

EVALUATION of
ECHO's ACTIONS in the
DEMOCRATIC REPUBLIC of CONGO (DRC)

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- Names of the consultants: Markus Michael (Public Health Expert and Team Leader); Véronique Thouvenot (Health Economist), Thomas Hoerz (Food Security Expert); Laura Rossi (Nutritionist, GFE)

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Acronyms

ACF	Action Contre la Faim
ALNAP	Active Learning Network for Accountability and Performance in Humanitarian Action
BCZ	Bureau Central de Zone (de Santé)
CAP	Consolidated Appeal Process (of UN)
CDR	Centre de Distribution Régional
cfw	cash for work
COOPI	Cooperazione Internazionale
CoSa	Comité de Santé (Village Health Committee)
CSB	Corn Soy Blend
CTC	Community based Therapeutic Care
DFID	Department for International Development
DRC	Democratic Republic of Congo
ECHO	European Community Humanitarian Office
ECHO	European Community Humanitarian Office
FAO	Food and Agriculture Organisation (UN)
ffw	food for work
FS	Food Security
HC	Health Centre
HP	Health Post
HZ	Health Zone
IDP	Internally Displaced Person
IRC	International Rescue Committee
KAP	Knowledge, Attitude and Practices
LRRD	Linking Relief with Rehabilitation and Development
MaSoSo	Maize Sorghum Soy
MICS	Multiple Indicator Cluster Survey
MID	Médecin Inspecteur de District
MIP	Médecin Inspecteur de Province
MT	metric tonnes
MoH	Ministry of Health
NC	Nutrition Centre
OFDA	Office of US Foreign Disaster Assistance
ORS	Oral Rehydration Salt
PHC	Primary Health Care
ProNaNut	Programme National de Nutrition
PUC	Pool d'Urgence Congo or Programme d'Urgence Congo
RUTF	Ready to Use Therapeutic Food
SFC	Supplementary Feeding Centre
STI	Sexually Transmitted Infection
STI	Sexually transmitted infection
T/A	(ECHO) Technical Assistant
TFC	Therapeutic Feeding Centre
WFP	World Food Programme (UN)

A. EXECUTIVE SUMMARY

Key conclusions and recommendations at the following levels:

1. Methodology

- If ECHO emphasises the formative and the programming components of an evaluation, it would be appropriate to involve at some specific stages an insider in the evaluation team, who has the memory of context and program.

2. ECHO's overall programming

- The situation of "neither war nor peace" is likely to last for years in DRC. ECHO should basically maintain its areas of intervention in 2005, since indicators of worst vulnerability must still be used, rather than contextual ones.
- Comprehensive, integrated multi-sectoral programmes per geographical area, and community-based targeting appear as the most sensible approaches to address the needs of the affected populations.
- Co-ordination with long-term EC instruments must be further pursued, to match humanitarian and development programming cycles wherever possible, and to develop mid- to long-term planning.
- Collected data on human rights abuses need to be better used in co-operation with sectoral co-ordination bodies, to overcome constraints to programmes' effectiveness.

3. ECHO's programming in the health sector

- Wherever possible, ECHO should aim at covering HZs in a more integrated way, including approx. 50% of Health Centres and one small or medium-size referral district hospital (see pre-conditions) with most of its services. Provided that the budget is kept at its current level, this may imply to cover slightly fewer HZs.
- Curative care should be expanded into preventive health, e.g. for safe drinking water, condom use, HIV/AIDS education, nutritional education and the distribution of impregnated bed nets.
- Access to treatment for victims of Sexual and Gender Based Violence must be improved.
- ECHO must pursue its efforts to contribute to shape an effective sectoral co-ordination body.

4. ECHO's programming in the sectors of nutrition and food security

- Admissions of severely malnourished children were found constant or even increasing, which was not in accordance with ECHO's 2004 data. Discrepancies must be checked, though nutrition is likely to remain a priority in the foreseeable future.
- TFCs represent the "hospital approach" to malnutrition; although Community-based Therapeutic Care can be comparably expensive, this alternative must be assessed.
- Facing huge needs, ECHO can only address the most severe forms of food insecurity that lead e.g. to starvation and displacement, in the most needy areas identified. At that level though, knowledge is insufficient, and sustainability may require a "critical mass" in terms of area and population covered. As a result, the numbers of beneficiaries may increase, together with the budget. Data collection and analysis (both by donors and partners) must be improved.

5. ECHO's sectoral programming for IDPs and returnees

- The objective of reintegration of IDPs must be mainstreamed through all programme components. Only in situations with clear evidence of beneficiaries being able to cover autonomously their needs (finding work or being able to do substantial farming), can assistance be carefully reduced.

6. ECHO partners

- Though generally valuable, strategies and technical know-how were found greatly varying between partners. Little effort seems to have gone into joint learning, sharing best practices and harmonising approaches. This needs to be systematically promoted.
- Due to the fragility of the health system and the operating environment, the effectiveness of projects is highly dependent on constant monitoring by the partner. Comparable monitoring through jointly used key indicators must be reinforced.
- The number of partners willing and able to work in remote regions of DRC is limited, and the quality of their staff is a key factor to success. However, presence is often limited in time, and detrimental gaps appear between missions. Partners should be encouraged to hire expatriate couples and nationals from neighbouring countries.
- There is still room for improvement in community participation (e.g. women in Village Health Committees).

A.1. INTRODUCTION

Despite the recent peace process, the Democratic Republic of the Congo (DRC) still features some of the world's worst mortality rates. The widespread extreme poverty is unlikely to improve significantly in the near future, partly due to the all-pervading effects of a pre-war chronic crisis that has been a textbook example of state failure, collapse and abuses. In this context, ECHO has spent €22.1 million in DRC between 2002-4, concentrating multiple sector activities in the eastern 'red zones', still most affected by conflict, and the 'blue zones' along the former frontline, which have gained a certain degree of minimal contextual stability. The vast majority of projects are being re-conducted on a yearly basis, considering i.a. the large LRRD gap created by still hesitant donors.

The main objectives of this evaluation were to assess the appropriateness of ECHO's actions, to establish whether they have achieved their objectives, to help defining a coherent and viable LRRD approach, and to produce recommendations for the global plan 2005.

Key findings are summarised below. For cross-references purposes with the relevant sections of the main report, paragraph numbers have been added in each case [between brackets].

A.2. MAIN CONCLUSIONS

A.2.1. Global strategy (conclusions for ECHO)

1. The context in the DRC does not correspond yet to a "post-crisis" as suggested in the ToR: neither at population level with regard to indicators of poverty, malnutrition, disease and death, nor at institutional level, with regard to state support to vital institutions and infrastructure. In particular, Eastern areas are still suffering from a high degree of insecurity that affects agriculture and animal husbandry, with consequent negative impact on nutritional status of vulnerable population groups.
2. There is, however, a growing consensus that the interventions to address this (chronic) emergency, must largely be developmental by design; a dilemma for humanitarian actors that requires venturing into 'grey zones' of programming. [§27, 79, 132, 185, 186]
3. Considering the high level of destruction and instability, as well as indicators for e.g. food insecurity or IDPs (the highest in the world in both cases), the DRC appears to have been a victim of a general donor bias that tends to favour small countries which often receive proportionally higher levels of funding. [§17, 25]
4. The horizontal co-ordination with other humanitarian donors (mainly OFDA) seems to function fairly well in the field, but there is room for improvement with regard to vertical co-ordination between different EC instruments. [§24]

A.2.2. Operational strategy (conclusions for both ECHO and partners)

5. The situation is characterised by 'short-term funding, long-term needs'. Short project cycles, as practised in a few instances, are especially detrimental to devising and implementing LRRD strategies. Best practice includes comprehensive, multi-sectoral programs and community-based targeting, which appear as sensible approaches to address the needs of the affected populations.
6. With few exceptions, the partners' operational capacity was found to be good. However, the number of potential partners willing and able to work in remote regions of DRC is limited. Other constraints were due to operational overstretch (some partners seem to have reached or overstepped their

operational capacity limits) or to inability to handle cash constraints. Interrupted drug supplies e.g. had a crippling effect on some health projects. [§62, 98]

7. Different ECHO partners have developed a host of refined assistance strategies and approaches. The technical know-how in respect to modules of intervention varies widely. Few efforts were visible to promote joint learning and programming, to harmonise approaches and to benefit from identified best practices. The 'emergency mode' of health assistance appears significantly more costly than a 'developmental' approach. [§20, 66]
8. Technical capacities of expatriate and local staff, and missions' duration of the former are a key determinant for the success of projects. Short missions and gaps between staff presence are detrimental to successful planning and implementation. [§63, 99, 135, 150]
9. ECHO encourages collection of data on abuses of human rights law (HRL) and international humanitarian law (IHL), within necessary parameters of security. In practice, awareness of this issue among field staff was found to be unequal. [§23, 30]

A.2.3. Sector strategy

Health (conclusions for ECHO)

10. Lack of prevention, insufficient access to health care and underlying factors such as malnutrition and lack of safe drinking water, have led in DRC to one of the world's highest mortality rates. Endemic and epidemic diseases are on the rise again. The health system is all but disintegrated, owing to long-standing pre-war negligence and war effects. What is functioning, remains singularly donor-dependent. ECHO is supporting the Primary Health Care system through its partners, retaining the health zone (HZ) as entry point for subsidising health care. In 2004, the target was 54 of the 306 (old) HZs. [§40, 46, 47]
11. ECHO and its partners are faced with chronic health needs that are exacerbated by an acute humanitarian crisis; chronic needs will not disappear with the end of violence, nor will the performance of the local health system improve. The return on investment in a local health system is nullified when this support is withdrawn prematurely. [§48, 80, 106]
12. Food security, safe drinking water and access to health care are arguably the main determinants of health and ill-health; ECHO's decision to concentrate on the geographical areas of 'red' and 'blue' zones remains justified with regard to both determinants. [§47]
13. Curative care in first-line health services remains extremely relevant for the health of the affected population. For reasons such as lack of capacity or widespread corruption (entailing e.g. drug supply gaps or non-respect of flat fees), the range of preventative and health promotion activities, or the support given by ECHO to first-referral hospitals and to Bureaux Centraux de Zones (BCZ) remains generally limited. Shortfalls of some components necessary to achieve synergy for the provision of care were frequently encountered: lack of water for washing, run-down and even dirty infrastructure, small equipment missing or an insufficient reward package for MoH staff. As a result, user rates are incomparably higher in health services supported by ECHO. Hospitals were generally found to be under-used, and were delivering substandard care in some instances. [§53, 54, 56, 74, 95]
14. This should not be generalised though, and some hospitals would deserve support. ECHO can also hardly avoid to be further involved in the assistance to some district hospitals, since it is currently active already at the level of the health system, rather than on the level of the patient as in more "typical" emergency situations. District hospitals are integral parts of the health system, and of PHC. As there are no natural boundaries within a hospital, partial support has either been diluted - and become less effective - or, where maintained separate, has created staff management problems and ethical dilemmas. [§75, 103]

15. ECHO-funded programs have slowly expanded from the provision of curative care into prevention activities. Opportunities are still lost in the field of health promotion, safe drinking water, condom use, HIV/AIDS prevention, malaria prevention and substantial support to EPI. Some promising inroads have been made in most of these fields. [§78]
16. The Programme d'Urgence Congo (PUC) appears to intervene more in the 'post-conflict' and 'development' zones of the Congo. Considering the complete lack of its sustainability, alternative strategies of coping with epidemics may be considered. [§92, 93]
17. The lack of co-ordination in the health sector has led to fragmentation and verticalisation. Beyond supporting general co-ordination efforts through OCHA and, more recently, funding two positions of WHO/HAC, ECHO has tried to fill some of this co-ordination void in the health sector by giving directives to its partners. [§67, 68, 100]
18. A small number of health projects were successfully handed over to other EC instruments. There is a chance again, that some partners can continue providing the support needed in places where ECHO plans to phase out, within the framework of the 9th EDF. [§88-90]

Health (conclusions for partners)

19. Most partners have applied an appropriate mix of relief and development strategies. A small minority of them however, have remained in the relief end of the spectrum, losing thereby opportunities to strengthen local MoH structures where this might have been feasible. Where no other donor is supporting the higher-level MoH administrations, shortcomings are noticeable. [§81]
20. No humanitarian donor can afford to cover HZs fully. There is agreement on a minimum quality of care below which assistance becomes ineffective; most partners have made a good choice with regard to the trade-off between coverage and quality, though errors were committed at both ends of the spectrum. [§72]
21. While community participation in the form of contribution to the health service infrastructure was generally excellent, there is room for improvement of the functioning of Village Health Committees, especially regarding representation of women. [§59]
22. Access to treatment for women suffering from Sexual and Gender Based Violence is still insufficient. This concerns psychosocial support in the community, medical treatment at first-line services and, in Maniema province, specialised surgical care. [§77]
23. The effectiveness of health projects is highly dependent on constant monitoring and supervision by the partner, owing to the fragility of both the health system and the operating environment. However, monitoring was not sufficient in some cases, preventing a timely shift in assistance strategy. This was due either to a fee system that makes monitoring difficult ('paiement par acte') or the failure to notice relatively low user rates. Partners have not been systematically monitoring satisfaction at household level, either. [§60, 61, 64, 65, 71]

Nutrition (conclusions for both ECHO and partners)

24. Despite numerous interventions, malnutrition continues to claim massive costs of lives. Child nutritional status remains a serious public health concern. Admission rates of severely malnourished children to the nutritional centres have been found constant or even increasing in certain areas by the evaluation, which was not in accordance with some other data collected by ECHO. The prevalence of chronic malnutrition and Kwashiorkor is widespread and mainly related to poverty. Anaemia levels are alarming, too. Malnutrition of adults can be associated with other pathologies. There are no data on prevalence of adolescent and adult malnutrition. [§140, 144, 145]
25. Nutrition has remained a primary focus for ECHO: therapeutic feeding centres (TFC) function in hospitals or health centres, supplementary feeding centres in more decentralised locations. However,

TFCs represent the 'hospital approach' to malnutrition. This strong clinical focus is not completely compatible with an overall nutritional strategy. [§142]

26. Nutrition centres are expensive; they have large requirements for resources, skilled staff and imported therapeutic products. Admission of a patient to a therapeutic feeding centre usually obliges the carer to leave the family for around 30 days. Furthermore, the effectiveness of nutrition centres is highly dependent on prefabricated and imported inputs and, particularly dependent on WFP food deliveries; both are vulnerable to supply disruptions. [§143, 150]
27. There is a clear, comprehensive national nutrition protocol. Mechanisms to provide feedback from the field, however, to foster further refinement of the protocol, are lacking. [§146]
28. Community-based Therapeutic Care (CTC) is an alternative for selective feeding in emergencies, though experience in this approach is still limited. Caring for people in their communities strengthens the social fabric and capacity and links with existing community interventions. CTC has also a strong LRRD potential. [§153]

Food Security (conclusions for both ECHO and partners)

29. The population of the DRC is the most food insecure in the world (FAO), with 75% of undernourished people. This is a major failure of both state and international assistance, considering the huge agricultural potential of DRC. Food insecurity has for decades followed a downward spiral driven by state failure, lack of purchasing power, reduced geographical access and, most importantly, by continued insecurity. Violence threatens large parts of the population and affects all elements of the agricultural cycle: field preparation, acquisition of inputs, marketing of products and storage of harvested food. [§178, 179]
30. Food insecurity in DRC constitutes, by all standards, a major emergency. Average consumption levels are estimated at 70% for calories and only 50% for proteins. There is, however, a growing consensus, that the interventions to address this situation must largely be development-driven; a dilemma for humanitarian actors that requires venturing into 'grey zones' of programming. [§185]
31. In this framework, humanitarian aid can only address severe forms of food insecurity (and extreme poverty) that lead to starvation and a deterioration of health status, that forces populations to leave their homes or to engage in harmful coping strategies. However, at that level impact must be targeted, with appropriate means. [§198, 225]
32. The lack of reliable and comparable national food security data has weakened humanitarian interventions. These were rightly undertaken in the most conflict-affected areas, access allowing. Part of the severely food insecure population has thus been excluded by a pre-selection that was dictated by accessibility and insecurity. Where possible, the beneficiaries have been the malnourished persons and their families, the IDPs, the returnees, and part of the host communities. [§180, 181]
33. While targeting malnourished persons follows strict scientific rules, selecting the 'poorest' or 'most vulnerable' households is more complex and requires participatory approaches. [§183]
34. If designs of food security projects are to provide a basis for continued and increasingly developmental approaches (LRRD), knowledge among beneficiaries and capacity among partners are crucial limiting factors and must be overcome. Measures to enhance community participation and involvement of the state structure (where this still exists) are in their initial stages and require further development. [§185]

IDPs and Returnees (conclusions for both ECHO and partners)

35. After Sudan, DRC has the highest number of IDPs in the world (UNOCHA used a figure of 2.329 million in Aug. 2004) though estimates can vary widely, as for their returns. Many IDP families in return areas, having spent months hiding in the forest, are in the same or in a worse situation than the 'official' returnees. Having received no assistance, they may even be more vulnerable. Only a fraction of IDPs receives official support. Solidarity of host families plays a significant role, often further eroding the livelihoods of hosts themselves. [§224]
36. ECHO-funded assistance focuses on registered IDPs/returnees and some host families. Support to social infrastructure like schools responds to basic priorities of the whole population, but leaves little room for (minimum) income generation or duplication without support. Support below the acceptable humanitarian minimum level may make IDPs staying away from home even longer; they will be too poor to risk the move back home. [§227, 234]
37. There is indeed a hard-dying myth that the meagre IDP rations, a blanket and a plastic sheet makes IDPs stay away from home. With or without relief, IDPs will not return to their homes if (i) the situation there is not safe; (ii) poverty does not allow them to survive until the next harvest; (iii) income opportunities are substantially below survival needs; (iv) they cannot overcome either a geographical, logistical, security or a financial barrier; (v) they do not expect to find health, water and school facilities in return areas. [§236]
38. Promoting return must therefore be based on sound knowledge, resulting in substantial return support. Half measures can remain without effect. Besides incentives, the timing and approach can be decisive for the success of promoting return. [§231]
39. As in other sectors, there is little exchange of lessons learned and best practices between partners to improve design and efficiency of projects. For example, current returnee kits respond to priorities but seem insufficient to overcome the 'poverty barrier' to return. They would benefit from further adaptation and fine-tuning, involving beneficiaries, FAO and concerned ECHO partners. [§230, 240]

A.3. MAIN RECOMMENDATIONS

A.3.1. Global Strategy (recommendations for ECHO)

- *Recommendation 1:* the level of ECHO's assistance in DRC should be determined as much as feasible by identified needs, irrespective of the larger size of the country compared to others in the region. Mid-to long-term planning is still needed, considering that the current situation of 'neither war nor peace' may last for years to come. ECHO should maintain the current definition of its 'exit strategy' according to the worst vulnerability indicators at population level and performance indicators of local capacities, rather than by contextual indicators (e.g. decrease in fighting).
- *R.2:* EC aid instruments should continue to co-ordinate their plans whenever possible, trying to match humanitarian and development programming cycles. This may lead to the joint development of 3 to 5-years scenarios, more appropriate for DRC than annual cycles.
- *R.3:* ECHO could play a more pro-active and facilitating role with non-EC donors, helping partners to obtain matching development funds, e.g. in the province of Equateur.
- *R.4:* ECHO should enhance its role of promoting of inter-agency exchange and learning by financing and supporting efforts of UN and other co-ordinating bodies. Assistance modules and training packages can be developed, and then adapted and applied to specific situations.

