location in a grey zone in villages	High concentration of refugees	Initially planned for Dungu, Doruma and five smaller locations (Bangadi, Faradje, Ngilima, Ndedu, Kaka). Not possible due to serious logistical and security constraints
General objective	Estimate retrospective mortality and nutritional situation among the population of Balbala, Djibouti town	Describe living conditions of IDPs scattered in the community in terms of health access, shelters, sanitation, food and non-food items.	Estimate retrospective mortality and nutritional situation among the CAR refugees in Cameroon's Eastern province	Describe the humanitarian situation of IDPs in OCG intervention area to orientate operational strategies
Specific objectives	Estimate the prevalence of malnutrition in children under 5 Compare prevalence of malnutrition as assessed by weight/height compared to mid-upper arm circumference (MUAC) scores Estimate measles vaccination coverage Evaluate mortality rates (CMR, U5MR)	Identify areas with high density of IDPs Describe the geographical, ethnic and social background of IDPs, reasons for moving Document the number of times families have been evicted before arriving in Kurdistan Document the amount of rent and job opportunities Understand coping mechanisms and their limits in the actual context	Estimate the prevalence of malnutrition in children under 5 Estimate measles vaccination coverage Evaluate mortality rates (CMR, U5MR) Evaluate the proportion of violent events Estimate the proportion of refugees registered	Describe the population (demographic structure, origin of IDPs, routes and experienced violence, retrospective mortality) Describe the living conditions of displaced population and host community (shelter, NFI, WatSan) Evaluate access to healthcare (utilisation of health facilities and main barriers to health) Describe the livelihoods, the access to food and coping mechanisms of both displaced and host community
Methods used	A cluster sampling survey (30 clusters of 23 families) was conducted, using standardized questionnaire	An exhaustive community-based household survey in Semel town Rapid assessments using convenient samples in rural areas	Retrospective mortality survey and exposure to violence Transversal nutritional survey and vaccination coverage (measles)	Nutritional screening (MUAC), interviews with refugees and key informants, prospective mortality surveillance
Results	CMR 0.34/10,000/day	62.9% live in rented houses, 18.9% in host houses, 58% shared house with	CMR	CMR 1.3/10,000/day