A.3.2. Operational Strategy

Recommendations for ECHO

The recommendations below could arguably fit a transition / development donor even better than ECHO; we would nevertheless like to point them out in the specific context of DRC, with due caveats.

- *Recommendation 1:* where circumstances allow and LRRD with development donors can be set up, the future of relief projects in DRC may go towards 'integrated basic needs projects', implemented by one partner or a consortium of NGOs. For example, integrated health, nutrition –with malaria and HIV prevention- and food security projects could be considered a standard intervention strategy, with links to the respective sectoral lead agencies. Such projects could have full responsibility for an area.
- *R.2:* as much as feasible for ECHO, a geographical intervention area, once defined, needs to be reassessed for validity at regular intervals. It must be borne in mind that only partly covering a territory / district may block this area from other donors' engagement and leave pressing needs not addressed.
- *R.3:* community-based targeting is a basic principle of any relief or recovery intervention. Wherever security and access allow, and where LRRD can be ensured with development donors, interventions must move away from even sensible pre-selection towards controlled and guided community based targeting.
- *R.4:* in a context of chronic emergency, funding cycles should generally be aiming at 12 months; renewal procedures must be alleviated as much as feasible, to avoid funding gaps in between.

Recommendations for partners

- *Recommendation 1:* ECHO should insist as much as possible in the professional qualifications of expatriate staff, in mission duration of ideally nine months, and that gaps between them are avoided. In view of the hardship conditions, partners should be encouraged to hire expatriate couples and nationals from neighbouring countries (who can skip home more often).
- *R.2:* monitoring of key indicators is to be streamlined. ECHO should insist that partners share some indicators. For example, marks given for the performance of health centres during supervisions are to be converted into a numerical score that can be monitored over time.
- *R.3:* if a partner uses vehicles temporarily, and these are marked with partner and ECHO emblem, care must be taken to withdraw these immediately afterwards.
- *R.4:* ECHO should continue exhorting partners to collect data on abuses of HRL, IHL and protection needs that are detrimental to the effectiveness of projects. Such data must be reported to sector lead or specialised agencies, for appropriate advocacy or other actions.

A.3.3. Sector Strategy

Health (recommendations for ECHO)

To achieve impact, a more integrated approach must be sought...

- *Recommendation 1:* ECHO should basically maintain its areas of intervention in 2005, though with a more integrated and resource-oriented approach. Certain partners should revise downward the area they cover. If ECHO does not increase its budget envelope and number of partners, this may imply a slightly lower number of HZs to be covered.

- **R.2:** it is important for impact that the covered area should present as much as possible an integrated and functional health structure, with health posts, approx. 50% of health centres (which appears to be both feasible for the partner and acceptable for the MoH), one small or medium-sized (50-70 beds) referral hospital with a wide coverage of its services. Indeed, there are no natural boundaries within a hospital. Partial support, unless given to hospitals that have a sufficient financial basis to cope with the rest (which was nowhere the case), remains a half-hearted, unsatisfactory assistance strategy. Support of the MoH administration should be gained through sector co-ordination (below). The neglect or lack of any of the components needed for the provision of care may severely jeopardises the effectiveness of the assistance program. The importance of co-operation with a partner hospital (e.g. in the Maniema province with regard to surgical treatment) could also benefit to the LRRD.
- **R.3:** however, considering the negative past experiences with many hospitals, it is evident that funds should not be poured into all of them. Pre-conditions need to be applied, such as (i) a willing and able partner; (ii) reasonably well managed hospital by committed management, with open financial books and MoU signed by both parties; (iv) monitoring of the quality of care by the partner, (v) flat fees, demanding in turn constant basic supply and (vi) potential continuity is ensured through a development donor or traditional partner.
- **R.4:** ECHO has to encourage the expansion from the provision of curative care into preventive health, especially for safe drinking water, condom use, population-based HIV/AIDS education, and the distribution of impregnated bed nets.
- **R.5:** in particular, efforts to improve access to treatment for victims of Sexual and Gender Based Violence are to be increased, by psychosocial support in the community, medical treatment at first-line services and specialised surgical care.
- **R.6:** no value of flat fee can be proposed that would be appropriate for the whole target zone, considering the regional differences. The current system of flat fees is to be maintained, with periodic adjustments according to the socio-economic level of the local context.

...and ECHO must promote a solution for sector co-ordination.

- **R.8:** co-operation with the institutional umbrella of the MoH must be promoted wherever possible in the areas where ECHO is focusing its assistance. Support of the higher level(s) of the MoH must be sought through the lead agency/international body in charge of the sector co-ordination. ECHO must therefore maintain its efforts to contribute shaping the health sector co-ordination, with a clear role.
- **R.9:** alternatively, claims against corrupted or detrimentally ineffective local administration should be brought to the attention of the co-ordination body in the appropriate form (to be discussed), for further action at MoH level with due supporting evidence and strength.
- **R.10:** support to the Bureau Central de Zone (BCZ) by ECHO partners should only be carried out when the effectiveness of the BCZ has been duly demonstrated.

Health (recommendations for partners)

Partners must use their resources in an optimum manner,...

- **Recommendation 1:** ECHO should be careful to attribute areas to cover to partners according to their operational capacities. Solutions with regard to the “découpage” of HZs are to be found locally on a case-by case basis.
- **R.2:** partners should widen the spectrum of activities in the field of prevention and health promotion. They should (continue to) apply an appropriate mix of relief and development strategies that needs to be continuously adapted to changing circumstances.

- **R.3:** health programs have the potential to greatly improve access to health care, especially at the level of Health Centres. Most partners have succeeded in this; where there are shortcomings, the analysis of their causes should lead to the necessary strategic changes.
- **R.4:** partners have to know where to strike a balance between the number of Health Centres to support, and the quality of care that can be guaranteed. Service profile and standards that define a minimum quality of care are to be more formally agreed upon between partners and the MoH.

...they must apply closer monitoring...

- **R.5:** user rates of supported health services are to be monitored closely; if they are low, an analysis of the possible causes has to be made.
- **R.6:** partners should systematically inquire into user satisfaction at household level as part of the supervision activities. Whenever possible, this should be complemented by regularly monitoring access to health care of the affected population.

... and enhance community-based approach.

- **R.7:** to help Village Health Committees to function better, partners need to use the 'development toolkit', which not all of them master well.
- **R.8:** the only possibility for replication of support at community level appears to be through an existing network, such as a traditional partner.

Nutrition (recommendations for ECHO)

- **Recommendation 1:** for the foreseeable future, nutrition should remain a priority of ECHO activities in DRC.
- **R.2:** the issue of conflicting data must be solved. There is a strong need for a national nutrition assessment with a micronutrient component; ECHO should consider co-funding a MICS 2005 (e.g. a specific sector, most relevant for its activities).
- **R.3:** results of the pilot experience of nutrition centres evolution into therapeutic home care centres should be discussed in a round-table; relevant stakeholders should review the national protocol (ProNaNut) in the light of this experience.
- **R.4:** epidemiological and contextual data for comparing and monitoring the effectiveness of classical nutrition centres and CTC approach are necessary. Better data on comparative costs are needed.

Nutrition (recommendations for partners)

- **Recommendation 1:** the admission in nutrition centres of children 5-18 years is not questionable. Malnutrition in adults can sometimes be associated with other illnesses. In such cases both the malnutrition and the underlying illness must be treated.
- **R.2:** the (100% inpatient) therapeutic feeding approach should evolve into a partially outpatient model, to increase family involvement and reduce absence of mothers from the family. Time mothers spend in nutrition centres can be better used to teach them about nutrition.
- **R.3:** supplementary feeding centres should become 'nutritional reference points' with a strong community involvement. Local production or preparation of therapeutic and supplementary food should become part of such an integrated strategy.
- **R.4:** where there are no specific nutritional programmes, doctors and nurses working in paediatric wards are to receive specific nutritional training, to recognise signs of malnutrition and to permit treating severe cases in paediatric hospitals wards.
- **R.5:** nutritional education is to be substantially improved with adapted visual material.

- **R.6:** iron supplement can contribute to treat iron deficiency in anaemia, but it must be combined with other public health measures (i.a. against malaria) to obtain a full benefit.

Food Security (recommendations for ECHO)

- **Recommendation 1:** to achieve actual impact on the worst forms of food insecurity, beneficiary numbers must increase beyond current targets. This may require increased ECHO funding for food security, after assessment of other key donors' plans. The alternatives are either shrinking geographical areas (with enhanced food security interventions) or a continuation of the 'curative approach' to food insecurity.
- **R.2:** ECHO must ensure that in targeted districts 'coverage' means covering the whole district, or sufficient parts of it to achieve an impact. Nutrition and food security situation in current and neighbouring territories/districts are to be assessed. Geographical allocation is to be re-oriented according to needs identified. Other donors are to be alerted if ECHO is unable to sufficiently cover a territory/district.
- **R.3:** data collection and analysis must be improved. Co-funding of specialised studies or jointly planned surveys have to be considered in the framework of multi-donor co-operation (FAO, UNICEF, WFP), to give clear indications about numbers of extremely food insecure populations per region, and to draw longer-term plans.
- **R.4:** for 2005, a more refined and flexible approach of the food security PUC is necessary to allow for a stratification of beneficiary needs and agro-climatic conditions.

Food Security (recommendations for partners)

- **Recommendation 1:** 'other vulnerable families' are to be selected (apart from families with malnourished members, registered IDPs and returnees) with the help of village committees.
- **R.2:** partners should carry out rural appraisals as a basis for the agricultural kit composition. FAO and concerned ECHO partners should jointly re-examine food security modules in workshops. Beneficiaries' knowledge, partners' capacity and community participation must be key issues. Where modules may be out of core mandate, pilot projects may be considered on a strict yearly basis, and plan for hand-over to development donors.

IDPs and Returnees (recommendations for ECHO)

- **Recommendation 1:** IDPs should be provided with similar support as is given to refugees. Only in situations with clear evidence of IDPs finding work or being able to do substantial farming, can assistance be carefully reduced.
- **R.2:** in IDP/returnee situations, it is most appropriate to adopt the 'affected area approach', with vulnerability as the main inclusion criterion.
- **R.3:** ECHO should consider mainstreaming IDPs and returnees into all programme components (Health, Nutrition, Food Security). This would facilitate a continuation of increasingly targeting the most vulnerable population, regardless of their status.
- **R.4:** an independent study is to be conducted of driving and hindering forces for return. Return campaigns are to be planned jointly with IDPs and other stakeholders.
- **R.5:** technical workshops are to be facilitated to further improve or develop the following topics: 1) from IDP/returnee projects - to 'affected-area-projects'; 2) income generation in refugee and IDP hosting areas; 3) social infrastructure; 4) return campaigns, and 5) return kits.

B. MAIN REPORT

B.1. INTRODUCTION

B.1.1. Background and Context

1. The main landmark of the peace process in the recent years remains the installation of the Transitional National Government in Kinshasa in June 2003; elections are planned for July 2005. Despite this peace process, the Democratic Republic of the Congo (DRC), once a 'rimland country' [1 in annex A: Bibliography] and one of the 'global borderlands' [2], tops the list of ECHO's worldwide vulnerability ranking; it features some of the world's worst mortality rates [3,4], which in 2002 were still reported to be twice as high as sub-Saharan averages [5]. While malaria is the main contributor to the burden of disease and death, other endemic (TBC, sleeping disease) and epidemic diseases (plague, cholera) have resurfaced, too. Some diseases, like measles, are linked to widespread malnutrition. HIV/AIDS is slowly spreading, though exact prevalence is not known¹.
2. The situation on the ground, especially the widespread extreme poverty, is unlikely to improve significantly in the near future; the causes of this current misery have earlier roots than the recent wars: the pre-war history of Zaire is a textbook example of state failure and collapse [6]. The state of Zaire had abdicated its responsibilities well before the war, with disastrous equity effects especially on health and education services. At the heart of the under-development of DRC lies the circular cause-effect relationship of extreme poverty and very low (and shrinking) agricultural production (annex B: flowchart). The dominant role of agriculture in any future way out of the current emergency is explained by the fact that there is simply no other economic activity for the majority of the population to generate income in the foreseeable future.
3. Abuses of International Humanitarian Law and Human Rights Law, especially in the East of the country [7], were and are commonplace. Sexual and Gender Based Violence (SGBV) [8,9,10] in the East and the continuous use of child soldiers [11,12] deserve special attention. Most perpetrators belong to Congolese armed factions, controlled or not controlled by the government, or armed factions of neighbouring countries, which continue acting on Congolese soil. The fragility of the current peace process has been illustrated by the recent armed upheaval in Bukavu in June 2004, which was also a considerable setback with regard to the humanitarian space; territories along the former frontline are in some instances not yet unified. Part of the explanation for this can be found in the fact that the root causes of the wars are still at work, especially with regard to illegal exploitation of mineral resources [13,14] and other interests of neighbouring countries and their Congolese proxies [15]. It comes as no surprise, that NGOs during the CHAP workshops in Eastern Congo in June 2004 unanimously considered the continuation of the status quo as the best-case scenario for the near future: 'neither peace nor war'. Glimpses of hope can be caught looking at the number of IDPs (reported as over three million in 2003 [16]) that are visibly returning by their thousands, or reading about the recent proposal of the UN Secretary General to significantly increase the number of the MONUC contingents.
4. The evolution of ECHO global plans (GP) is characterised by a near exponential increase, from 1.5 m € in 1997 to 32 m € in 2002 and to 40 m € in 2004. Including smaller, special decisions, ECHO has spent 122.1 m € in DRC between 2002-4. ECHO has funded activities in the sectors of: 1) Health, 2) Food and nutrition, 3) IDPs & returnees, 4) Special mandates for international agencies (annex C: Partner list). Geographically, the GP 2004 concentrates activities (annex D: DRC map), in the Eastern 'red zones', still most affected by conflict, and the 'blue zones' along the former

¹ Over-all, around 5 %

frontline, which have gained a certain degree of minimal contextual stability. The vast majority of projects are being re-conducted from previous years in the form of yearly projects. Foreseeing a phase-out by the end of 2004, ECHO has set a shorter time horizon to partners, of initially 6 months, to be extended, if need be, until the end of the year. In view of the continuing instability, however, even another Global Plan is now foreseen for 2005. At whatever point in time, however, ECHO decides to phase out humanitarian aid, the notorious 'gap' between relief and development aid appears programmed: bilateral development donors will continue to hesitate implementing budgetary support to a government that has yet to prove it really functions.

B.1.2. Objectives of the Evaluation

5. The purpose of this external evaluation, according to the Terms of Reference (annex E: ToR), is "to assess the appropriateness of ECHO's actions, in accordance with ECHO's mandate, in order to establish whether they have achieved their objectives and to produce recommendations for improving the effectiveness of future operations in DRC" (ToR). The timing of the evaluation has been chosen so that its findings can feed into the financing decision for the GP 2005, to be taken by the Humanitarian Aid Committee in November 2004.
6. More specifically, operational and sectoral strategies were to be evaluated, not only to inform for the GP 2005, but especially to "assist ECHO and other EC services to define a coherent and viable LRRD (Linking Relief, Rehabilitation and Development) transition plan for its future eventual progressive and partial phase down/phase out from DRC" (ToR).

B.1.3. Methodology

7. The team of consultants consisted of four members: a public health physician (team leader), a health economist, a nutritionist and an agronomist. After three days of briefing and desk study in Brussels, the team spent four weeks in the DRC between 17 July and 14 August 2004 (annexes F and G: Itinerary and contact list), travelling in two separate teams (Team A: Health; Team B: Nutrition/Food Security/IDPs) within and between provinces by air (ECHO, commercial and MONUC flights). After some initial contacts in Kinshasa with health and agricultural authorities, UN agency representatives, partner national representatives, and briefing by the respective ECHO Technical Assistants (T/As), the time in the field was used visiting partners and their projects, using ground transport (motorbike, car).
8. Extensive literature study included the use of peer-reviewed literature, reports found on the internet and reports provided by ECHO and partners, as well as UN agencies and the MoH (annex A: Bibliography). Semi-structured individual and group interviews were held with key informants at the level of partners, the Ministry of Health (MoH), UN agencies, other health care providers, health service users, local authorities and community leaders, as well as randomly selected members of the affected population. Interviews were often coupled with direct observation, during visits to health services, feeding centres and agricultural projects. Interviews with beneficiaries and the general population needed translation. Whenever possible, independent translators were used (hired or volunteers) to eliminate bias by using agency staff; such bias could not always be avoided, though. Triangulation was employed throughout the process of data gathering and analysis, comparing interview material, observation and documents from different sources. Certain data were used that had been gathered by the team leader during a WHO mission to the DRC two months prior to the current assignment.

9. The consultants visited/evaluated 12 of the 19 health projects, 7 of the 14 Nutrition/food security projects and 9 of the 13 IDP projects (annex C: Partner list). Individual evaluation files for each partner were filled on the spot and handed out to them for comments immediately (nutrition/food security/IDPs) or after the mission, via electronic mail (health). The return rate for comments made from the latter was 50 % only.
10. Constraints of time and logistics prevented the evaluation team from making a choice with regard to sampling of partners and projects; the choice of individual locations of project components was very limited, too. Random sampling was only possible at the level of service users and affected population. Excellent preparation and logistical support allowed optimising the duration of the field visits, but time spent with individual partners was at time at the lower limit, or too low. In the end, however, the rather large sample size guaranteed to evaluate a representative cross-cut of partners/projects and local contexts. The ranking of projects along the five main criteria was difficult especially in the beginning of the field visits, without comparison between projects. Also, explanatory notes for evaluation criteria as annexed to the TORs (annex E) do not in all cases conform to the splitting of criteria in sub-points in the form to be filled for partners.

Conclusions

11. Despite the fact that random sampling of sites visited was impossible owing to logistical constraints, a representative sample of partners/projects and local contexts was evaluated. Time spent with partners, however, was at times at the very lowest limit. Ranking of project work from 'a' to 'e' – if at all necessary – requires an overview and contextual understanding, which evaluators possess only towards the end of a mission.
12. Throughout the evaluation process, ECHO has emphasised the formative element of this exercise, together with programming purposes. For programming purposes, ECHO, however, and some of its partners, has more much more knowledge and memory of the DRC and the programs than external evaluators can acquire.

Recommendations

13. The evaluators should be asked to give feedback to partners at the end of mission only, in order to allow for a minimum of distance and be able to adjust marks by comparing between projects. The forms to be filled for partners should contain sub-criteria that are coherent with the ones in the explanatory notes (and that are more widely used).
14. Purely external evaluations are less apt to fulfil the programming purposes of an evaluation than a mix of internal and external evaluators. ECHO should consider involving at specific stages some of its own staff in the evaluation team, to enhance adequacy of programming recommendations (while generally respecting the independence of the external evaluators).

Lesson learned

15. Logistical constraints may prevent random sampling of sites to visit. In such cases, it is important that ECHO stratifies the sampling according to different categories of sub-contexts.

B.2. MAIN FINDINGS

B.2.1. CROSS CUTTING ISSUES

B.2.1.1. 'According to need'? [17]

16. Overall ECHO funding for the DRC has gradually and constantly increased over the last years, reaching 44 m € in 2003. Nevertheless, funding level compared to other countries in other regions appears to be at the lower end, considering the high degree of destruction and instability in the DRC. That the cost of delivery differs between contexts has to be taken into account [18], of course (though the logistical constraints of the DRC would only increase the bias that appears to work against it). A factor that has limited funding is the finite number of willing and able implementing partners and, in the past, limited humanitarian space.
17. Such inequities of resource allocation between humanitarian situations have been described in the literature [20, 17]; donors in general "tend to be more generous towards countries with small populations" [21]. In the DRC, the response of the humanitarian system as a whole has been called "grossly inadequate" [17]. One of the principles adopted by donors at the 'International Meeting on Good Humanitarian Donorship,' held in Stockholm in June 2003, was to allocate humanitarian funding in proportion to needs [22]. In the chapters below, it will be shown that the most basic needs in the DRC are far from fulfilled.

B.2.1.2. The context: 'post-crisis'?

18. Experience has taught that even if organised military fighting were to end in the DRC, this does not entail a quick improvement of indicators at population level with regard to security, poverty, health and nutrition. Many of these indicators in so-called 'pacified' areas continue to be at rock-bottom level, owing to the war and pre-war decrepitude of institutions and infrastructure. Agricultural production continues to be low (and shrinking), malnutrition rates (in acute and chronic forms) are slow to come down (if at all), immunisation coverage lags far behind and epidemics continue flaring up regularly. It is known that "monitoring is typically focused on the input-output equation of project management, rather than on assessment of the external environment and the changing nature of risks" [17]. The key risk factors, however, that contribute to patterns of poverty, malnutrition and disease, continue to work, even in the absence of organised military fighting. The context also corresponds to an emergency situation in the sense that other (interdependent) factors contributing to health and nutrition status are not at a level that allows a targeted intervention to be entirely effective.
19. In a few instances, too short a time horizon (6-month 'phase-out' periods) has been detrimental to effective strategic planning. For example, setting up nutrition centres with connected demonstration gardens and an animal breeding unit, plus the outreach agricultural extension, requires a minimum of three months to function fully and at least nine months to start producing sustainable impact. Any inter-agency exchange and technical refinement will not happen during a 6-months phase, which is, in addition, a major problem for attracting qualified and experienced staff. ECHO is well aware that the 'end of outright war' does usually not mean the 'end of emergency'. At best, the humanitarian situation is in the initial stages of a 'transition' from war emergency back to the 'normal emergency'. A withdrawal of humanitarian assistance, prior to the measurement of e.g. increased household income, increased agricultural production, increased calorie/protein intake, increased quality of the

diet, and state support to the health services, will only result in 'internalising the cost of war' [23], if development donors and partners cannot ensure continuity.

B.2.1.3. Joint learning and programming, defining best practices and harmonising approaches

20. Although all ECHO partners are confronted, in their respective sectors, with a similar range of problems, they appear to work in relative isolation from each other. All partners taken together have probably found appropriate solutions for all relevant problems within their control, but individual lessons learned are hardly put to use beyond a specific situation and partner. ECHO's technical assistants do make considerable efforts to streamline approaches, but the mechanisms for joint learning and programming need to be strengthened (without over-burdening ECHO T/As and without taking over a coordination role that other [UN] agencies have). A few examples serve as an illustration of such missed opportunities.

- Including an integrated feeding component in paediatric services of hospitals without Therapeutic Feeding Centre.
- Writing and using a Memorandum of Understanding with the local MoH.
- Shared indicators for monitoring and evaluating primary health care programs.
- Use of standard training modules and visualisation materials in all intervention areas.
- Collection and transmission of cases of abuses of Human Rights Law and International Humanitarian Law (IHL).
- Introducing systematic local purchase for nutrition centres to fill WFP gaps.
- Introducing seed fairs rather than seed procured from commercial producers outside DRC.
- Developing standards for road rehabilitation and systems of sustainable road maintenance.

B.2.1.4. Donor communication strategy

21. With a very small number of exceptions by partners that obviously didn't care, cars used by them and by institutions supported were duly fitted with ECHO stickers (some did look conspicuously new, though). The ECHO emblem also featured on T-shirts, folders used and distributed by partners, and on billboards with project specifications. In one instance, a truck on the road was clearly put to 'normal' use, i.e. loaded with cargo and passengers (among them even military), but still marked with stickers of a partner and ECHO.

B.2.1.5. Protection

22. Although in certain areas (e.g. parts of Equateur Province) security risks have disappeared nearly completely with the disappearance of armed troops, security risks do persist in others, where villagers, for instance, still sleep in the forest at night out of fear of pillaging militia, or where people avoid keeping small animals so as not to be targeted by militias. The specific problems of child soldiers and SGBV also persist and are well documented [8,11,12]. SGBV has also a negative impact on household economy and children's nutritional status: out of fear, women tend to limit their movement with consequent decrease of access to land for cultivation and water for the family.

23. The mere presence of international actors can arguably have a passive protection effect. The evaluation team, however, found only anecdotal evidence that partners collected information about abuses of Human Rights Law and IHL and passed them on either to their own hierarchy or to other agencies such as OCHA.

B.2.1.6. Donor co-ordination

24. Horizontal donor co-ordination - between humanitarian aid donors in different geographical regions or technical areas at the same time - is to be distinguished from vertical co-ordination: between humanitarian aid donors and development donors in the same geographical region and/or in the same technical area, following each other along a time line. With regard to the latter, ECHO through its partners possesses a wealth of experience that should be capitalised and used by other EC instruments (B.2.3.4.). On the other hand, ECHO should ideally put LRRD into practice – e.g. through lobbying with other EC instruments - before even implementing its own relief strategy. Examples of good synergy seen in the field were a small number of partners running integrated multi-sectoral programmes with contribution of different humanitarian and development donors.

Conclusions

25. Considering the high level of destruction and instability, as well as the high indicators of poverty and mortality, the DRC may have been a victim of a donor bias that favours small countries, with regard to the level of funding.
26. The context in the DRC does not correspond yet to a “‘post’-crisis” as suggested in the ToR: neither at population level with regard to indicators of poverty, malnutrition, disease and death, nor at institutional level, with regard to state support to vital institutions and infrastructure. In particular, Eastern areas are still suffering from a high degree of insecurity that affects agricultural and animal production, with consequent negative impact on nutritional status of vulnerable population groups.
27. There is, however, a growing consensus that the interventions to address this (chronic) emergency must largely be developmental by design; a dilemma for humanitarian actors that requires venturing into ‘grey zones’ of programming.
28. Different ECHO partners have developed a host of refined assistance strategies and approaches. The technical know-how in respect to modules of intervention varies widely. Few efforts were visible to promote joint learning and programming, to harmonise approaches and to benefit from identified best practices.
29. With few exceptions confirming the rule, the ECHO emblem features visibly on partners’ cars, T-shirts, offices, billboards, stickers and institutions supported.
30. The mere presence of international actors can arguably have a passive protection effect. Although ECHO encourages collection and discreet use of data on abuses of Human Rights Law and IHL, this was not found to be practised systematically by all partners.
31. The horizontal coordination with other donors (mainly OFDA) seems to function fairly well in the field. It is more or less known and accepted, which donor is active in which technical and geographical region area. There is room for improvement with regard to vertical co-ordination between different EC instruments and other donors with developmental instruments (see chapters on LRRD).

Recommendation

32. The level of ECHO's overall assistance to the DRC should be determined according to the needs, irrespective of the larger size of the country compared to others in the region.
33. ECHO should maintain the current definition of its ‘exit strategy’ according to the worst vulnerability indicators at population level and performance indicators of local capacities, rather than by contextual indicators (e.g. decrease in fighting). Considering that the current situation of ‘neither

war nor peace' may last for years to come, mid-to long-term planning is still needed. ECHO should continue to stimulate and help partners to approach other donors for long-term programmes and diversification of funding.

34. ECHO should enhance its role of promoting inter-agency exchange and learning by financing and supporting efforts of UN and other co-ordinating bodies. Best practices in various sectors are to be identified and documented in technical workshops; assistance modules and training packages can be developed and then adapted and applied to specific situations.
35. If a partner uses vehicles temporarily, and these are marked with partner and ECHO emblem, care must be taken to withdraw these immediately afterwards.
36. ECHO should continue exhorting partners to collect data on abuses of HRL, IHL and protection needs that are detrimental to the effectiveness of projects. Such data must be reported to sector lead or specialised agencies, for appropriate advocacy or other actions.
37. EC aid instruments should better co-ordinate their plans for the DRC, through the joint development, in Brussels and Kinshasa, of 3-5 year scenarios. With regard to non-EC donors, ECHO can play a more pro-active and facilitating role in helping partners to obtain matching or following development funds. This starts in the Donors Contact Group for the DRC and should lead to trilateral discussions between ECHO, partner, and developmental donor.

Lessons learned

38. The end of organised military fighting does not trigger automatically an improvement of indicators, neither at population nor at institutional level. Indicators of poverty, malnutrition, disease and death may continue to be high as long as key factors contributing to them are at work.
39. ECHO, being "more partner than donor"², goes very far in prescribing partners what to do, and how. For sectors for which there is no effective sectoral lead agency, and for which ECHO itself does not have expertise, its responsibility would be to foster learning between partners.

² ECHO official

B.2.2. HEALTH

40. In the DRC, the lack of prevention, insufficient access to health care and underlying factors such as malnutrition and lack of safe drinking water have led to one of the world's highest mortality rate [3,5,24,25,26]. Malaria is the main contributor, responsible for close to half of childhood deaths. Other important contributors to the latter are acute respiratory tract infections, diarrhoea and measles-associated diseases. Endemic diseases such as sleeping disease and tuberculosis are on the increase. Among the diseases that regularly cause epidemics are cholera, meningitis, bloody diarrhoea, plague and measles. Immunisation coverage for the latter is reported to be fewer than 40% countrywide and was found to be just over 50% in the Health Zones (HZs) visited.
41. Maternal mortality is high, linked to the low percentage of professionally attended deliveries and high fertility (5-7 births per woman [27]); there is a near-complete lack of family planning services. With regard to reproductive health, the high prevalence of Sexually Transmitted Infections (STIs)³ and misconceptions about the mode of transmission of HIV/AIDS [28] augur ill for the spread of the virus. Prevalence is estimated to be around 5% - still lower than in most neighbouring countries. The evaluators found means of 8.25% and 3.33% in samples of blood donors⁴ and SGBV victims. Lastly, an increasing morbidity related to SGBV has been recorded, especially in Eastern Provinces [9,29,30,31,32].
42. The health system in the DRC has all but disintegrated, owing to long-standing pre-war negligence and the effects of the wars: brain drain, looting, lack of infrastructure maintenance and of resources. 'Public' and Church-supported health services were effectively functioning like the private sector before the war, owing to the state's demise; the system of basically full cost-recovery had produced a high rate of economic exclusion⁵. At present, the generally impoverished population is still not able to pay more than nominal fees. Catastrophic diseases such as an obstetric emergency requiring a caesarean section can throw a family into even worse – iatrogenic – poverty [33].
43. Health care is mainly provided outside the regular MoH system, through auto-medication or prescription by semi-trained drug vendors. Traditional healers are sought for the setting of fractures; other establishments frequented are the 'chambres de prière'. The private for-profit sector supplies at present 80% of the drug market [34]. The MoH has since this year started to pay salaries⁶, but only to a fraction of its staff and with delayed disbursement. Owing to the lack of funds for the intermediate MoH structures, the interesting phenomenon occurs of upward transfer of money from peripheral health services [34].
44. The near absence of any post-conflict health policy is also crippling. The MoH has defined a 'Paquet Minimum d'Activités' (PMA) to be provided by Nurses in Health Centres (HCs) and a 'Paquet Complémentaire d'Activités' (PCA) to be provided by referral hospitals. Who will provide these services, however, and at what price for the patient, remains unclear. Most probably, there will be a mix of MoH provision of services (de facto nearly privatised again), and something between 'contracting-in' and 'contracting-out' of services, especially to traditional, Church-based partners. A caveat is indicated with regard to the attachment to the pre-war model by both the MoH and traditional partners (a general phenomenon well known [21]) of health service provision whereby the

3 found by Merlin during a KAP survey to be 10%

4 clinically screened replacement donors, which implicates a downward bias

5 A caesarean section in a service that is not subsidised costs between US \$ 40 and 150

6 5 US \$ for an Infirmier Titulaire (IT), 10 US \$ for a medical doctor

full cost of care is borne by the patients. The decision to nearly double the number of Health Zones⁷ (HZs), was theoretically justified, but proved to be a disaster at implementation level, owing to the complete lack of own funds and donors, who were not consulted in the matter, against the known advice that “serious plans must be obsessively linked to available resources” [21].

45. With regard to drug supply, there is room for hope that the policy of buying and distributing drugs by and through a Centre de Distribution Régional (CDR) becomes part of the system. Currently, five of ten CDRs foreseen until the end of 2004 [34] are functioning. The umbrella organisation of the CDRs, the Fédération des Centrales d'Approvisionnement en Médicaments Essentiels (FEDECAME) has just recently become parastatal.
46. What is functioning of the Congolese health system remains singularly donor-dependent, be it of development or humanitarian funds. Among the former, the Belgian government, for instance, provides institutional support to the MoH, and the World Bank is contracting out the provision of health services to NGOs in the West of the DRC - a sign that it does not judge the MoH able to provide health care yet. The main instrument in the field of health of the 8th European Development Fund (EDF) is the Programme d'Appui Transitoire à la Santé (PATS I and II), which subsidises health care through the delivery of essential drugs. Currently, the 9th EDF is in preparation (B.2.3.4.). ECHO is the major humanitarian donor in the field of health (18 m € in 2004); other important ones are OFDA and DfID.

B.2.2.1. ECHO's Overall Intervention Logic

47. Acknowledging that excess morbidity and mortality were to a large part attributable to insufficient access to health care, ECHO has decided to support the Primary Health Care (PHC) system, making gradual inroads from curative care at the level of HCs into prevention and selective care at second-line health services. Judging judicious to retain the Health Zone (HZ) as entry point for subsidising health care, ECHO has also retained for 2004 the target to support 54 of the 306 (old) HZs.
48. The DRC is too vast a country for any single donor to cover all the health needs; vast stretches remain insufficiently covered, or not at all. The distinction of ‘emergency’ vs. pre-development is small and artificial. Arguably, the main determinants of health and ill-health are food security, safe drinking water and access to health care. The decision to concentrate on the geographical areas of ‘red’ and ‘blue’ zones (annex D: DRC map) remains certainly justified with regard to these determinants. Although the degree of poverty in the green and yellow zones may be just slightly lower, health services are not performing better there. The key difference lies in the higher chance for a development donor to intervene in those areas. A phase-out by ECHO from any currently supported HZ without hand-over to a development donor will set it back to square one (B.2.3.4.).
49. Apart from the size of the budget envelope, another important limiting factor for ECHO is the number of potential partners willing and able to work in these remote regions of the DRC; this was mentioned in the 2001 ECHO evaluation already: “Ceci est aussi un argument pour ne pas préconiser l’extension géographique” [35]. Most partners have reached (or overstepped) the limit of their operational capacity. The recommendation made by the recent ECHO mission in May 2004 [36], that partners are to adopt clusters of zones instead of one HZ only, can therefore not be generally applied. The present evaluation, on the contrary, has recommended to some partners to significantly reduce their area of operation (B.2.2.2.). The recommendation of the last ECHO evaluation of 2001[35], to prioritise quality over geographical extension, is still valid. Apart from combating acute epidemics and implementing preventive activities (though even immunisation is

⁷ from 306 to 515; a HZ consists of HCs and Health Posts always clustered around a Hôpital Général de Référence (HGR), with a Bureau Central de Zone (BCZ)

difficult without a functioning health system...), food security and safe drinking water interventions are liable to have more impact on the health of affected population than extending the coverage of health care that risks to become substandard.

50. The recent 'découpage' of Health Zones – without the needed financial resources - has created serious problems for the local health administration and ECHO partners alike. ECHO's stance that it should not pick up the bill for the découpage is legitimate. Solutions are to be found locally on a case-by case basis. In some areas, for instance, the découpage has simply been ignored, in others, assistance given is being split between new and old zones and in others again, the partner ended up working with new zone only.
51. The "pièce de résistance" in the standard package of assistance to a HZ continues to be the free delivery (to the MoH) of essential drugs. Flat fees for the patients, however, have been introduced almost everywhere, even when working with a third, Church-affiliated partner. The donation of drugs is usually flanked by financial incentives to staff⁸, activities of capacity building and, in most – but not all – cases, support to the intermediate MoH structure, the Bureau Central de Zone (BCZ), especially for supervision activities. While curative care in HCs remains extremely relevant, the range of equally relevant preventative and health promotion activities remains limited (B.2.2.4.); equally limited is the support given to the first-referral hospitals (B.2.2.2.). Most partners do support the BCZ, a few chose not to. While the high indicators of morbidity and mortality do evoke a classical emergency, the existence of a - however malfunctioning – ubiquitous MoH does not legitimise that partners simply bypass it, in a context of - however chronic – 'post'-conflict. A thorough needs assessment, however, is a prerequisite for interventions at BCZ and hospital level.

B.2.2.2. Effectiveness

52. Key determinants for effectiveness were the project design, the professional quality of expatriates, the partners' operational capacity and, as a fourth (which is less controlled by the partner), capacities of the local MoH administration and health staff. In a few successful cases, all these factors were found to be optimal. Interestingly, no other single pattern emerged; excellent expatriate professionals, for instance, were unable to overcome shortfalls of operational capacity, while a good project design was still effective despite professional shortcomings.
53. The best indicator for access to health care is the user rate (new consultations/capita/year), found to be incomparably higher in health services supported by a partner than in the ones receiving no support, illustrated by some examples in table 1.