32 Similar survey was carried out by MSF in Adamaoua Province in September 2007.

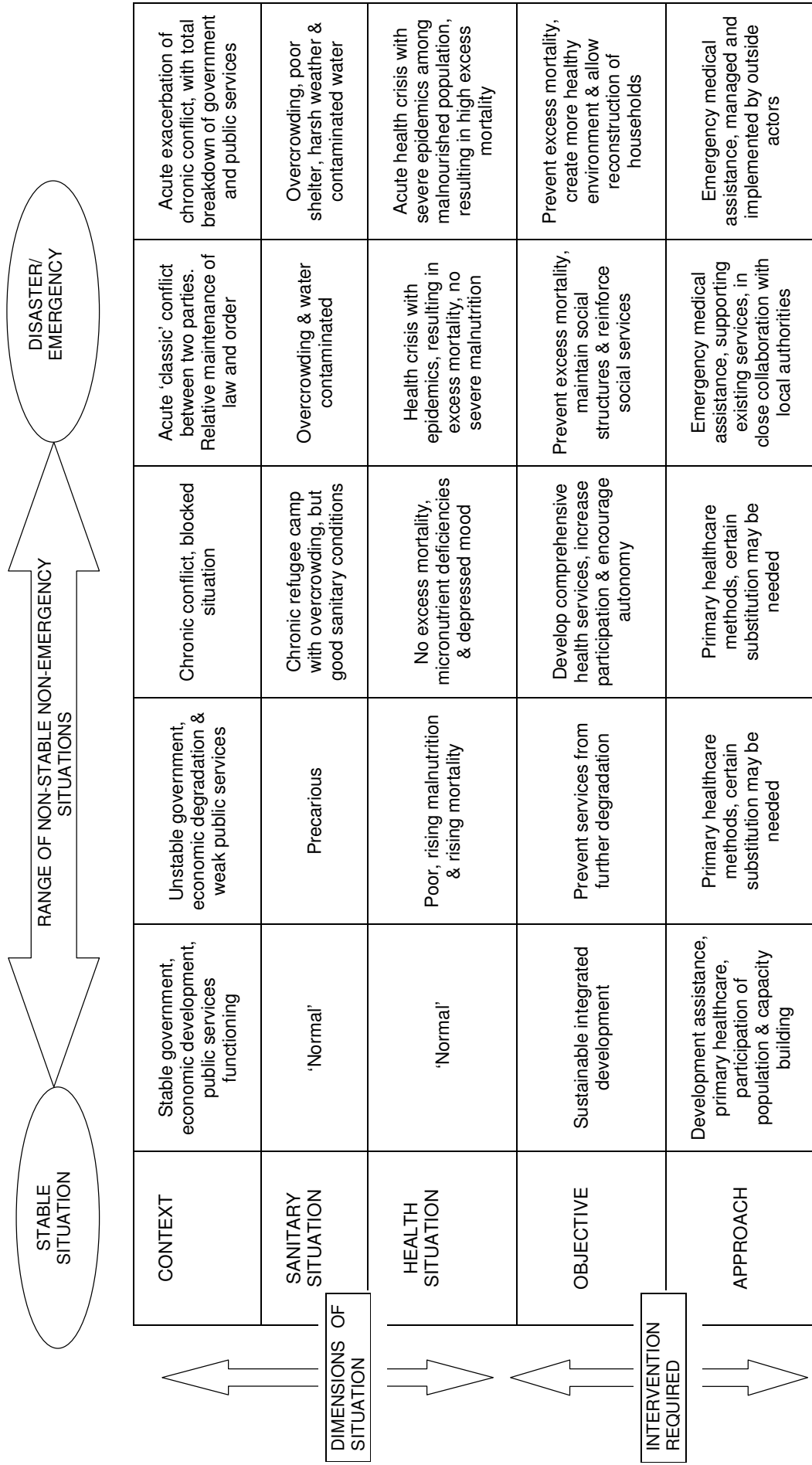|			
	U5MR 0.46/10,000/day Severe Acute Malnutrition (SAM)[33] 8.2%, Global Acute Malnutrition (GAM)20.8% Measles vaccination coverage 94.4% .	other family 93% good access to water, sanitation, 30% basic needs in NFIs, 87% no access to food distribution, 15.6% of families had no income 36.8% of families had at least one person with chronic disease, 93% had access to healthcare 28% of persons affected by violent event	1.8/10,000/day U5MR 5.1/10,000/day SAM[34] 4.2%, GAM 15% Measles vaccination coverage 54% 70% of refugees were registered with UNHCR	U5MR 1.2/10,000/day 65% IDPs affected by violence
Conclusions	Although the mortality rates are below emergency levels, the malnutrition rates are well above emergency levels Although a nutritional programme is in place, majority of malnourished children identified in the survey were not included in the programme.	Satisfactory access to healthcare, but might deteriorate The lack of access to food and kerosene distribution and lack of free access to medication could put IDPs in precarious situation during winter season	Emergency situation with mortality rates above emergency level and high level of acute malnutrition	Precarious situation of IDP and host community in Haut Uélé Uncovered needs in WatSan, NFI Problem of access to healthcare in Dungu (cost recovery) Access to food complicated by insecurity, coping mechanisms okay but may deteriorate High proportion confronted violence
Recommendations	Improve identification and inclusion of malnourished children (CHWs, local associations) Lobby with WHO and MoH for changing MUAC cut-offs Monitor food security	Mobile clinics for psychosocial support Distribution of winter NFI kits, logistic support for roofing Monitoring, rapid health assessment in sub-urban areas	Management of acute malnutrition, access to healthcare, measles vaccination, surveillance	Prospective mortality surveillance, nutritional screening, targeted blanket feeding, mental health and violence, access to health (lobbying with MEDAIR, support to health facilities), vaccination, WatSan, training of local staff in rapid assessment

33 Expressed in WHO z-scores.
34 Using NCHS z-scores.

Annex 8: Matrix of Conflict Settings According to Income and Life Expectancy

	Low income and life expectancy	Medium-to-high income and life expectancy
Camp-like settings		
Occurrence	Common (eg, long-term refugee camps in Nepal and Kenya; IDP camps in Darfur and northern Uganda)	Uncommon (eg, Palestinian refugee camps in Jordan)
Demographic and epidemiological profile	Young populations, often disproportionately female; ageing populations in long-term refugee camps; acute but timebound excess mortality; exception is inaccessible IDP camps; mostly infectious disease burden; increasingly non-infectious diseases	Ageing populations; low excess mortality; mostly non-infectious disease burden
Main challenges	Expand humanitarian access to IDP camps; negotiate land to avoid overcrowding; ensure equity of health care of displaced and host communities by supporting services for host communities; integrate parallel services into government systems through common policies and guidelines and fair allocation of resources; address malnutrition and micronutrient deficiencies	Arrange and pay for complicated and expensive referrals outside of camp settings
Urban settings		
Occurrence	Common (eg, urban refugees and IDPs in Nairobi, Kenya; IDPs in Peshawar, Pakistan)	Common (eg, refugees in Damascus, Syria; IDPs in Tbilisi, Georgia, and Bogotá, Colombia)
Demographic and epidemiological profile	Young but ageing populations, often disproportionately male; possibly high excess mortality during acute crises, although not well documented; mainly infectious but increasingly non-infectious disease burden	Ageing populations; mild to moderate excess mortality depending on context; exacerbation of existing chronic diseases; mostly non-infectious disease burden
Main challenges	Identify and count populations; avoid fragmentation of services attributable to concentration of resources and humanitarian organisations in urban settings; improve quality of care in unregulated environments; integrate services into often weak government systems, while expanding services for new arrivals, reduce financial barriers to access; scale up mental and reproductive health services	Identify and count populations; integrate into government services while expanding services for new arrivals; reduce financial barriers to access; triage and pay for complicated and expensive secondary and tertiary care cases; achieve equity with host populations
Rural, dispersed settings		
Occurrence	Common (eg, IDPs and affected residents in eastern DRC; refugees in Cameroon; affected residents in Darfur)	Unlikely scenario
Demographic and epidemiological profile	Young populations, often disproportionately female; often very high excess mortality if exposure to conflict is protracted or access to services is very poor; mostly infectious disease burden	
Main challenges	Provide essential health services despite poor accessibility or large geographical areas; expand range of interventions including use of temporary mobile services when relevant; undertake mass campaigns when accessibility allows; reduce financial barriers to access; scale up mental and reproductive health services	