Table 1: Examples of user rates (new consultation/capita/year) of supported and unsupported Health Centres

Partner, province	Average user rate in supported Health Centres	Average user rate in unsupported Health Centres
MSF – B, Equateur	1.47	0.145
IRC, Katanga	0.38	0.059
PSF, Katanga		0.018
Caritas, Kasai	0.49	

⁸ In most cases, reduced to five per HC, instead of the MoH norm of eight; a modification considered legitimate by the MoH

54. In the few cases where low user rates were found in partner-supported HCs, this could be attributed to drug supply gaps (supply line failure or leakage), the non-respect of the flat fees, or a sudden steep increase thereof. Hospitals were generally found to be under-used, with a rate below 0.01 hospitalisations / capita / year.
55. While preventive services were usually free, the level of flat fees for consultations⁹ charged in partner-supported HCs ranged from US \$ 0.05 to US \$ 0.6. No value of flat fee can be proposed that would be appropriate for the whole target zone, considering the regional differences. A study in N-Kivu, for example, found the income/person/year to be US \$ 57.47 (in very poor households, however, only 20% of that) [37]. HCs that charged only nominal fees, however, reported seeing a portion of 'false' patients; in such cases, an upward revision is indicated.
56. The affected population or the users of health services are not the only beneficiaries, however, but also the local health system. A prerequisite for the provision of care is the equal availability of human and material resources, the latter consisting in infrastructure, equipment, finances and medical supplies. In some instances, shortfalls of one or the other component prevented achieving the necessary synergy: water to wash was more often than not missing in consultation rooms, infrastructure at times found too run-down and even too dirty to provide a decent working environment, small equipment was missing, or an insufficient reward package for MoH leads to corruption, diminishing thereby accessibility for patients. In some instances, care provided in partner-supported hospitals was found to be substandard, e.g. insufficient testing prior to blood transfusion, or the execution of Caesarean sections without an operating theatre.
57. Partners with an emergency approach tend to neglect support to the BCZ as part of the local health system. Despite the bias linked to the fact that the MoH officials in charge were benefiting personally from a financial incentive, they did voice disappointment about not being able to carry out a range of minimal routine activities, especially with regard to preventive ones, like immunisation.
58. The capacity and preparedness for response to epidemics was found to be adequate. While only MSF - B made frequent and good use of the 'Programme d'Urgence pour le Congo' (B.2.2.6.), others usually have responded on their own. The evaluators found anecdotal evidence for the effectiveness of such responses (e.g. a cholera outbreak with a case/fatality rate of 1% only); in no instance local health authorities reported insufficient reaction.
59. Partners invested in Village Health Committees (Comité de Santé : CoSa) in varying degrees. In some cases, where there were none anymore, their mere creation was an achievement. While most of the criteria that determine the good functioning of a CoSa according to the national protocol were respected¹⁰, the rule of the quorum never was; absence of representatives from other villages from meetings makes the CoSa less representative. Near constant was the massive under-representation of women in the CoSas: many had no female members at all, others 2-3 only and rarely active ones. Anecdotal evidence was found that historically, women were represented in the CoSa¹¹, and that one traditional partner has currently achieved a 50% representation. Many partners admitted, typically: "the CoSas do not function properly". Often, the *infirmier titulaire* (IT) was found to be a member of the CoSa; another frequent malfunctioning was the lack of a list of indigents, to be exempt from paying the flat fee for a consultation¹²; in the areas visited, this represents a volume of roughly 20% of all consultations.

9 which include the consultation, drugs and, in some instances, laboratory exams, all for one disease episode

10 E.g. the control of drugs upon receipt, monthly meeting with minutes, representatives from other villages a members

11 Even today, clues can be taken from the Congolese 'institution' of the 'maman bonguisa' ('qui arrange'...)

12 The military, police, however, in most places, are automatically exempt

Ideally, such a list is to be established by the CoSa and members of the Church, traditional leaders etc. With one exception to confirm the rule (which seemed to be a regional particularity), community participation in form of contribution to health service infrastructure was found to be excellent and a good sign for local ownership.

60. With the exception of partners that work in 'emergency mode' (who tended towards a paternalistic attitude), communication of partners with MoH officials and health staff as beneficiaries was found to be satisfactory. There is room for improvement, however, of communication between partners and communities. None of the former, for instance, has the habit of systematically checking user satisfaction during supervisions.
61. The effectiveness of the health projects was reported and found to be highly dependent on constant monitoring and supervision by the partner, owing to the fragility of the health system and the environment; partners have observed drops in quality during periods of decreased access. Contingency plans for the increase of hostilities and a reduced humanitarian space include plans – explicit or not – for health assistance through 'remote control'. The recommendation of the 2001 ECHO evaluation that 'dropping of supplies' was not acceptable, is to be maintained, unless for a limited amount of time, and to health services that are known to be reliable.

B.2.2.3. Efficiency

62. The partners' operational capacity was generally found to be good, even with regard to the ability to overcome difficult logistical constraints. Exceptions were linked to two main causes: operational overstretch and inability to handle cash constraints. In all but one case (cash flow problems at partner HQ), the latter had to do with gaps between funding cycles. Interrupted drug supplies, for instance, had a rather crippling effect on a small number of projects. Operational overstretch was observed in a few cases where a partner intended to cover a high number of HZs and HCs, without the capacity to supervise and monitor. This was linked to overestimating the absorption capacity of the MoH administration. Leakage of medical supplies was the consequence (delayed payment of incentives invites corruption), frequent and long periods of out-of-stock for essential drugs, and expiry of vital diagnostic items.
63. Technical capacities of expatriate and local staff, as well as the duration of the formers' missions were found to be a key determinant for the success of health projects. The recommendation of the 2001 evaluation, that ECHO is to be "plus exigeant vis à vis de ses partenaires en matière de ressources humaines et de capacités techniques" remains valid, within ECHO's (limited) possibilities. Operations of partners with a typical emergency profile were found to suffer from very short duration of missions of - sometimes inexperienced - expatriates, and with gaps in between them (which precludes an analysis of, and support to, the local MoH administration). Due consideration has to be given to the fact that with one or two exceptions on the shores of the big lakes, all stationing has to be considered as hardship mission for expatriates. One partner has found quite an ingenious, peripatetic, style for midlevel management, which may be cost-efficient, but possibly not sustainable for single expatriates.
64. Monitoring and adjusting are needed to guarantee quality of outputs, for which a humanitarian partner is accountable, even when working through local structures [38]. As mentioned in the previous chapter (see effectiveness), the quality of outputs can generally be improved at HC level. Substandard quality of care jeopardises not only the health of the affected population, but also the credibility of the partner and ECHO alike. A specific field where quality of care is linked to efficiency is the treatment of malaria. This most frequently registered disease is at present certainly over-diagnosed, without laboratory confirmation.

65. In a couple of cases, more careful monitoring should have provoked a change of strategy earlier on, for example in the sense of shifting the focus from coverage to quality. This can be due to a system that makes monitoring difficult (the system of 'paiement par acte' does not allow to control whether prices for drugs are respected in the HCs), the failure to analyse the causes of relatively low user rates, or to monitoring of the wrong indicators: crude mortality rates may be of interest at an aggregated national level, but do not serve as an immediate management tool. Annex H provides a short list of indicators that could be shared by all partners, at the level of HC's curative and preventative activities, hospitals and MoH administration. Every partner does and should of course monitor other indicators; the ones provided, or similar ones, would play the role of the biggest common denominator.
66. One very rough efficiency indicator is the amount of money budgeted by health service. Not surprisingly, partners working rather in 'emergency mode' proved to spend significantly more: an average of US \$ 410.4/y/health service for two of them, compared to an average of US \$ 49.3/y/health service of the other PHC projects.
67. Generally, the lack of co-ordination in the health sector has produced the result – typical for humanitarian situations - of fragmentation and verticalisation. Some of this was probably unavoidable, due to historical and strategic reasons. A typical health zone straddling the former frontline features 17 HCs, of which an ECHO partner supports five, the ICRC six¹³, a traditional partner (Caritas) three, but with insufficient own means; three HCs have no support at all. Vertical support by partners can produce situations that are awkward and ethically difficult to sustain: a HIV test can be used only for a SGBV victim, but not for a woman who has aborted and needs a blood transfusion; a child with an intestinal perforation (caused by typhoid fever) pays US \$ 78 for surgery, while other child patients pay only the - subsidised - price of US \$ 3 in the paediatric ward.
68. A factor that can severely hamper co-ordination of interventions with the MoH authorities at higher level (district, province) is the distance of the partner's country or regional office to the district or provincial capita: "they only come [to the capital] to discuss when there are problems" was a typical comment made. On the other hand, PSF, who had the courage to move its office to Mbuji Mayi, reported a marked improvement of working relations. ECHO has tried to fill some of this co-ordination void in the health sector by giving directives to its partners, but apart from the fact that health sector co-ordination is not a traditional role of a donor, ECHO's role is necessarily limited to its own partners. The situation outlined above and elsewhere (with regard to missed opportunities to promote best practice, see chapter B.2.1.) is in fact much worse, when taking all other, also non-ECHO actors into account.
69. Some unplanned, negative results of interventions are closely linked with co-ordination, of the lack thereof. The two departments in a hospital that received selective subsidies by a partner ended up – owing to increased accessibility - severely overcrowded and understaffed. One emergency actor (not a ECHO partner, but working in 'ECHO partner territory') introduced dumping prices for primary consultations in the hospital, thereby converting it into a 'giant HC'. Another partner's high level of incentives to local staff– three times the average - raised discontent even in a neighbouring district.

¹³ Most probably discontinued by the end of 2004; moreover, as no incentives are paid, the exclusion rate is currently very high already

B.2.2.4. Impact

70. Short of measuring mortality and morbidity at population level, which is a cumbersome procedure that is not in everyone's budget and operational capacity¹⁴, access to health care can be taken as a legitimate proxy for the impact of health programmes. For the case when indicators at either level improve, however, an immediate caveat is indicated: it is a fallacy to conclude that humanitarian aid can then be dispensed of; indicators have improved because of humanitarian aid. There is sufficient anecdotal evidence that in the likely absence of any other significant contributions to the health system, any achievements made will immediately be nullified in such case.
71. The programs implemented have generally greatly improved access to health care at the level HCs (see effectiveness: B.2.2.2.). In the few cases where this was not so, or to an insufficient degree, improved monitoring and analysis of causes can lead to the necessary strategic changes (see efficiency: B.2.2.3.). In many areas health authorities have conducted a population census early in 2004, which allows for calculating fairly accurate user rates. Where this is not the case, the partners know the areas well enough to judge the magnitude of user rates and always, to monitor trends.
72. The toughest choice to be made – and errors were committed at both ends – is the trade-off between coverage and quality. No humanitarian donor can afford to cover the DRC – or even the Health Zones in the 'blue' and 'red' target areas - with the number and kind of health structures needed. Whether by calculation or by trial and error, a number of partners know where to strike a balance at the level of HCs. Not everywhere is it possible to support all HCs in a HZ; this requires both a particularly strong BCZ and partner (where this is not the case, results can be rather disastrous). The MoH as an institution always gives priority to coverage before quality, being accountable mainly at the level of inputs¹⁵. Individual MoH officials, however, agree that it is preferable to achieve coverage of, say, 50% of HCs in a HZ (which has been found to be an acceptable minimum), quality and financial accessibility provided.
73. Minimum standards for the kind and quality of care provided are to be respected and will set the limits to coverage. It can be argued that it is preferable that a woman finds good and affordable care for a sick child further away than finding substandard or inaccessible care nearby; this is supported by anecdotal evidence of patients walking up to 1-3 weeks to reach a hospital¹⁶, and of statistics of HCs that feature a regular 15-20% of 'hors-zone' patients. Although there is no common agreement on what these minimum standards are, there is sufficient good practice among the partners to define them in a more formal way, based on the national PMA. Strategic management over time is important: most partners have started with modest coverage levels, expanded according to the humanitarian space and own operational capacities and reached a level where threshold effects make further expansion impossible without e.g. creating a new base. A small number of partners have erred at both ends of the spectrum: keeping a small 'île de merveilles' or wanting to cover too much with little effect in the end. The trade-off is to be solved on a case-by-case basis by supporting a portion of strategically placed health services. While the marginal cost of supporting (i.e. 'opening', in most cases) one more HC, the possibility to support/introduce Health Posts (HP) has been insufficiently explored. HPs are part of the

14 the resource allocation is also being queried: "while we are short of fuel for immunisation and supervision, they keep driving around; we don't know what for" (MoH official). More/better explaining may be needed

15 an illustrative example is the decision to double the number of HZs without having the means to do so

16 exceptional cases of women seeking reconstructive surgery for SGBV-related trauma

national system, furnished with a minimum of essential drugs (anti-malarials, antipyretics and ORS) and first aid material. Prevention activities are of course included in the service profile.

74. It is important that the area 'covered' should represent functional units of HPs, HCs, one first-referral hospital and the BCZ. Such functional units are to be treated as projects, with short, mid- and long-term objectives. The support given must achieve synergy of all resources that contribute to the provision of care, including knowledge, skills and financial incentives where needed.
75. Second line health services, i.e. first-referral hospitals are an integral part of PHC. They usually "suffer badly.... this intermediate layer of care can end up as the most neglected one..." [21]. ECHO support to first-referral hospitals has been gradual and, it appears, almost against its will: "même si un support limité doit être accordé aux hôpitaux de certaines ZS sélectionnées" (GP 2001 [36]). Partners had difficulties to face the complete lack of access to hospital care of their beneficiary population; the evaluation found that less than 10% of patients referred from HCs actually reached the hospital. Gradually, ECHO has accorded partial budgets, especially for the departments of obstetrics, paediatrics, emergency surgery and the transfusion service. Which leaves *de iure* only elective surgery and internal medicine without ECHO support, and raises the question, with regard to the latter, why an adult patient suffering from cerebral malaria is less in need of, and entitled to, humanitarian aid, than, say a child suffering from the same. De facto, however, as there are no natural boundaries within hospitals, most partners have decided to dilute their support in all services, which makes it less effective, of course. Where partners cling to strict separation, the hospital management faces personnel problems and ethical dilemmas. Cases are exceptional of hospitals that run sufficiently well (owing to the strong presence of a traditional partner¹⁷) to be able to absorb partial support only. Calculations based on empirical figures from the field suggest that expenses for global support to a first-referral hospital of 50-70 beds would amount to roughly US \$ 70'000 per year¹⁸.
76. While it is common knowledge that for the same amount of money, more lives are saved at the level of prevention and first-line health services, hospitals are important for the building of trust by the population in a health system [40] because lives are saved there in real, and not economic terms. In most cases, if not all, patients have nowhere else to go. ECHO's reticence to get further involved is understandable with regard to two arguments: the complexity of the task and budgetary consequences. True: not all partners have experience in this field. But the DRC is a good example of how some partners perform well in a field which is not been their traditional core mandate. Admittedly, a completely run-down, 'mouroir'-type district hospital would need a significant initial investment, in infrastructure and equipment¹⁹ and the presence of one full-time expatriate during six months to kick-start it and put it on track. The limited service profile of these hospitals, and the great distances, however, will limit the use of hospitals for years to come²⁰, and prevent running cost from soaring. Different calculations than for the ones made above (US \$ 70'000 per year) would have to be made for the small number of bigger hospitals, and with easier geographical access, in the East. The higher purchase power in these areas would allow for higher flat fees than in the impoverished rural areas.

17 in such cases, the degree of financial exclusion is high; 'hostage taking' is still common for patients who cannot pay

18 US \$ 24'000 for incentives, 9'000 for consumables/i.v. fluids, 18'000 for drugs, and 20'000 for transport and others

19 an estimated US \$ 200'000 for a medium size hospital of 50-70 beds

20 it was found, for instance, that the limit of geographical distance for problem deliveries to reach the hospital was around 30 km in places without roads nor cars (the majority). Humanitarian aid cannot solve this (it can, however, make a major contribution by helping to refer problem pregnancies early).

77. A specific area where the impact of humanitarian aid has been limited so far is the treatment of women suffering from Sexual and Gender Based Violence (SGBV). SGBV has consequences that are often completely devastating for the victim: STIs (including HIV), unwanted pregnancies, rejection by the husband and/or the community [9]. Beyond the psychological trauma, victims often suffer physical mutilations: injuries inflicted purposively and/or consequences of the rape itself. HCs are ill-equipped to provide specialised services to rape victims; only Malteser attempts to provide a discrete entry point at this level into the health system for all victims through a community-based network of women that are known to provide this service. Only two referral hospitals provide specialised surgical treatment; ECHO supports one of them (Panzi) successfully through a partner (PMU). At both levels, expansion or replication of the assistance model is needed²¹, in view of the vastly unmet needs in the East.
78. ECHO-funded programs have slowly expanded from the provision of curative care into prevention activities (such as antenatal care and support to EPI) and even a little bit of health promotion. This trend is to be continued and reinforced. Numerous opportunities are still lost: health promotion is limited to women visiting the antenatal care service, most villages visited used (contaminated) surface water for drinking purposes, condoms are rarely used (neither for prevention of STIs nor family planning), hardly anything is done to prevent the spread of HIV/AIDS, malaria prevention is minimal, EPI functions only well in places where the partner supports it specially. One or the other partner has made inroads in most of these fields, with results that are promising, or at least not totally discouraging: water projects were successfully implemented in the past, the distribution²² of impregnated bed nets has shown that there is popular demand for them, and condoms, if mostly used for STI prevention, are at times being requested for family planning purposes. Institutional backing with regard to malaria and HIV/AIDS preventions should be provided; the European Commissioner himself writes: "L'histoire nous jugera sévèrement si nous n'utilisons pas tout ce qui est en notre pouvoir pour combattre le VIH/SIDA, la malaria et la tuberculose" [41].
79. ECHO is currently spending US \$ 2.64 per capita / year in the HZs its partners are covering. A World Bank estimate that pitches the cost of delivery of basic health services is 12 US \$ per capita / year [42], and a more recent WHO opinion is that below US \$ 10 / capita / year "no equitable nor effective health care is realistically within the reach of the health sector" [21]. In reality, however, donors do tend to spend less than these recommendations, even in development settings: in Afghanistan, where health is currently being contracted out to NGOs, the Basic Package of Health Services is priced at US \$ 4.55 \$ / capita / year [39]. It appears clearly, however, that with the current level of funding, it is impossible to provide a full package of basic health services to the affected populations of the HZs chosen. Table 2 shows how, with the present set-up, expenses for one HZ would increase with the inclusion of preventive components. The evaluators are well aware of the limits of ECHO's mandate and means and that the task to provide the full package of basic health care is a task for development donors and actors. In the field, however, partners face the dilemma between the developmental strategy of supporting a potentially complete health system, and allocation of limited means.

21 Though the psychosocial support component remains a judgement-based intervention until its evaluation

22 WHO proposes, not without reason, to skip the stage of selling them at a subsidised price, this procedure being much too cumbersome (the payment of a small fee that can be retained by the seller is not excluded, however). Near-donation in a first stage would create a demand; in a few years' time, the market can then be left to private enterprise.

Table 2: Health expenditures for a new HZ (100'000 inhabitants), with estimates of added prevention components

Item	Budget for 1 new HZ / year (US \$)
Current program	264'000
HIV/AIDS prevention ²³	3'300
Impregnated bed net distribution to all pregnant women	20'000
6 Water projects	20'000
Total	307'300

B.2.2.5. Phase Out Strategy and LRRD

80. The current context in the DRC is one of neither war nor peace - a possibly chronic 'post'-conflict situation. In this type of context, it is not unusual that "the international community is called to replace the state, as service provider" [21]. With their health projects, ECHO and its partners are attempting to cover health needs that are exacerbated by the war (epidemics, malnutrition) and basic health needs that are emerging because of the complete breakdown of the health system²⁴. The point is that although the former are supposed to decrease over time, neither will disappear in the foreseeable future. Common wisdom has it, therefore, that "no new health activities should be started without ensuring their funding over a long period of time [21].
81. The situation in the DRC evokes a typical emergency with regard to the high morbidity and mortality; the context does not yet qualify as a development situation: there is no real peace and the state has neither a grip on the periphery with regard to security nor is it providing services. If development as content of programmes is premature, it is useful and appropriate, though, to use development strategies. Most partners use a judicious mix of development and emergency strategies: working through the MoH and investing in institutional strengthening, for instance, as opposed to 'importing' paid health staff for the short term and substituting for drug supply. Entry points of drug supply show strategic differences between partners who supply the HCs directly, and the ones who supply the Bureau Central de Zone (BCZ) pharmacy. Such differences are revealing and illustrate choices that are more linked to institutional habits than external factors.
82. One partner - though mentioning repeatedly in internal reports that "there is no real emergency" - decided to use the emergency approach of adding tents to the local 'hospital'. This 'hospital' is actually a referral HC that has just been upgraded to be a referral hospital of a new HZ; it has been the dream of the traditional (Church) partner for two decades to enlarge it with an operating theatre (which is badly needed). When the sister superior went on a fundraising trip to Europe, however, the Donor Church told her: "You have a partner in your hospital, who can provide". The partner's stance, on the other hand, is: "we do not build". Such mismatches between needs and strategies are rare. Many partners have even a double mandate, i.e. of emergency and development. A small number of them have actually engaged in a comprehensive local package of food security, infrastructure rehabilitation, education, and health. This is arguably the most appropriate assistance model, at the other end of the spectrum.

23 Empirical figure taken from CARE-F program in Maniema Province, which includes distribution of condoms and educational material, radio messages, meetings with target groups and training activities

24 SGBV-related health needs can be classified as additional needs created by the war, i.e. they are supposed to nearly disappear one day.

83. Most partners work with and through the local MoH administration, the BCZ; provided the latter is effective, this not only is a more efficient mode of assistance, but also fosters local ownership and continuity. Such support typically consists in financial incentives for a small core staff, contribution to running cost and logistical support. Activities of formal capacity building are rare. Some partners (e.g. Malteser) use a contractual approach with success – although a certain caveat is indicated with regard to ‘punishing’ in case of under-performance – a principle that might not always be well understood. More sophisticated ways of relating incentives to performance are being explored, such as linking the amount of running cost to the performance at HC level. As mentioned in the chapter on intervention logic (B.2.2.1.), other partners have chosen to bypass the BCZ, owing either to own institutional limitations and/or to a different perception of ‘emergency’. This missed opportunity can be detrimental to some key functions of the BCZ (such as immunising in the whole HZ, not only in the supported HCs), and can even hamper the work with the supported HCs: the BCZ, not fulfilling its role as an employer’s representative, has no handle over a ‘problem HC’, nor has the partner, who is not the legal employer.
84. Taking this logic one or two levels higher, there is a notable difference between some Médecins Inspecteurs de District (MID) and Médecins Inspecteurs de Province (MIP) who do receive institutional support for their administrations and those – the majority – who don’t. Again: if there are problems at the level of the BCZ, if the MID or MIP is not able to fulfil his or her role employer’s representative, who is? Support to district and provincial MoH administrations is likely to be beyond ECHO’s mandate, but where ECHO funds partners in various HZs, it should lobby with other donors to foster such support.
85. At community level, the fact that most HCs are built by the community, serves as evidence that there is a sense of local ownership. Despite certain functional shortcomings (effectiveness: B.2.2.2.), the near ubiquitous existence of Village Health Committees is a guarantor of ownership as well. A caveat is indicated, however, to blindly follow the ‘developmentalist’ recommendation to “just leave it to the CoSas (Health Committees)”. Once external support ceases, the CoSas revert to the pre-war habit to increase prices to a level that may make the health service economically viable, but excludes most of the population.
86. According to the model of ‘conveyor belt approach’ [43], a development partner with a development donor would continue the work of emergency partners funded by the emergency donor ECHO. In some instances, this has actually been the case: partners with a double mandate have successfully continued ECHO-funded health programmes with EDF funds. If the partner has no double mandate, however, and no other partner or donor steps in, all investment made into the local health system is lost²⁵ once support is discontinued²⁶. Anecdotal evidence shows that while HCs all but disintegrate, hospitals have better chances to survive as functioning structures, but at the price of immediate and high exclusion rate. This entails not only a massive reduction of entitlements for the affected population, but represents also a loss of return on investment²⁷. The ‘exit strategy’ chosen in a small number of projects visited has been to fund a – supposedly last – cycle of six months, which had a negative impact on them²⁸. The main point

25 All but “les the âmes sauvées”, as Soeur Charlotte puts it.

26 The cowardly practice of leaving some months’ drug supply behind does not alter the end result

27 Estimated at €1.25 – 3 for every €spent by ECHO on health

28 fall in attendance rate of over 50% in 3 HZs supported by a partner, after a 500% rise in flat fees (only to 0.24 US \$, \$) for a new consultation, which the partner felt it had to introduce suddenly in order to achieve a minimal degree of sustainability

to be made, however, is the one already stated by the recent ECHO mission: "...the DRC Health Ministry, even with the help of external donors, will not be able to sustain the health system as it is now set up in the health zones which receive significant financial and technical support from external sources" [36]. "Short-term funding, long-term needs", as Smillie puts it pointedly [43] - what comes after ECHO?

87. The State will not be ready soon to foot the bill to provide basic health care, despite the help of other important donors; the World Bank and the Global Fund, for instance, will contribute for the provision of PHC, institutional support and disease-specific programs (HIV/AIDS, tuberculosis, malaria) with a total of a three-digit figure of millions. As mentioned above, there are severe limits to the patient's contribution: a Church-affiliated NGO partner in South Kivu attained an adherence to a (slightly subsidised) health insurance of 10% of the local population only within five years; a Church-affiliated NGO to whom the World Bank contracted out provision of PHC in the West, attained a percentage of 15-30% of the cost as patients' contribution. The recent ECHO report also projects 20% of the cost of health care as a realistic contribution by the patient [36].
88. The Commission's main instruments to support health have been the successive PATS (Programme d'Appui Transitoire à la Santé). The main operational objectives of PATS II in the 8th EDF, which will come to an end in April 2005, were the provision of PHC at the level of HZs (including the first-level referral hospital) and institutional support to the BCZ. The 9th EDF envelope of DG Development (DEV) implemented by EuropeAid (AIDCO), which is in preparation, totals a sum of 205 m € of which 35-50 m € are destined for health in the A-envelope for institutional support [44]. Innovative, decentralised EDF instruments have always allowed for "grey zone" activities to cover some of the gap between relief and development [45]. The same will be true with a B-envelope of the 9th EDF (a total of 34 m € [46]), consisting in non-programmable funds that can be more easily mobilised for transition programmes.
89. A mission for the 9th EDF is currently under way in the DRC, assessing how to best allocate the budget destined for health (including 2 m € unspent from the 8th EDF [44]). The general idea is to continue to support health in a decentralised way in the areas covered by PATS II (Western Provinces, but also the Kasais and the Kivus), and to extend activities to certain stabilised provinces in the East (Maniema, Katanga), especially to take over certain ECHO-funded projects. There are no plans, however, to take over ECHO-funded projects in the 'blue-zone province' of Equateur, which, though basically pacified, is poor and isolated.
90. Efforts from both sides to be complementary were at times successful (such as the hand-over of ECHO-funded projects to EC instruments in Ituri), at times, less so. A Church-affiliated partner in South Kivu, who had benefited from PATS I, fell between two stools during PATS II: the 8th EDF alleged ECHO support, which was very partial only. An ECHO staff member complains: "development donors are not interested in experiences made".
91. ECHO's mandate has led to donate the drugs; the patients' financial contribution – nominal or not – is therefore used for running cost and financial incentives for staff. In a distant future, this relation is liable to be reversed: the MoH will pay its employees and the patients will buy the drugs – maybe at a subsidised price. The strategy of flat fees per disease episode, however, proved to be efficient and accepted by all stakeholders²⁹, can allow passing from one system to the other without causing greater upheavals at the level of patient contribution. Finally, the

²⁹ under the condition that the supply line functions; if this is not the case, staff tend to resort to 'paiement par acte', which allows them to raise their income to compensate for the lack of drugs

policy of other Commission instruments, of supporting the drug supply through the creation of CRDs (Centre de Distribution Régional), appears to have been accepted by the MoH [34], despite opposition of the private sector that still controls most of the drug market.

B.2.2.6. Programme d'urgence Congo (PUC)

92. MSF-B has been running the Programme d'Urgence Congo (PUC) since 1996. It consists in early detection, rapid investigation and immediate reaction to epidemics and other situations that endanger populations. Interventions are free for the beneficiaries and are not supposed to exceed 30 days. The budget (1 m € for 2004) covers, beyond the actual interventions, the cost of permanent logistical and administrative set-ups in Kinshasa, Mbandaka and Lubumbashi, plus many small 'antennas', some of which are equipped with a radio. In the period between 1996-2002, the PUC has realised an average of three monthly interventions. The most common reasons for interventions were: cholera (31%), measles (16%), IDPs (14%), meningitis (10%) and dysentery (9%).
93. The consultants were not able to evaluate the PUC, owing to the wide geographical territory that would have to be covered for this purpose. There is anecdotal evidence that in one area in Equateur province, where MSF-B was running a PHC project, the PUC had intervened repeatedly and effectively. This evidence is mitigated by near-universal ignorance of its existence in the other provinces visited. A look at the respective maps of MSF-B presence and PUC interventions [47] reveals quite a degree of congruence between the two. The statement of a provincial MoH official - "the PUC intervenes where there is MSF or no other NGO, but not where there is another NGO" - points at a potential conflict of interest. MSF-B, as it is often the case in the humanitarian world, prescribes and provides nearly on its own. Though PUC interventions are realised in close co-operation with the MoH, the latter is notoriously weak and not liable to call the shots. With regard to ECHO, situations of "finding a common 'narrative' that fits the priorities of agency and donor alike" are known in the humanitarian world, and include the danger that "the narrative may not be based on sound analysis, given the potential organisational interests of both parties in the acceptance of one narrative over another" [17]. While such considerations may well be un-founded, the absence of external monitoring and evaluation appears still striking. The 2001 ECHO evaluation has already recommended to "rétablir des liens formels entre MSF et les autres ONG (la coordination est ici aussi plus que nécessaire) et de définir clairement les Termes de Référence de MSF" [35]. While the evaluation does not call into question the effectiveness of individual PUC interventions, it questions the allocative efficiency and the lack of sustainability for a type of interventions that will be needed for years to come.

Conclusions

94. Apart from the budget size, the number of potential partners willing and able to work in these remote regions of the DRC is an important limiting factor for ECHO. Most partners have reached (or overstepped) the limit of their operational capacity. ECHO's stance that it should not pick up the bill for the doubling of the number of Health Zones is legitimate.
95. While curative care in first-line health services remains extremely relevant for the health of the affected population, the range of preventative and health promotion activities and the support given to the first-referral hospitals remain generally limited. In some instances, the Bureau Central de Zone (BCZ) does not have the means to carry out basic activities.

96. User rates are incomparably higher in supported Health Centres than in the ones receiving no support. In the few cases where low user rates were found of supported health services, this could be attributed mainly to drug supply gaps (supply line failure or leakage) or non-respect of the flat fees. Hospitals were generally found to be under-used, with a rate below 0.01 hospitalisations/ capita / year. No value of flat fee can be proposed that would be appropriate for the whole target zone, considering the regional differences.
97. Shortfalls of one or the other component necessary to achieve synergy for the provision of care were frequently encountered in Health Centres: lack of water to wash, run-down and even dirty infrastructure, small equipment missing or an insufficient reward package for MoH staff. Hospital care was found to be substandard in certain instances.
98. With few exceptions confirming the rule, the partners' operational capacity was found to be good. Where this was not the case, it was due to either operational overstretch or inability to handle cash constraints during gaps between project cycles. Interrupted drug supplies, for instance, had a rather crippling effect on a small number of projects.
99. Technical capacities of expatriate and local staff, as well as missions' duration of the former are a key determinant for the success of health projects. Short missions and gaps in between have found to be detrimental to successful planning and implementation. The 'emergency mode' of working appears also to be significantly more costly than a more developmental approach.
100. The lack of co-ordination in the health sector has produced, the result – typical for humanitarian situations - of fragmentation and verticalisation in the DRC. Beyond supporting general co-ordination efforts through OCHA and, more recently, funding two positions of WHO/HAC, ECHO has tried to fill some of this co-ordination void in the health sector by giving directives to its partners.
101. The health programs have the potential to greatly improve access to health care, especially at the level of first line services (Health Centres). Most partners have succeeded in this; for the few cases where there are still shortcomings, the analysis of their causes will lead to the necessary strategic changes.
102. No humanitarian donor can afford to cover Health Zones with the number and kind of health structures ideally needed; this task remains to be completed by development actors. However, there appears to be general agreement on a minimum quality of care below which assistance becomes ineffective. Whether by calculation or by trial and error, most partners have made a good choice with regard to the trade-off between coverage and quality, though errors were committed at both ends of the spectrum.
103. There is insufficient access to second line health services (first-referral hospitals), owing to their relative neglect in the assistance package. As there are no natural boundaries within a hospital, partial support has either been diluted - and become less effective - or, where maintained separate, has created staff management problems and ethical dilemmas.
104. Access to treatment for women suffering from Sexual and Gender Based Violence is still insufficient. This concerns psychosocial support in the community, medical treatment at first-line services (e.g. with regard to STIs), and, in the case of Maniema province, specialised surgical care.
105. The current level of per capita funding by ECHO (US \$ 2.64) does not allow for the provision of a full basic health care package. The limits of ECHO's mandate and budget poses a dilemma for partners, who are allocating the limited means to (mainly curative) first-line services, in a system that functionally includes upstream promotion and downstream hospital care – both relatively neglected.

106. ECHO and its partners are attempting to cover health needs that are exacerbated by the war and basic health needs; neither will disappear with the cessation of military hostilities, nor is the performance of the local health system liable to improve. Evidence shows that the return on investment that can be reasonably expected through support to a local health system is nullified when this support is withdrawn prematurely.
107. Most partners have applied an appropriate mix of relief and development strategies. Some emergency actors however, owing more to own institutional habits than contextual constraints, have erred by clinging for too long to the relief end of the spectrum, losing thereby opportunities to strengthen local MoH structures. Where no other donor is supporting the higher-level administrative MoH structures, shortcomings are noticeable.
108. The situation is characterised by 'short-term funding, long-term needs'. Best practice is arguably the implementation of comprehensive, multi-sectoral assistance programmes that have a chance to be funded by development donors.
109. The PUC appears to intervene more in the 'post-conflict' and 'development' zones of the Congo. Considering the complete lack of its sustainability, alternative strategies of coping with epidemics may be considered, such as the quick disbursement of emergency funds to all ECHO partners (and other NGOs) on the spot (or in neighbouring areas) on request, or support to the fledgling 'Programme National des Urgences et Action Humanitaire' of the MoH by a development donor.

Recommendations

110. ECHO should basically maintain its areas of intervention. Certain partners should revise downward the area they cover, rounding it in accordance with the découpage of the new Health Zones (HZ). If ECHO does not increase its budget envelope and number of partners, this implies a slightly lower number of HZs covered.
111. ECHO should be careful to attribute areas to cover to partners according to their operational capacities. Solutions with regard to the 'découpage' of Health Zones are to be found locally on a case-by case basis.
112. Partners should widen the spectrum of activities in the field of prevention and health promotion (HIV/AIDS prevention, provision of safe drinking water, malaria prevention, and increased support to immunisation). While basic support to any functioning BCZ should be part of the assistance package for ECHO partners, ECHO should lobby for support to the higher level(s) of the MoH administration.
113. User rates of supported health services are to be monitored closely; if they are low, an analysis of the possible reason has to be made, to allow taking appropriate action. The system of flat fees is to be maintained, with periodic adjustments according to the socio-economic level of the local context. Causes of drug supply gaps are to be analysed in order to avoid them as much as possible.
114. Partners should make sure that women and members of other villages are better represented in Village Health Committees. In general, their functioning deserves more attention.
115. Partners should systematically inquire into user satisfaction at household level as part of the supervision activities. Whenever possible, this should be complemented by assessing access to health care of the affected population.
116. In a context of chronic emergency such as in the DRC, funding cycles should continue to be of 12 months. Partners should take care to submit renewal proposals in time in order to avoid funding gaps in between cycles. ECHO should discontinue funding partners that are unable to disburse funds transferred to them on time.