IDP=internally displaced people. DRC=Democratic Republic of the Congo.

Table: Matrix of conflict settings according to income and life expectancy, with demographic and epidemiologic profiles and key future challenges

Annex 9: Examples of Situations Between Stable Situations and Disasters

STABLE SITUATION ← RANGE OF NON-STABLE NON-EMERGENCY SITUATIONS → DISASTER/EMERGENCY

	STABLE SITUATION		RANGE OF NON-STABLE NON-EMERGENCY SITUATIONS	DISASTER/EMERGENCY	
CONTEXT	Stable government, economic development, public services functioning	Unstable government, economic degradation & weak public services	Chronic conflict, blocked situation	Acute 'classic' conflict between two parties. Relative maintenance of law and order	Acute exacerbation of chronic conflict, with total breakdown of government and public services
SANITARY SITUATION	'Normal'	Precarious	Chronic refugee camp with overcrowding, but good sanitary conditions	Overcrowding & water contaminated	Overcrowding, poor shelter, harsh weather & contaminated water
HEALTH SITUATION	'Normal'	Poor, rising malnutrition & rising mortality	No excess mortality, micronutrient deficiencies & depressed mood	Health crisis with epidemics, resulting in excess mortality, no severe malnutrition	Acute health crisis with severe epidemics among malnourished population, resulting in high excess mortality
OBJECTIVE	Sustainable integrated development	Prevent services from further degradation	Develop comprehensive health services, increase participation & encourage autonomy	Prevent excess mortality, maintain social structures & reinforce social services	Prevent excess mortality, create more healthy environment & allow reconstruction of households
APPROACH	Development assistance, primary healthcare, participation of population & capacity building	Primary healthcare methods, certain substitution may be needed	Primary healthcare methods, certain substitution may be needed	Emergency medical assistance, supporting existing services, in close collaboration with local authorities	Emergency medical assistance, managed and implemented by outside actors

DIMENSIONS OF SITUATION

INTERVENTION REQUIRED

Adapted from: Van Damme et al, 2002

Annex 10: Summary of Findings on Initial Assessments

	Cameroon	DRC	Djibouti	Iraq	South Africa
Objectives	Improve the knowledge of security situation in northwest region of CAR and its impact on humanitarian situation in eastern Cameroon Clarify the nutritional situation, reported as alarming by UNHCR	Not reported	Assess the situation of refugees, migrants and asylum seekers living or passing through Djibouti Assess nutritional situation and food security situation in Djibouti	Assess the living conditions and the needs (food, health, shelters, etc.) of the IDP families living in the communities in the Dohuk area	Evaluate the medical, sanitation and legal needs of the Zimbabwean migrants
Length of assessment	13 days	6 days	1 months (13 days jointly with MSF OCBA)	8 days	13 days
Conclusions	Emergency situation with mortality rates (CMR, U5MR) above emergency threshold High prevalence of GAM and SAM	Problem of access to healthcare due to financial constraint, problem of food and NFI	No emergency situation, however: High level of acute malnutrition Large presence of refugees and illegal migrants High risk of cholera epidemic	Satisfactory access to healthcare, but might deteriorate Lack of access to food and kerosene, and lack of access to free access to medication could put IDPs in precarious situation during winter season	
Recommendations	Rapid emergency response Food distribution Mobile clinics Develop communication strategy on humanitarian situation of refugees	Short emergency intervention in Bangadi: Reinforce health structures Mobile clinics Measles vaccination NFI, WatSan	STAGE 1 (ASAP) Relief activities in Ali-Adeh refugee camp (food, NFI, shelter, health) Nutrition activities (ambulatory treatment of acute malnutrition and support for Intensive TFC) STAGE 2 Medical, psychological and humanitarian assistance	Mobile clinics for psychosocial support Distribution of winter NFI kits, logistic support for roofing Monitoring, rapid health assessment in sub-urban areas	Intervention in Musina and Johannesburg: protection-legal status, access to health services Epidemics Care for victims of violence Access to TB and HIV treatment. Relief (shelter, NFIs, etc) Psychosocial activities