117. Within its (limited) possibilities, ECHO should insist not only in the professional qualifications of partners' expatriate staff, but also that missions' duration be ideally nine months, initially, and that gaps between them are avoided. In view of the hardship conditions, partners should be encouraged to promote the stationing of expatriate couples and African nationals from neighbouring countries (who can skip home more often).
118. Monitoring of key indicators is to be improved and streamlined. ECHO should insist that all partners use up to a dozen shared indicators: at the level of prevention, curative care at Health Centres and hospitals, as well as health management. All partners currently grade the performance of HCs during supervisions; these are to be converted into a numerical score that can be monitored over time, as aggregated score or separate components.
119. ECHO must maintain its efforts to contribute shaping the health sector co-ordination, with a clear role. In the meantime, ECHO should intervene punctually, e.g. foster better co-ordination within its own partners and MoH administrations. ECHO flight could be used, for instance, to facilitate quarterly meetings with all stakeholders in Kalemie.
120. Access to health care is to be measured periodically at population level.
121. Partners have to know where to strike a balance between the number of Health Centres to support and the quality of care that can be guaranteed. Service profile and standards that define a minimum quality of care are to be more formally agreed upon between partners and the MoH; the possibility to support Health Posts (HPs) to narrow strategic gaps is to be explored. It is important that the area 'covered' should represent functional units of HPs, Health Centres, a first-referral hospital and the MoH administration. Such functional units are to be treated as projects, with short, mid- and long-term objectives.
122. ECHO should include the possibility of global support to some first-referral hospitals. For budget calculations, different projections have to be made (and discussed with partners) relating levels of subsidy (through drugs and incentives) and the respective flat fees³⁰; empirical data put the cost at roughly US \$ 70'000 per year. However, pre-conditions need to be applied, such as (i) a willing and able partner; (ii) reasonably well managed hospital by committed management, with open financial books and MoU signed by both parties; (iv) monitoring of the quality of care by the partner, (v) flat fees, demanding in turn constant basic supply and (vi) potential continuity through a development donor or traditional partner.
123. ECHO has to encourage – and, in the case of HIV/AIDS prevention, to declare mandatory - the expansion from the provision of curative to preventative health care. This concerns specially the fields of safe drinking water, condom use (for prevention of STIs and family planning), nutritional education, population-based HIV/AIDS education (through schools, Churches, youth groups), malaria prevention (through impregnated bed nets for pregnant women) and substantial support to EPI. To cover the bulk of these additional activities, additional funding of US \$ 0.433 per capita / year would be required.
124. In order to avoid the otherwise inevitable gap in the provision of care, continuation has to be sought at both the levels of partners (double mandate?) and donors. ECHO should avoid funding projects with little or no chances for continuity. The timing of withdrawal of ECHO assistance – unless a development donor continues support - should not be determined by contextual indicators, but rather according to health indicators at population level, and performance indicators of the local health system.
125. ECHO and other Commission aid instruments are to develop jointly, in Brussels and Kinshasa, 3-5 year scenarios of the area ECHO is currently working in, so as to fully exploit the potential

30 If pregnant women and children to be targeted as more vulnerable, flat fees can be relatively lower for these patient groups

of the latter. In case there are no possibilities for Commission aid instruments to step in, the opening of gaps may be avoided through proactive co-ordination with other donors. Specific focus should be put on Equateur province, which is not included in the 9th EDF.

126. In cases of withdrawal of support to health services, evidence shows that while HCs all but disintegrate, hospitals may survive as functioning structures, but at the price of immediate and high exclusion rate. This entails not only a massive reduction of entitlements for the affected population, but represents also a loss of return on investment.
127. Careful contextual analysis and own institutional flexibility allows finding and adapting the 'right' mix of relief and development strategies.
128. Using an integrated, multi-sectoral approach has a higher impact on the affected population through synergy between sectors, increased sustainability through wider donor basis, and increased efficiency through economy of scale.
129. Should ECHO continue to finance the PUC (health), a separate evaluation of this programme would be necessary (budget volume, long duration and potential conflict of interest).

Lessons learned

130. The degree of poverty in the 'green' and 'yellow' zones may be just slightly lower than in the 'red' and 'blue' zones; with regard to the capacity of the health system to deliver, however, there is no difference if not the bigger chance of the 'green' and 'yellow' zones to attract support of a development donor.
131. The impact of health care projects is significantly lessened if a partner bites off more of a geographical area than he can chew.
132. Prevention, health promotion and, first-referral hospitals and the MoH administration are integral and relevant parts of the local health system. The fact that they receive less support than curative care in first-line health services creates a certain imbalance that is difficult if not impossible to resolve within the limits of ECHO mandate and budget.
133. User rates of health services are a good quantitative indicator of their accessibility. Without qualitative complement at population level, however (user satisfaction of patients and access to health care of the affected population), they do not explain possible shortfalls.
134. The resources needed for the provision of care (human resources, infrastructure, supplies, finances, equipment) are multiplicative, and not additive. The lack of just one component risks to nullify the effectiveness of the assistance program.
135. Staff policies of typical emergency partners (high turnover of sometimes relatively inexperienced expatriates) are not suited for a context of chronic, even 'post'-conflict emergencies.
136. The monitoring of crude mortality rates may be of interest at an aggregated national level, but is not an immediate tool for management.
137. Once indicators of health at population level or of access to health care improve, it is a fallacy to conclude that humanitarian aid can then be dispensed of, as long as the improved performance of health services is to be attributed to humanitarian aid.
138. A solution in the trade-off between coverage and quality can be found for first-line health services, on a case-by-case basis with regard to number and location. As a general rule, coverage of a minimum of 50% of Health Centres appears to be both feasible for the partner and acceptable for the MoH.
139. Using an integrated, multi-sectoral approach has a higher impact on the affected population through synergy between sectors, increased sustainability through wider donor basis, and increased efficiency through economy of scale.

B.2.3. NUTRITION

B.2.3.1. Analysis of the current nutrition situation

140. Numerous nutritional interventions characterised the least years of activity in the DRC Eastern areas. Unfortunately, despite these large efforts, the nutritional status of children remains a serious public health concern especially in the “red zone” still most affected by conflict (Table 1 of annex I) [48]. The admission rate of severely malnourished children to Nutrition Centres (NCs) is constant or even increasing (see 2.3.2). National nutritional data collected in the framework of the Multi Indicator Cluster Survey (MICS) [49] showed an alarming nutritional situation with 38% prevalence of chronic malnutrition, 13% prevalence of acute malnutrition and 16% of under-nutrition in children under five; oedema was present in 3% of infants. MICS data were collected in 2001; the following years were characterised by widespread food insecurity and even famine across the DRC that affected children's nutritional status as demonstrated by KAP survey (2003) [48]. Stunting prevalence ranged from 32% and 59% in the different provinces; wasting ranged from 6% to 11% and oedema was still present in more than 3% of children reaching the prevalence of 14% in south Kivu (see Table 1 of annex I for details). According to international references [50], the public health level of attention of these indicators ranges from high (more than 40% of children stunted), over alarming (more than 10% of children wasted) to catastrophic (oedema present in at least in 2% of children). The number of people vulnerable due to food insecurity is now estimated at 16 million, with 4.3% of the households classified as chronically food insecure [51]. Stunting (chronic malnutrition) and wasting (acute malnutrition) are the two main forms of malnutrition in children. Marasma and Kwashiorkor aggravate clinical consequences of chronic and acute malnutrition, the first mainly related to reduction of energy intake, the second mainly related to impaired protein metabolism. Clinical signs of kwashiorkor are apathy, absence of appetite, skin and hair depigmentation, and, in the most severe cases, oedema, which is the only sign of kwashiorkor determining the admission in TFCs. The prevalence of chronic malnutrition and Kwashiorkor, with or without oedema, is widespread and mainly related to poverty. It was very common to find children in households with classic clinical signs of Kwashiorkor that did not fit into the criteria for admission in NCs. Growth retardation was evident and often severe: e.g. 7-year old children with a body size corresponding to a 4-year old. Anaemia levels are alarming, too: approximately 10% of the children admitted to NCs needed a blood transfusion prior to nutritional therapy.

B.2.3.2. Analysis of ECHO-funded nutrition interventions

141. The performance of the NCs was found to be generally good, in some case excellent, with well-trained staff and key indicators under the Sphere minimum cut-off points (Table 2 in annex I) [52]. The data reported in Table 2 are graphically presented in Figure 1 of annex I, panel A for TFCs and panel B for SFCs. Food stock ruptures and security constraints were the most important reasons reported by IPs to explain the cases of not reaching the minimum sphere standards. The good performance of NCs in a difficult area such as Congo represents a challenge for both donor and IPs. Admission criteria strictly follow the national protocol and international guidelines. The admission rate of severely malnourished children to NCs is constant or even increasing: in Bunia, for example, data provided by COOPI showed a 30% admission increase in TFCs in the first 6 month of 2004. A similar level (29%) was found in Shabunda from February to October 2003 (data provided by ACF). It should be pointed out that NC admission rate is only in part related to the prevalence of malnutrition in the area. External factors, as reported by IPs, highly affected the level of attendance to the NCs. A partial picture of NC admission rate is

provided in Figure 2 of annex I. Even if the data presented do not represent all sites visited, they give a general idea of the situation. Obviously, constant monitoring and in-depth knowledge of local conditions permitted the best interpretation of the all cause-effect mechanisms. According to IPs' explanation of the phenomena, the profile of admission rates was affected by security (Shabunda, Walungu, Nyangezi, Kaziba), access to the centers (Lemera), and seasonality (Baraka). Information about the existence of NCs reaches the communities via local communication networks. A system of home visitors and training of Health Centre staff to recognise signs of malnutrition are additional strategies to increase coverage.

142. Therapeutic Feeding Centres (TFCs) function in local hospitals or health centres. Often, TFCs represent as much a medical as a nutritional intervention; most severely undernourished patients are also extremely sick. TFCs operate every day, 24 hours a day, including weekends and holidays. In all the centres there is a space for registration and anthropometrical measurement. The phases of treatment have their own designated areas or rooms. The initial treatment phase had also a place set aside where medical emergency cases are grouped together for special care interventions, and an isolation ward for patients with contagious diseases (especially for adults). Kitchens, washing areas, showers and latrines permit preparation of food and an acceptable level of hygiene. Food, medicines and equipment have their own designated storage areas. Mothers of hospitalised children receive training on health and nutrition topics.
143. Supplementary feeding Centres (SFCs) were established to correct moderate wasting or to prevent moderately undernourished children from becoming severely undernourished. After permanence in a TFC, moderately undernourished children are referred for follow-up to more decentralised SFCs, usually near health centres. Food is in general distributed once a week; jointly with clinical support, anthropometrical evaluation and nutritional education activities for mothers. NC performance was found to be highly dependent of WFP food deliveries. The quantity of food distributed, regulated by the national protocol, is highly affected by its availability: the quantity of Corn Soy Blend (CSB), for example, ranged from 60 gr/day to 250 gr/day according to the ability of the partners to compensate for shortage of food delivered.
144. In general, the age breakdown of the admission in the NCs showed that children under five represent the majority of beneficiaries, followed by children 5-18 years old and women of childbearing age. Adults are generally less represented. Adult admission rate vary a lot between the different areas. Detailed figures were reported in table 3 of annex I. Summarising, in Bunia (COOPI) adult admission rate was 6% (TFCs) and 3% (SFCs); in Walungu area (Malteser) adult admission rate was 10% (TFCs) and 12% (SFCs); in the areas covered by ACF these rates were higher, with 43% (TFCs) and 32% (SFCs) in 2003 and 37% (SFCs) in 2004. The interpretation of these data is difficult without knowing the prevalence of adult malnutrition in the areas. Probably, a combination of IPs policy and a different level of adult malnutrition the activity zones was responsible for these large differences. Severe malnutrition does occur as a primary disorder in adolescents and adults in conditions of extreme deprivation and famine [53]. Adolescents have not traditionally been considered at high nutritional risk in emergency situations; there are no data at national level on the prevalence of malnutrition in this age group. But the protracted emergency in the DRC has also affected age groups that are different from the classically vulnerable individuals. The nutritional requirements of adolescents are higher than in other age groups, owing to rapid growth in stature, muscle mass, and fat mass during the peak of the adolescent growth spurt [54]. Malnutrition in adolescent can therefore have multiple adverse health outcomes with delays of normal maturation and compromising future labour capacity [55]. In addition to that a large proportion of girls have their first pregnancy during adolescence in the DRC. Improvement in nutritional status can improve pregnancy outcomes, including

maternal and foetal death and pre-term delivery [56]. While it is unlikely that adolescents are the only group in a population with substantial under-nutrition, it is highly possible that protracted food shortage and absence of health care has affected this age group.

145. Malnutrition in adults is commonly associated with other illnesses, such as chronic infections, intestinal mal-absorption, alcohol and drug dependence, liver disease, endocrine and auto-immune diseases, cancer and AIDS. In such cases both the malnutrition and the underlying illness were treated, referring the patients to nearest hospitals or health centres. The physiological changes and principles of management of adults with severe malnutrition are the same as those in children. Nutritional oedema, particularly common during famine, was also observed in adult patients in NCs. The classical protocol for treatment of children can be adopted also for adults once the causes of malnutrition are under control. In fact, an important problem in assessing adult under-nutrition during famine is the inability to differentiate between primary and secondary under-nutrition. There are no data on the prevalence of adult malnutrition neither at national nor at regional level. Nor are data available, in the current NC registration system, for discrimination between primary and secondary adult malnutrition.
146. The 'Protocole National de Prise en Charge de la Malnutrition Aigue' (ProNaNut) [57] is the result of collaboration by MoH nutrition experts and relevant NGOs and UN agencies. There is no mechanism, however, for agencies running NCs to provide feedback on practical lessons, observations and other implementation issues. Such information could be used for further refinement of the Protocol at national level.

B.2.3.3. Evaluation criteria for nutrition interventions

ECHO's Intervention Logic in Nutrition and Food Security (FS)

147. The integrated response to malnutrition (TFCs, SFCs, IDP/ returnee programmes combined with FS activities) was found to be the most sensible approach to tackle the needs of the affected rural populations. Nutrition and FS are highly linked issues. To achieve nutritional improvement, a solid foundation on improved FS and health is indispensable. This requires active collaboration from all actors working in health, agriculture, education and other areas. The nutritional status of the population is a key indicator for general food security and even development; this recognition needs to be reflected in sectoral priorities. The collaboration efforts must involve the whole civil society and their representatives, NGOs, UN agencies, donors and research institutions.

Programme Design

148. Partners started operations following a nutritional assessment; they also monitor regularly the nutritional condition in the area. Results of these assessments show a clear need for NCs. Certain programmes manage to reach remote and insecure areas; others were insufficiently integrated with regard to components of health and food security.

Effectiveness

149. Activities are in general appropriate and well managed, even if carried out in insecure and isolated areas, as in some cases. The good performance of NCs was demonstrated by high cure and low death rates. The presence of the TFCs inside hospitals has the advantage to be able to make use of health personnel to train staff, but at the risk of losing their primary focus - nutrition. The absence of protective family rations (either due to a decision of the partner or constraints of food availability) compromises the final objective of the reduction of malnutrition. Partners have

adopted different strategies to deal with food distribution shortage, including the utilisation of locally manufactured food as CSB replacement.

Efficiency

150. Establishing and managing NCs is expensive. Treating children is their primary focus. Treatment of adolescents and adults affected by malnutrition is an ethical issue: severe malnutrition can lead to death or permanent impairing of health. The marginal cost for treating other age groups other than children in an established NC, however, is minimal. Community participation is stimulated when a local NGO is involved in the project. Turnover of expatriate staff, with few exceptions, is high, which limits the understanding context and coordination of project activities. Often, the high level of responsibility of local staff compensates for this shortcoming. Coordination with local health authorities and other relevant agencies is generally good. Training activities are often lacking and, when present, are not controlled for quality.

Impact

151. The impact of NCs in the areas covered was beyond doubt. Malnutrition rates were often lowered, even if the context did not permit consolidation of these results. In fact, admission rates of severely malnourished children to NCs are constant or even increasing. Longitudinal data with the pattern of malnutrition prevalence in the last two or three years were not available at the time of the evaluation. Most surveys are planned within the end of 2004; these data will provide a clearer picture of the impact of NCs in the area covered. Figure 3 in annex I shows the prevalence of acute malnutrition (global and severe) in the areas covered by NCs. Mortality was also reduced among admitted patients. The long-term impact of nutritional programmes is related to capacity building of health staff and increased knowledge among families on nutrition and care practices. A negative impact of NCs is related to the absence from their family of mothers who have a child in a TFC, or who visit the SFCs (in some cases, at one day's walking distance). This absence from the family represents an important risk factor for other young siblings that are exposed to the same environment.

Potential Sustainability

152. TFCs and SFCs are pure emergency activities, with low sustainability. Training of local staff can contribute to sustainability; other possibilities are related to policy support at national level and Community based Therapeutic Care (see above: B.2.3.2.), and cooperation with local NGOs. Alternatives to prefabricated inputs (CSB, F-100/75) were studied and proposed (e.g. MaSoSo), but local alternatives to F-75 and F-100 are still missing.

B.2.3.4. LRRD and Exit Strategy

153. Nutrition remains a primary focus for ECHO strategy. The classical approach of management of acute malnutrition has been very successful in terms of clinical outcomes. However, the NC model had limitations related to coverage, carer's absence from the family and ignores the socio-economic factors involved in severe malnutrition. There is an increasing consent in the literature [58,59] on the opportunity and need of an evolution of NCs into a Community-based Therapeutic Care (CTC). A CTC programme has the following elements [60].

- Stabilisation phase: the initial phase of treatment of severe malnutrition for children with complications. Life-threatening problems are identified and treated, specific deficiencies are corrected, metabolic abnormalities are reversed and Ready-to-Use Therapeutic Food

(RUTF)³¹ is administrated. This is an inpatient phase and takes place in a Stabilisation Centre, which may be located in a hospital or clinic.

- Outpatient Therapeutic Programme – providing specialised RUTF and simple medical protocols through existing health infrastructure.
- Supplementary feeding programme (SFP).
- Community mobilisation component - identifies traditional leaders, healers and other people within the community to maximise participation and engagement in the programme leading to increased impact. Later, the programme identifies community resources, works with the community to develop other interventions, engages mother to mother mobilisations and follow-up case finding, etc.

154. A further advantage of CTC is that the programme strategy is based on the idea that emergency programmes should 'leave something behind', i.e. lead into development programming and sustainability. Owing to the emphasis of CTC on strengthening inter-sectoral links, the programme aids the transition from emergency feeding to food security programming.

155. At the start, a combined approach with CTC complementary to TFCs can be a transition solution for accompanying the evolution of the two approaches. In this way, complicated cases can be briefly admitted in the pre-existing TFCs for initial rehydration, antibiotic therapy, and to re-establish appetite. Uncomplicated cases can then be followed closely with home-based treatment. Including a community-based therapeutic care component in famine relief programme has many potential advantages, but there are still some criticisms: the mixed inpatient/outpatient system, for example, could be expensive. But the economic impact of carer's absence from households has to enter the equation, too. Large-scale studies that compare the effectiveness of CTC approach with traditional NCs system using epidemiological and contextual data are still missing. The application of a CTC-approach in the Congo would therefore need a careful monitoring of outcome variables and cost.

Conclusions

156. The present nutritional status is the direct result of successive wars and disruption of socio-economic structures, in a context of pre-existing poverty and resulting in chronic malnutrition that affected a large part of the population. High level of stunting combined with high level of poverty and low energy intake represents a worst-case scenario with chronic and short-term deprivation.

157. NCs have huge requirements for resources, skilled staff and imported therapeutic products; they are expensive. In addition, TFCs are often too small to attain high population coverage. Admission of a patient to a TFC usually obliges the carer, most often the mother, to leave the family for around 30 days. SFCs present an opportunity for nutrition education activities.

158. There is a clear, comprehensive national nutrition protocol (ProNaNut). Mechanisms are lacking, however, to provide feedback from the field, in order to foster further refinement of the protocol.

159. All nutrition activities match the criteria for emergency humanitarian intervention, to save lives and alleviate suffering. A high level of integration of sector components leads to complex, large projects that require a high level of interaction between agencies and good quality management.

160. NCs in general are performing well. The integration of TFCs in health services can lead to lose the primary focus on nutrition. Dependency on WFP food distribution was found to be high.

³¹ Researchers have developed a ready-to-use therapeutic food (RUTF: plumpynut; Nutriset, France), designed to be nutritionally equivalent to Formula 100 that can be used easily and stored safely for several months in a simple, opaque, airtight container. RUTF is sold as a paste that patients can eat directly from the packet, and does not require mixing or cooking.

161. As stated, establishing and managing NCs is expensive; the marginal cost for treating other age groups than children in an established NC, however, is minimal. The often high turnover of expatriate staff can limit efficiency.
162. Reduction of malnutrition in project areas was often demonstrated, at least in the short term. Mortality was also reduced among admitted patients. While feeding and educating mothers in NCs helps preventing child malnutrition on the one hand, their absence from the family has also a negative impact on the siblings.
163. CTC is a alternative model for selective feeding in emergencies, though it can arguably also be costly. Severely malnourished children with no medical complications could be safely treated (at least for phase II) in their homes; inpatient approach could be limited to phase I and for medical complications. Caring for people in their communities strengthens the social fabric and capacity and links with existing community interventions. CTC has a strong LRRD potential by providing a platform for longer-term intervention.

Recommendations

164. Nutrition should remain a priority of ECHO actions for the following years. Public action to reduce malnutrition is both a moral imperative and an excellent investment. Investing in nutrition is one of the most effective and sustainable pro-poor economic growth strategies.
165. For anaemia, iron supplement can contribute to treat iron deficiency, but anaemia in Congo is also due to other causes (hookworms, malaria, infection, other micronutrient deficiency). It is essential to combine iron supplements with other public health measures to obtain the full benefit on health of iron supplement.
166. The (100% inpatient) therapeutic feeding approach should evolve into a partially outpatient model, to increase family involvement and reduce absence of mothers from the family. SFCs should become 'nutritional reference points' with a strong community involvement, focused on surveillance and prevention. Local production or preparation of therapeutic and supplementary food should become part of such an integrated strategy. Nutritional education needs to be substantially improved with visual material adapted to the local situation. Preventive health modules (malaria, AIDS, vaccination) and food security aspects are to be integrated in all nutritional programmes.
167. The admission to NCs of children 5-18 years is not to be questioned. Malnutrition in adults can sometimes be associated with other illnesses. In such cases both the malnutrition and the underlying illness must be treated; adult selective feeding programmes must be designed accordingly. There is a strong need for a national nutrition assessment with a micronutrient component; ECHO should also consider co-funding a MICS 2005.
168. Results of the pilot experience of NC evolution into therapeutic home care centres should be discussed in a round-table; relevant agencies should adopt a common protocol and review the national protocol (ProNaNut) in the light of this new statement.
169. Integrated health, nutrition and FS projects should be considered a standard intervention strategy, with links to the respective sectoral lead agencies. Malaria and HIV prevention should be part of the nutritional programmes.
170. TFCs operators should benefit from specific nutritional training. Partners experiencing periods of food shortage should receive support to bridge the gaps. Experiences made to reduce dependency on WFP should be capitalised.
171. Training components for nutrition are to be improved. Methodological aspects of training should be standardised between agencies.
172. The reduction of malnutrition in project areas is to be consolidated through integrated food security interventions involving the families of treated children.

173. More village-based nutritional expertise is needed. Mother-to-mother educational techniques can improve the transfer of knowledge. Preventative programmes are to be considered, which focus on the overall aspects of children malnutrition, including stunting and anaemia.
174. Epidemiological and contextual data for comparing and monitoring the effectiveness of classical and CTC approach are necessary. Better information on costs for both TFCs and CTC is required. This information is particularly important for governments and donors.
175. Where there are no specific nutritional programmes, doctors and nurses working in paediatric wards are to receive specific nutritional training, to recognise signs of malnutrition and to permit them treating severe cases in paediatric hospitals wards.

Lessons learned

176. The classical 'emergency reasoning' that children under five and women in fertile age are the most vulnerable and therefore the only target group for nutritional intervention does not apply to the particular situation of the DRC. The protracted emergency has compromised population groups – adolescents and adults – that are not traditionally considered high risk and high priority.
177. While the classical approach to malnutrition in emergencies has limitations (cost, sustainability, coverage), experience with CTC approach is still limited. Funding for severe malnutrition in emergencies is limited; difficult choices need to be made with the aim to maximising benefits: between access for all, individual care, sustainability, and community empowerment.

B.2.4. FOOD SECURITY IN DRC

B.2.4.1. Analysis of the Current Food Security Situation

178. Food insecurity in the DRC follows a circular cause-effect pattern of very low (and shrinking) food production levels and extreme (and rising) poverty. The decade-long downward trend of this spiral is caused by the effects of mismanagement, war and continuing insecurity (annex B: Poverty-agriculture flowchart). The major limiting factors for food production in ECHO Food Security (FS) intervention areas are (likely in this order):

- insecurity: displacement, loss of productive assets and animals, fear to access fields and markets, storage insecurity;
- poverty: ability to supplement own production, ability to replace lost assets and to buy inputs, ability to invest, sharply reduced purchasing power of urban consumers;
- lack of geographical access to markets: road conditions, bridges, barges, distances.

179. An estimated 75% of the population are considered food insecure³²: 34% of surveyed households do not possess any food stocks, neither in store nor on fields [51]). Main indicators for the national food security situation are:

- rates of acute malnutrition (severe and moderate) and chronic malnutrition (stunting)³³;
- calorie/protein intake levels per person in percent of requirement³⁴;
- agricultural production figures vis-à-vis food requirements by geographical area³⁵;
- market analysis of major food crops in regular intervals to determine food security trends for urban (consuming) vs. rural (producing) populations in relations to prevalent income levels³⁶.

180. For none of the above indicators, reliable and updated national figures are available that go beyond informed estimates. The best brief overview of the FS situation in the DRC is currently found in the UN Consolidated Appeal Process (CAP) draft document [62].

B.2.4.2. ECHO Funded Food Security Interventions – Programme Design³⁷

181. The specific objective of food and nutrition interventions³⁸ seems largely achieved. The 'target population' is defined by war and insecurity and by the capacity of partners to identify and register malnourished persons, internally displaced persons (IDPs), returnees and host families. With the widening of the humanitarian space, 'severely food insecure population' can increasingly be

³² Making DRC the world leader, after a terrible decline from 31% in 1990/1 [61]

³³ see B.2.3.1. : Nutrition status

³⁴ a May 2004 survey in selected localities of 6 Provinces gave an average of 65.5% of kcal intake and 63.8% of protein intake vis-à-vis a required intake of 2,300 kcal and 70 g of protein respectively FAO (2004) unpublished survey . The CAP draft document on food security quantifies food intakes as 70% for calories and only 50% for proteins.

³⁵ no updated Crop and Food Supply Assessment Mission (CFSAM) report of WFP/FAO available. FAO estimates that since 1998, the production of manioc, covering 70-80% of the national calorific intake has dropped by 20%. The reduction of 45% in fish production and a near total loss of animal husbandry in heavily war affected areas have devastating effects on rural incomes and on the nutritional status, mainly of children (FAO quoted in CAP draft 12. 08. 2004). An estimated 3 Million IDPs can be considered almost non-producing, while 700,000 returnees (estimate for 2004/05) will produce per capita even less than the catastrophic national levels.

³⁶ 80% of the population live on less than 0.5 USD / person / day (FAO quoted in CAP draft 12. 08. 2004). The agricultural labour wage varies from 0.5 to 3 USD per day, whereby employment can be found usually during less than half of the year. Where large numbers of IDPs are hosted, agricultural labour is often remunerated with food, firewood or thatching material of a value below 0.5 USD (own inquiries).

³⁷ For ECHO's Intervention Logic Nutrition & Food Security: see section nutrition (B.2.3.2.)

³⁸ 'Acute malnutrition rates among targeted population groups are contained within emergency thresholds through integrated nutrition and food security programmes' ECHO 2003 DRC Global Plan 2004 p. 17, Brussels

identified and registered as a sole category³⁹. With current 'curative' FS measures that reach a single digit percentage of the overall population, we fear that the pool of families at risk will remain largely constant, not allowing for any exit strategy for expensive nutrition programmes. Within the existing project set-up, an expansion of FS activities (beneficiary numbers) would significantly reduce the cost per beneficiary reached.

182. Basis for rational geographical targeting are 1) nationwide assessments, 2) knowledge of other donors' geographical focus, and 3) ECHO's historical geographical focus. The current intervention area is well chosen, based on the erosion of the population's coping mechanisms during years of war, insecurity and destruction of (social) infrastructure. Based on an arguably limited review of 2 projects, it was found however, that there is limited knowledge of the nutritional and FS status of current geographical areas and very little data for most territories that are neighbouring the currently covered areas. Only such information would allow revising the geographical targeting.
183. While targeting malnourished persons follows strict scientific rules, selecting the 'poorest' or 'most vulnerable' families is substantially more complex. Widening the numbers of beneficiaries for FS interventions requires modified approaches in targeting. Even though designed for food aid programmes, the targeting standard and key indicators of the Sphere Project⁴⁰ can give valuable guidance. Important is the recommendation that 'the disaster-affected population has the opportunity to participate in the design and implementation of the assistance programme'⁴¹. 'Severely food insecure families' need to be identified in a fully transparent and participatory manner. Annex K: 'community-based beneficiary targeting' provides a possible approach; annex L proposes a profile and Terms of Reference for a Facilitator for Technical Workshops Food Security.
184. FAO has been an important source of advice and complimentary inputs for the ECHO FS programme, and a reliable partner for the PUC (Programme d'Urgence pour le Congo) project for FS. In order to set up a rapid PUC programme, FAO has standardised the major two input packages (agriculture kits for returnees and families registered in nutrition centres). Following the same intervention logic, beneficiary targeting follows largely the registration of returnees and families with malnourished persons.
185. Lastly, LRRD in the food security portfolio can be fostered by ensuring that project designs provide a basis for continued and increasingly developmental approaches. Modules for such a design will be increasingly out of the ECHO core mandate, even though the situation still is an acute emergency. Of increasing importance for ECHO's work in 2005 and beyond will therefore be to build bridges between relief situation and development action.

B.2.4.3. ECHO Food Security Modules

186. All visited FS projects were run fairly effectively and efficiently. With changing frame conditions, there is increasing room for improvement and innovation. Some recommendations to improve efficiency are found in the modules below. The systemic approach requires a much closer cooperation of partner NGOs. The main tools for this are technical workshops in FS and other disciplines (B.2.1.3: Joint learning and programming). Some of the modules already have a strong developmental character, which seems very appropriate for the chronic emergency situation. As

39 Even though the consultant agrees that 'The overriding principle [...] in emergencies is to ensure that everyone receives adequate assistance to sustain a life with dignity' [63] in the DRC context, this will not be realistic in the foreseeable future. However, current beneficiary numbers are grossly inadequate

40 'Targeting standard : Recipients of food aid are selected on the basis of food need and/or vulnerability to food insecurity. Key indicators : 1. Targeting objectives are agreed between the coordinating authorities, female and male representatives from the affected population and implementing agencies. 2. Targeting criteria are clearly documented, whether in terms of population group(s) or geographical location. 3. The distribution system is monitored to ensure that targeting criteria are respected. [64]

41 *ibid* p. 144

activities, they are at the fringes of ECHO core mandate, while the objectives they are contributing to are still purely humanitarian. Only part of ECHO's partners, often emergency oriented NGOs, currently have the skills to do emergency work with developmental tools.

187. The DRC has the potential to not only feed itself, but to be a major food exporter. Large-scale food aid imports bear the danger of slowing down agricultural recovery, whereas careful local purchase can stabilise markets and stimulate overall production; this has been successfully undertaken in some cases, even though quantities and qualities have sometimes been insufficient. No co-ordinated local food purchase programme has been developed to stimulate local production and to bridge gaps in the (WFP) food pipeline. The international funding structure of food-aid has led to reluctance to embark on local purchase. FS surveys can point out the potential for local purchase, which in turn can help to lobby for cash, rather than in-kind (food) donations.
188. Rehabilitation of roads through cash-for-work (cfw) is an excellent tool to inject cash into rural economies and, at the same time, improve market links to stimulate agricultural production; it is much more a FS instrument than an ingredient of IDP / returnee programmes. Some road works do not form part of an infrastructure master plan that takes overall economic considerations into account. Little is known to which degree cash reaches the household (most cfw participants are men). WFP is implementing parallel food-for-work (ffw) programmes to rehabilitate roads. The rationale for food vs. cash for work is not driven by the search for the most appropriate form of payment, but by agencies' available resources. No joint programmes were found whereby ECHO provides the cash (for work) component and WFP the food (for work) component.
189. The impact of road works depends on the choice of participants (men / women? poorest or fittest?), remuneration (food vs. cash - what reaches the household level?), the quality of work (how long will the road remain passable?), and the choice of the stretch (how much traffic will use the road? Is there a link between surplus and market area?). The choice of road stretch and the quality of work are as important for food security as the remuneration to workers: a lasting stimulation of agriculture production (to reduce extreme forms of food insecurity) essentially requires transport arteries that last beyond the next rainy season.
190. Road works are so far the only activity that can have a positive impact on disarmament and demobilisation through participation of fighters in road works. Safety for agency staff on newly opened roads has been negotiated successfully. So far, this 'carrot' for armed groups (participation in road works) is not utilised to negotiate safety for the rural population at large (provided this is possible at all).
191. The example of southern Sudan shows that WFP can get major donor support for road rehabilitation if this substantially reduces food and personnel transport costs (switch from air to road transport). One partner, together with local communities and authorities, has set up a road toll system with the intention to finance ongoing road maintenance works by adjacent communities. At the time of the evaluation it was too early to evaluate the success of this undertaking.
192. FS interventions attached to nutrition centres: the standardisation of the principal approach (training, demonstration gardens and fields, kits, home visits) is convincing and a starting point for joint learning among donors, agencies and beneficiaries. The contents of FS kits given to families with malnourished members are largely appropriate. Fine-tuning to adapt kits to local conditions is required, but needs the input of beneficiaries and local experts within NGOs. Demonstration gardens are generally well maintained and regularly utilised, but never were all promoted varieties visible, nor were checklists available of items to be demonstrated (annex M: checklist vegetable gardens). Only one partner multiplied the effects of central demonstration gardens by creating an additional 10-15 contact gardens each, close to the homes of beneficiaries.

193. A large part of the seeds that are distributed in agricultural kits are procured from commercial seed traders, partly from outside DRC. A positive step forward is the local production in seed cooperatives and distribution to beneficiaries, though this not always cheaper. In order not to destroy local markets for seeds and to leave a bigger choice to beneficiary farmers, an NGO has embarked on organising 'seed fairs'. Beneficiary farmers (e.g. returnees or selected poorest farmers) receive vouchers for which they can exchange seeds of their choice from the invited seed producers. No similar approach has yet been tried for tools or animals in ECHO funded programmes (annex N: seed fairs).
194. ECHO is currently not funding any animal production projects, but other donors do. Owing to slow multiplication and distribution, the impact of small animal husbandry on protein malnutrition and widespread anaemia is still not satisfying. The production of soy beans, arguably one of the best plant protein sources, has not yet been developed as a second-line strategy, mainly due to the lack of processing options. The multiplication of guinea pigs, rabbits, or the support to soybean production is only appropriate where this is already known and accepted.
195. Manioc (cassava), though considered nutritionally poor, is by far the most important provider of calories and remains the backbone of FS in the DRC⁴². FS interventions by ECHO and FAO aim at reducing the dependence on manioc, for valid nutritional and agro-ecological reasons. FAO runs only a limited programme to multiply planting material of manioc varieties resistant to the mosaic virus. If the negative trend in manioc production continues unabated, it can be safely assumed that all efforts of ECHO funded FS projects will be neutralised by the mosaic virus, exacerbated by a population increase of 3.1% annually.
196. Security for farmers and traders, being perhaps the most serious threat to food security, has not been systematically addressed by ECHO-funded programmes. Entry points could be the above mentioned road rehabilitation as a 'carrot' for armed groups, involving them in the works against security guarantees. The other, so far untested approach might be to support 'storage security', for farming communities: rather than storing the harvest at home, it is brought to central and protected storage facilities chosen by the community and only small amounts are kept for consumption. Yes, if organised on a community basis (school, health facility).

Conclusions

197. The lack of national reliable and comparable FS data has weakened humanitarian intervention. In the past, interventions were rightly undertaken in the most conflict-affected areas and where access allowed this. In future, if access continues to increase significantly, ECHO will require a more stringent rationale, based on food (in)security indicators.
198. ECHO FS interventions have been a remarkable success in 'doing the possible' in situations of extreme insecurity and limited access. With increasing access and improving security, and with mortality and malnutrition rates still at emergency levels, the current FS interventions are *not* sufficient to alleviate the most severe forms of food insecurity *where this is possible*.
199. While targeting malnourished persons follows strict scientific rules, the 'poorest' or 'most vulnerable' families in a given area can only be identified with well-structured methods of community participation.
200. If the project design is to provide a basis for continued and increasingly developmental approaches, a strong emphasis on beneficiary training, partner capacity building, community participation and involvement of the state structure, where this still exists, is necessary.

⁴² In 2003, FAO estimates a manioc production of 14.93 Mill. MT. Dwarfed in comparison, the second and third most important calorie providers are plantains with 1.25 Mill MT and maize with 1.10 Mill MT [66]

201. Local purchase of food has been hampered by low availability and quality. Under changing frame conditions, local purchase may become important to help and kick-start an agro-economic recovery process. WFP as the main mover of food lacks cash resources to shift from foreign food aid to local purchase. There is little knowledge about potential positive and negative impacts of local purchase.
202. Road works by cash-for-work / food-for-work produce multiple benefits for the FS situation. Technical details (for sustainability of the road) and project design (to maximise direct benefit for the most vulnerable households) need to be elaborated in a technical workshop to improve the overall impact of such projects.
203. The intervention logic and project design of interventions attached to nutrition centres appears largely correct, but most technical details require fine-tuning. Centralised approaches of animal breeding and demonstration gardens penetrate villages insufficiently and lack potential sustainability. ECHO partners have not sufficiently shared experiences and best practices.
204. Seed (tool) fairs are undisputedly a more sustainable approach than seeds (tools) supply. Later savings, in terms of prices for seeds and logistics, should compensate for substantial organisational investment in the beginning [67].
205. The speed of animal multiplication and distribution is still slow. The potential of soybean production and processing has been insufficiently utilised. Both activities are not typically emergency interventions, even though they focus on urgent emergency needs (high levels of protein malnutrition and anaemia).
206. By concentrating only on staple crops other than manioc, ECHO runs the risk of losing the race between shrinking manioc production and increasing production of alternatives.

Recommendations

207. ECHO should intensify support for multi-donor co-operation, together with FAO, UNICEF and WFP to draw a plan for the most urgent assessments in 2004/05, and define individual responsibility per assessment. This should include longer-term plans for gathering of crucial data.
208. Beneficiary selection and beneficiary numbers are to be revised in order to impact on severe food insecurity within targeted areas. This will require increased ECHO funding for FS and matching WFP, UNICEF and FAO inputs. ECHO is to liaise closely with donors and UN lead agencies to harmonise increased beneficiary numbers for plans and appeals in 2005/06 and to develop a joint rationale for increase by geographic area. Funding of specialised studies has to be considered to determine most rational increases. Jointly planned surveys should give clear indications about numbers of severely food insecure populations.
209. ECHO must ensure that in targeted districts 'coverage' means covering the whole district. Nutrition and FS situation in current and neighbouring territories / districts are to be assessed, following the same methodology as recommended for nationwide surveys. Geographical allocation is to be re-oriented according to needs identified. Other donors are to be alerted if ECHO is unable to fully cover a territory / district.
210. Severely food insecure families are to be selected (apart from families with malnourished members, registered IDPs, returnees and host families) with the help of village committees. The recommended methodology that is feasible in an emergency situation and with existing partners' capacity, including checks and balances, needs to be jointly defined by partners in a technical workshop. Of crucial importance is the composition of the village committees.
211. For 2005 a more refined and flexible approach of the FS PUC, implemented by FAO, is necessary to allow for a stratification of beneficiary needs and agro-climatic conditions.
212. FAO should support partners to carry out rural appraisals as a basis for kit composition. FAO, ECHO and partners should jointly re-define FS modules in technical workshops.

213. Many of the recommendations made below for FS projects are basically developmental in nature (even though addressing an emergency need). It is generally recommended to give them a limited duration (1 year, if possible up to 1 ½ years) to pilot for a development phase and –donor.
214. ECHO should, as soon as possible, advocate for and co-fund a study on local purchase of food, in cooperation with FAO and WFP and conduct technical workshops on the subject, to share experiences made. EuropAid should be encouraged to earmark cash funding to WFP or ECHO FS partners for local purchase. Funding of the position of a 'Local Purchase Officer' within WFP is to be considered. In 2005, FS partners are to be funded for small-scale local purchase to stabilise ongoing programmes, in particular nutrition centres. Revolving buffer stocks from local purchase are to be considered to balance WFP pipeline breaks.
215. Road works: stretches are to be prioritised that form part of the national master plan roads [68]. Stretches of 100 km and above are to be prioritised, to attain economy of scale with regard to expertise and logistics. For each road project, the most appropriate mix of cash-for-work and food-for-work has to be defined in a participatory exercise, involving potential participants, women (!), authorities and WFP. Common road projects with WFP are to be identified to reduce air transport costs for personnel and material. 'Best practice' for road rehabilitation and subsequent maintenance is to be defined in a technical workshop.
216. Demonstration gardens of nutritional centres should demonstrate a defined list of items, depending on nutrition needs and agro-ecological conditions. Contact gardens, run by contact groups of beneficiaries, supervised by the partner's agronomist can be the nucleus for commercial seedling production for the wider population. Agronomists should have a detailed training and demonstration plan including a participatory methodology that draws from best local practices. Three to four standard kits are to be developed per area to cover specific needs. Relevant modules are to be shaped in technical workshops.
217. The feasibility of seed (tool) fairs is to be explored in a technical workshop. Experienced organisers of seed fairs among the partners are to be invited. Applying the principle of vouchers and fairs to tools and animals should be explored.
218. Each central animal breeding station⁴³ should supervise 10-15 multiplication centres in villages, supported with advice, medicines and fresh genetic input. Partners should buy from village multiplication centres for distribution to beneficiaries; later, a voucher system may be introduced. Pilot projects for soybean production should be started / intensified and combined with training and provision of implements for soybean processing. ECHO's approach here we above (seed fairs) should be limited to implement pilots for future development.
219. The development of manioc production in the DRC should be closely monitored. If necessary, emergency measures are to be funded to speed up the introduction of virus-resistant varieties and/or the compensation by other staple crops.
220. ECHO should encourage partners working in FS and other sectors to explore activities within their projects that improve the security situation. Entry points may be the involvement of armed groups in road rehabilitation against security guarantees or systems of improved storage security. Pilot activities should be set up and closely monitored for impact and cost.

⁴³ funded by FAO, not ECHO

Lessons learned

221. Community-based targeting is a basic principle of any relief or recovery intervention. Agency pre-selection, where necessary due to high levels of insecurity, must give way to participatory methods as soon as the situation allows.⁴⁴ [65].
222. The potential of local markets - given sufficient cash in circulation - is easily overlooked. Fairs can be organised, after sufficient start-up time, for almost anything that is locally produced. Procurement, handling, packaging and transport costs can be significantly reduced. The organisational cost of organising fairs may be high initially, though.
223. Important questions for planning emergency FS interventions are: 'which agricultural crops and practices have sustained people so far?' 'Why is this not working anymore?' and finally: 'what needs to be done to re-establish the old system or compensate with an alternative?' An emergency recovery of any agricultural system must start from the known and the practised, to be efficient.

⁴⁴ ALNAP (of which ECHO is a full member) recommends in its 2003 study on DRC: 'The use of participatory methods is strongly recommended [...] training in participatory approaches in emergency contexts should be provided' and 'It is highly recommended to distance oneself from standardised categories and try to identify the truly vulnerable groups' [reference No. p.111, 112].

B.2.5. ASSISTANCE TO DISPLACED AND RESETTLING POPULATIONS IN THEIR HOST COMMUNITIES

B.2.5.1. Analysis of the Current IDP and Returnee Situation

224. Only rough estimates are available regarding numbers of IDPs; they range between 1.7 [69] and 3.5 [70, 71] million even within one agency's (WFP) estimates. For this report, the UNOCHA figure of 2.329 m [62] (Aug. 2004) is used. The return of camped and spontaneously settled IDPs has started in most areas, both in assisted return programmes and in a spontaneous, non-assisted way. Depending on the security and economic situation in hosting and home areas, the percentages of returnees vis-à-vis IDPs vary widely⁴⁵. Many families in return areas (having spent months hiding in the forest) are in the same or in a worse situation compared with 'official' returnees. They also had their houses destroyed, their fields looted and have lost their seeds and animals. The only difference seems often that they fled a shorter distance, did not receive IDP or returnee assistance and were never registered. As a result, they are often even more likely to be impoverished, malnourished and sick.
225. There is little evidence of a consensus among agencies regarding the future of IDPs. OCHA is convinced that most of the currently registered IDPs will not go home in the coming months for fear of their security, in particular if they belong to a minority ethnic group. This is in contrast with opinions of other discussion partners, who see the IDP crisis as artificially prolonged by continued assistance to IDPs. The humanitarian situation for most IDPs is still precarious. Humanitarian aid is nowhere above the tolerable minimum in terms of supply of food and non-food items⁴⁶. Many groups of IDPs hardly receive any, or only irregular assistance, such as the ones along the main axes leading out of Lubero in North Kivu⁴⁷. Reducing aid to IDPs will not lead to increased return, but to unsustainable and harmful coping mechanisms e.g. selling labour under value or criminality.
226. Besides the security situation in return areas, poverty is a major hindrance to return home. Many IDPs fear that their resources will not be sufficient for their re-establishment (rebuilding homes, restarting agriculture, surviving until the next harvest). If all conditions are conducive to return home, the time of actual return may still be delayed in view of the school-, the agricultural- and the seasonal calendar.

B.2.5.2. ECHO-funded IDP/Returnee Interventions

227. ECHO funded interventions in IDP hosting and return areas benefit the entire population with regards to social and road infrastructure, nutrition centres and health care. The distribution of non-food items and agriculture kits focus on registered IDPs and returnees. All interventions together are to kick-start the local economy in targeted areas. Affected areas and population groups seem to be correctly (pre-)selected by need. Specific support in the form of agricultural kits or NFI does not necessarily reach impoverished families who stayed in hiding close to their home area. Little is known about the suffering of IDPs and returnees in areas that neighbour ECHO's geographical intervention areas. A change in frame conditions (security, accessibility) may now allow to shift from pre-selection for certain interventions to a more needs-based and community driven beneficiary selection (see B.2.4.2.).

45 Variation between 15% in 'Aero Camp' Bunia and 50% in Makala Camp (Kalemie) among camps visited by evaluation mission

46 Along the Oicha-Eringeti axis north of Beni (N.Kivu), for example, WFP has reduced IDP rations to 50% of recommended rations for refugees, families interviewed are sharing 1-2 blankets.

47 See 'Mission Inter Agence au Grand Nord vers le Sud de Lubero 16. – 19. Aout 2004' OCHA, Beni

228. As most of ECHO's intervention areas are to some degree IDP hosting and/or return areas, the IDP/returnee portfolio in the Global Plan of ECHO may be less than helpful for the 2005 GP. Mainstreaming IDPs and returnees into the health, nutrition and FS portfolio while retaining attention to their specific vulnerabilities would allow and encourage a fine-tuned allocation of funds and promote the integration of programme components.
229. ECHO partners working in IDP / returnee projects have been found competent and dedicated to the improvement of living conditions of IDPs and returnees. As in other intervention areas, however, there is little exchange of experiences; the partners' capacity to shape project design and implement technical solutions are not sufficiently harnessed and promoted.
230. Seeds in kits for returnees contain maize and bean seeds as main component, addressing the need for calorie / protein supply. Added are 30 g vegetable seed. Interviews confirmed that the content largely addresses beneficiary priorities. Given the variety of agro-ecological conditions and specific beneficiary needs, content of kits requires further adaptation and fine-tuning. This process should be driven by participation of beneficiaries and exchange between FAO and ECHO partners.
231. To improve IDP – returnee programmes, ECHO, other donors and NGOs need to better understand the reasons for return or stay. IDP / returnee assisting partners keep a 'standing invitation' to return home. Little advantage is drawn from an optimised timing of return campaigns and the safety in numbers that group return would offer. Return campaigns usually include information about assistance and security in place of return and offer transport. They coincide with end / begin of the school year and the 'right' agricultural season. To determine the best time of return, thorough consultation with IDPs and early returnees is required.
232. Water and sanitation (WatSan) activities in IDP camps (such as provision and maintenance of toilets and shower rooms and the rehabilitation of natural springs) appeared well managed, sufficient in number and functional. However, they provide little incentive for the IDPs to duplicate WatSan activities after return. The materials chosen (plastic sheeting, cement) are not available in most return areas. Examples for 'replicable techniques' are family toilets and family shower rooms made from local materials, springs protected by stones rather than cement, spring intake protection by live fences, covered hand-dug shallow wells with or without pump, drip cans for hand washing or soap making.
233. Schools are important structures with high symbolic value for 'normality'. All interviews with beneficiaries have confirmed their high priority. Agencies have constructed schools and health centres with considerable participation of the local population, in some cases fixed in a formal contract between representatives and partners⁴⁸. Buildings follow a standard design with locally constructed walls, pre-fabricated doors, windows as well as timber and iron sheet roofs. Instead of the fairly expensive roof construction, a possible outcome of negotiations with teacher-parent associations could be that the poorest parents build a local roof, receive some of the cost of iron sheets, timber as cfw. The remaining amount could be allocated to subsidise teachers for one year
234. The most promising approach for income generating projects in return areas is intensified support with inputs to promote agricultural and animal production. Other trades can be promoted as individual choice. The beneficiary selection must include others than returnees (annex K: community-based targeting). Support to returnees and poorest neighbours should leave the biggest possible choice to beneficiaries. The adoption of seed and tool fairs is therefore highly recommended. A choice of tools should be offered for agriculture and other economic activities (e.g. brick moulds, saws for timber production, masonry tools, wheelbarrows, tools to dig shallow wells, tools for roof construction etc).

⁴⁸ e.g. the 'Protocole d'accord entre l'association Premiere Urgence et les associations de parents d'élèves des écoles primaires du territoire de l'Ituri'

235. Labour intensive works (mainly road improvement) should include only cfw if a substantial food component is given to returnees; cfw projects require sensible timing, as the rebuilding of houses and preparation of fields has absolute priority (B.2.4.3. ECHO Food Security Modules)

Conclusions

236. There is a hard-dying myth that the meagre IDP rations, a blanket and a plastic sheet makes IDPs stay away from home. With or without relief, IDPs do not go home if:

- the situation at home is not safe;
- poverty does not allow them to survive in the return area until the next harvest;
- income opportunities in return areas are substantially below survival needs;
- they cannot overcome a geographical, logistical, security or financial barrier;
- they do not expect to find health, water and school facilities in return areas.

237. The focus on 'status' (IDP/returnee) has – except for social infrastructure – neglected other vulnerable groups in IDP hosting and return areas.

238. As in other intervention areas, there has been little exchange of experiences with regard to IDP / returnee projects.

239. Given the variety of agro-ecological conditions and specific beneficiary needs, content of kits requires further adaptation and fine-tuning.

240. The 'return kits' so far developed seem insufficient to overcome the 'poverty barrier' to return. In particular, the WFP return food ration is insufficient to take a family safely through re-establishment to the next harvest – an estimated 5 months.

241. Technologies used for water and sanitation activities in IDP camps are not suitable to be replicated upon return, because most materials chosen (plastic sheeting, cement) are not available in most return areas.

242. The construction of schools in return areas leaves little opportunities for income generation and does not address the problem 'education' as a whole.

243. Sustainable income generating projects offer an important pull-factor for return. They should be integrated into the village economy.

Recommendations

244. Wherever this comparison is possible, IDPs are to be provided with similar support as is given (by other donors) to refugees. Only in situations with clear evidence of IDPs are able to cover autonomously their needs (finding work or being able to do substantial farming - a 10 m² vegetable garden is NOT substantial farming!), can assistance be carefully reduced.

245. A specific IDP/returnee objective should be included in all programme components (Health, Nutrition, Food Security). Focus should first be on areas with high numbers of IDPs and returnees, but beneficiaries are to be selected in a participatory manner, based on vulnerability (B.2.4.2.: beneficiary targeting).

246. The 'pull-factors' for return should be improved, while 'push-factors' (punishment of stay as IDP) should be avoided. ECHO should consider (co-)funding an independent study of driving and hindering forces for return, to foster innovative approaches to support populations in their respective decisions. Return campaigns should be jointly planned and organised between agencies, with IDPs, early returnees, churches and local authorities.

247. ECHO is to facilitate technical workshops for the following topics: 1) from IDP/returnee project to projects that target the affected area; 2) income generation in return areas; 3) social infrastructure (WatSan, schools, health centres, roads); 4) return campaigns; 5) return kits.
248. Seeds for the most popular vegetable varieties are only to be included where irrigation facilities are available in return areas. Mosaic virus resistant manioc cuttings are to be included, where appropriate. A network of demonstration and contact gardens is to be installed in main returnee areas, drawing on experience with nutrition centre demo/contact gardens.
249. Water and sanitation projects in IDP camps should use technologies that can be replicated upon return. WatSan projects should therefore explicitly contain an objective such as 'IDP know WatSan techniques and technologies and are trained to apply them after their return home with no or limited external support'.
250. A cash amount is to be allocated per school, depending on student and teacher numbers. Agreements are to be made with teacher-parent associations on how to best use this amount to promote education - as opposed to building a school.
251. Support to returnees and most vulnerable neighbours should leave the biggest possible choice to beneficiaries. This can be achieved through seed and tool fairs, offering a choice of tools for agriculture and other economic activities (see B.2.4.3.).

Lessons learned

252. IDP support below the acceptable humanitarian minimum level will make IDPs more likely to stay away from home longer: they will simply be too poor to risk the move back home.
253. In IDP/returnee situations, it is most appropriate to adopt the 'affected area approach', with vulnerability as the main inclusion criterion.
254. Promoting return must be based on sound knowledge in order to result in substantial return support. Half-measures are liable to remain without effect. Besides incentives, the timing can be decisive for the success of return campaigns.
255. The construction of a school building may not be sufficient to revitalise education. Parents and teachers need to be consulted to find the best individual solution per school, per village, per area.

B.2.6. TECHNICAL ASSISTANCE

256. ECHO has increased the number of positions for technical assistants (T/A) from only one position in 2001 to currently almost four (one position is shared with the region). Partners generally appreciated the close contact this allows, being able, for instance, to signal difficulties in implementation early on. In many instances, modalities of implementation were negotiated in a way that a satisfactory compromise for both ECHO and partner was reached between initially different positions. Almost all partners appreciated the role, accessibility and qualification of ECHO's T/As, given their long-standing experience in the DRC ("ECHO is certainly the most knowledgeable donor in the DRC"). By default, T/As are generalists and therefore limited in their specialised technical competence. Many decisions taken, however, are of extremely technical nature: MoH officials frequently reported, for instance, that partners justified decisions taken with "ECHO has decided this" (however, as pointed out by ECHO, this may originate from the role often played by ECHO to alleviate intense pressure put on partners by local authorities). Some grievances were therefore voiced about ECHO being too 'dirigiste' or not flexible enough for new and untried approaches⁴⁹.
257. ECHO's technical experts (health, nutrition, watsan) are based in Nairobi and have to cover all Western and Eastern African countries where ECHO is present.. Due to heavy workloads, visits from the specialised T/As can not be regular enough. T/As in RDC therefore have to rely on technical competence of partners or (UN) lead agencies; for health, however, there is no such lead agency. ECHO should still reinforce its new staffing policy of affecting specialised technical experts to regional and if possible national-based offices.
258. Lastly, all partners working in areas where ECHO flight operates were full of praise for its services.

Conclusion

259. ECHO T/As are more than donor representatives; they exercise a strong influence on project design and project implementation. However well qualified - and appreciated - they are, their specialised technical knowledge, as generalist, is limited. In cases where there is neither a technically strong partner nor a UN lead agency, a deficit in expertise is revealed.
260. ECHO flight operations were extremely appreciated.

Recommendation

261. Where there is an expertise deficit, ECHO should enhance its role as facilitator of a participatory development of modules in humanitarian aid by partners and (UN) lead agencies. This can be done by funding technical expertise and facilitating participatory technical workshops and should lead to harmonise project designs, approaches and standards.
262. Whenever feasible, ECHO to reinforce specialised expertise through regional and/or national specialised T/As.

Lesson learned

263. ECHO continues to occupy a peculiar middle ground between an old-fashioned donor who writes checks in Metropolis and a humanitarian agent with full-fledged operational and technical influence. The latter role requires approaches to replace missing specialised technical competence.

⁴⁹ On the other hand, one or the other T/A complains about lack of innovation coming from partners...